Health for All Now!
People's Health Movement

PHM Policy Brief - WHA78 – 19-27 May 2025

While still recovering from the lingering impacts of the COVID-19 pandemic, the world is being shaped by climate change, ongoing conflict and war, deepening health emergencies, severe health workforce strain, increased privatization of healthcare systems and inequalities in accessing medications. In this time of multiple intersecting and sustained crises, WHO's stability has been challenged by the financial and political shifts due to the withdrawal of the USA. Despite this, WHO remains central to coordinating global health responses and upholding the right to health. We encourage Member States to engage with renewed political will to ensure WHO can fulfill its mandate in this rapidly evolving landscape.

Based on this context, we invite Member States to give close attention to the following agenda items.

The People's Health Movement (PHM) is a global network that brings together health activists, civil society organizations, and academic institutions from around the world, particularly from low- and middle-income countries (LMICs). We are currently active in nearly 70 countries. Guided by the People's Charter for Health (PCH), PHM works on various programs and activities and is committed to providing comprehensive primary health care and addressing the social, environmental, and economic determinants of health.

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Agenda Item 13.1

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

Background

In 2018, the UN General Assembly adopted the Political Declaration of the 3rd high-level meeting of the GA on the prevention and control of non-communicable diseases. Non-communicable diseases (NCDs) were included in the 2030 Agenda for Sustainable Development. There is currently a preparatory process for the 4th High-level Meeting of the UN General Assembly on the prevention and control of NCDs and the promotion of mental health and wellbeing. This meeting will take place in 2025, later this year.

The WHO has identified 8 pillars of work towards this year's high-level meeting: primary health care as a scalable solution to NCDs; access to essential medicines and health technologies; sustainable financing of NCDs and mental health; mental health and NCDs having a shared but differentiated agenda; multisectoral governance and action; addressing air pollution; addressing commercial determinants of health; and NCDs and mental health in emergencies.

Current issue

Progress towards SDG target 3.4 related to NCDs is off track and health systems need to be reoriented towards primary health care with a focus on NCDs and mental health. The way NCDs continue to be addressed shies away from issues such as the political economy of health and social determinants of health. Root causes behind the increasing prevalence of NCDs and mental health issues need to be examined. Short-sighted neoliberal economic policies and aggressive capitalist market dynamics have direct effects on NCDs in both developed and developing countries. Governments' economic decisions have impoverishing effects on their people. Economic hardship reduces the quality of food, lowers the standard of living and quality of health, and certainly mental health.

PHM position

Addressing NCDs goes beyond action within the health sector at national level, because of its transborder root causes. Neoliberal economic policies and corporations strongly contribute to the rise of NCDs in developed and developing countries. Governments and corporations need to be held accountable for their decisions and practices.

Call to Action

- Impoverishing policies adopted by Member States need to be examined in light of their impact on NCDs.
- Private sector practices need to be more strongly regulated by governments so that populations' health is protected. This includes controls over production, marketing and advertising of their products, particularly food, confectionary, and tobacco related products. This needs to be reflected in stronger and binding language of the future political declaration of the 4th High-level Meeting of the UN General Assembly on the prevention and control of NCDs and the promotion of mental health and wellbeing.

Agenda Item 13.2

Mental health and social connection

Background

The Executive Board presented a report on mental health and social connection (EB156/8), and requested a dedicated report on mental health to be presented separately from consolidated reporting on noncommunicable diseases (NCDs) in EB156/18. Both documents indicate an increased awareness of mental health issues globally.

The report on mental health and social connection reflects a focus on the importance of relationships in improving mental health of individuals and communities. According to the report, nearly one in four older adults experience social isolation across all regions and at least one in six adolescents are socially isolated or lonely. Statistics provided in the report are alarming. Social isolation and loneliness pose significant risks to mental health, according to the report, including a 14–32% higher risk of mortality, comparable to other risk factors like smoking and obesity; 32% increase in the risk of stroke and 29% for cardiovascular disease; and a contribution of 5% to the risk of dementia. There are other more social effects on education, employment and workplace productivity.

The WHO Commission on Social Connection (2024-2026) will propose a global agenda on social connection.

PHM position

The report identifies social connection as an entry point to address mental health in its broader sense, hence adopting a social non-medicalised approach to mental health.

There is a need to examine social isolation from a broader perspective and identify its root causes, so that addressing it is not merely symptomatic relief of persistent problems.

Our world is suffering increasing levels of loneliness and social isolation, particularly among younger people whose lives are increasingly virtual and digitalised, with less mobility and social interaction. Newer forms of peer pressures on social media, in a challenging global political and economic context, all contribute to individuals' sense of isolation.

Mental health has got its political perspective as well, within countries and across borders, particularly in relation to people's movement. Within countries, gentrification and urbanisation in the name of development leads to the fragmentation of socially cohesive communities.

Currently, economic hardship, political instability and conflicts around the world are causing waves of migration across regions, creating whole socially 'disconnected' populations in affected regions. Border measures set to control such movement are themselves causes of mental health problems among migrants, such as anxiety, depression, post-traumatic stress disorder (PTSD) following family separation and detention, for example. Needless to say, women and children are among the most vulnerable groups at risk of trafficking and exploitation.

Call to Action

- Mental health and social connection need to be examined in light of the current conflicts, waves of migration, sociopolitical changes, and economic crises around the world.

- In the context of migration, mental health is the first to be hard-hit. WHO needs to see mental health interventions as essential humanitarian responses, similar to food, shelter and medicine, and to institutionalise such responses, particularly for women, children and adolescents. This links to last year's resolution WHA77.3 on "Strengthening mental health and psychosocial support before, during and after armed conflicts, natural and human-caused disasters and health and other emergencies", and to the WHO global action plan on promoting the health of refugees and migrants, 2019–2030.
- There is a need to link mental health and social connection to peace processes around the world. Calling for peace is at the heart of the WHO mandate.
- The WHO Commission on Social Connection (2024-2026) will propose a global agenda on social connection. This agenda needs to respond to the social reality in our world today, look into the influence of political and economic changes on people's lives and develop bold lines of action.

Agenda Item 13.5

Substandard and falsified medical products

Background

Low- and middle-income countries spend an estimated $30.5 billion on substandard and falsified medicines, accounting for 10.5% of medicines samples in the supply chain in these countries. The WHO Member State Mechanism on Substandard and Falsified Medical Products (MSM) was created in 2012 as a global forum at which Member States convene, coordinate, decide and organize activities to address substandard and falsified medical products. It is a voluntary body open to all Member States' National Medicine Regulatory Authorities and ministries of health. The objectives of the MSM include identifying major needs and challenges, making policy recommendations and developing tools in the areas of prevention, detection methodologies, and control; and strengthening national and regional capacities in order to ensure the integrity of the supply chain.

Current issue

An independent evaluation of the MSM was commissioned to an external evaluator (HealthGen Evaluation and Research Consulting) and an evaluation report was released in October 2024.

The evaluation exercise assessed progress made by the MSM in achieving its objectives since the 2017 and made recommendations to inform its future strategic direction and ways of working by examining the criteria of relevance, effectiveness, efficiency, coherence, sustainability and equity.

The report's most important recommendation relates to revising the format of the MSM so it can benefit from more technical expertise. The recommendation proposes 2 options: Option A) dissolution of the MSM and the establishment of a new format that would report directly to the WHO DG; and Option B) use the existing MSM with increased involvement of technical experts and engagement of external stakeholders.

PHM position

PHM supports the dissolution of the MSM. Addressing substandard and falsified medical products need not be through a standalone mechanism within the WHO – it is work that has to be mainstreamed building on expertise, while investing in Member States' regulatory capacity at national level. Resource constraints, as outlined in the report, comprises a threat to the sustainability of the mechanism. Hence, it is also more cost effective to dissolve the MSM while keeping its mandate running through the Secretariat regular activities.

It is important to keep in mind that neither the WHO nor the MSM have the legal mandate to enforce penalties against producers and distributors of SF medicines. They can, however, issue alerts and provide technical assistance, but law enforcement falls under the jurisdiction of national authorities, hence the need to invest in national regulatory capacity.

Agenda Item 13.7

Health and care workforce

Relevant Documents

EB156 (14): WHO Global Code of Practice on the International Recruitment of Health Personnel
EB156(15): Global strategy on human resources for health: workforce 2030

Background

The 'crisis in human resources' in the health sector has been described as one of the most pressing global health issues of our time. The WHO estimates that the world faces a global shortage of almost 4.3 million doctors, midwives, nurses, and other healthcare professionals. The fourth round of reporting on the WHO Code of Practice on the International Recruitment of Health Personnel indicates that approximately 15% of health and care workers globally are working outside their country of birth. Ten high-income countries currently host 23% of the global stock of doctors, nurses, and midwives, while the entire African region holds only 4%.

A global shortage of healthcare professionals is unfolding in the context of globalization and market liberalization facilitating the migration of health workers to higher-income nations, intensifying the brain drain in low- and middle-income countries and further depleting their already limited health workforce.

PHM's Position and concerns

We recognize that the Workforce 2030 report and the WHO Global Code of Practice remain vital in the context of increasing global health worker mobility, interconnected health systems, and evolving health threats. Their continued relevance depends on stronger uptake by Member States in the post-COVID-19 era. The Code has played an important role in raising awareness, improving health workforce data, documenting bilateral agreements, and encouraging ethical recruitment practices across stakeholders. However, to maximize its impact, it must evolve to include care workers, strengthen regulation of private recruitment agencies, and reinforce efforts to build sustainable, equitable health systems—especially in low- and middle-income countries.

PHM is concerned about the WHO's current approach to the implementation and monitoring of *the* Workforce 2030, and Global Code of Practice on the International Recruitment of Health Personnel, as notable equity gaps still persist. While Member State reporting demonstrates broad awareness of the challenges associated with health worker migration, including the geographic maldistribution and workforce sustainability, there remains a lack of accountability mechanisms and enforcement. The absence of comprehensive, disaggregated data on bilateral agreements - quantitative data is available for fewer than 40 out of 94 reported agreements - undermines transparency and the ability to track the real-time impacts on source countries. The WHO must ensure Member States adhere to WHA63.16, which calls for the development of sustainable health systems and retention strategies, especially in low- and middle-income countries (LMICs), where aggressive recruitment by high-income countries (HICs) is exacerbating workforce shortages that are predominantly driven by marketisation of healthcare workforce.

The voluntary nature of reporting under the WHO Code limits accountability and action. Member States should move toward mandatory global audits on health worker migration and its impact on source countries, and prioritize protections for workers in fragile and conflict-affected settings. High-income countries should be held to binding commitments that ensure ethical recruitment and reinvestment in health systems of source nations. This would help curb exploitative practices and promote global workforce sustainability. The Workforce 2030 reporting should also expand beyond data collection to assess the lived realities of health workers, particularly in fragile states. WHO Member States, should offer technical and financial support for laws promoting fair pay, safe conditions, and labor rights. Safe, dignified working environments must be seen as fundamental to justice and sustainability. WHO should also require Member States to report disaggregated, qualitative data tied to measurable workforce well-being and retention outcomes.

Call to Action

- We call on all Member states to actively support the strengthened implementation of the WHO Code of Practice. Member States should take steps to reinforce its principles to better protect migrant health and care workers, and to uphold health systems, particularly in the Global South. This includes advocating for ethical recruitment practices and adopting policies that prioritize health equity and workforce sustainability over profit-driven motives.
- We urge Member states to recognize and elevate the central role of the health and care workforce in advancing the right to health, with particular emphasis on the rights of migrant health workers. Migrant health and care workers must be treated with dignity, equality, and fairness - ensuring they receive the same protections and entitlements as local workers.
- We c all for health workforce governance grounded in sustainability, equity, and justice— not capitalist, extractive models that commodify health workers and prioritize profit over public health needs.
- We call on Member States to embrace progressive financial reforms for the LMICs, including cancelling sovereign debts – which would free up critical fiscal space for investment in health systems - particularly in the recruitment, training, and retention of health workers;

Agenda Item 13.8

Draft global traditional medicine strategy 2025–2034

Relevant Documents

WHA78/4; WHA78/4 Add.1; EB156/2025/REC/1**;** Decision EB156(28)**;** EB156/16
World Health Organization. Draft traditional medicine strategy: 2025-2034: universal access to safe, effective and people-centred traditional, complementary and integrative medicine for health and well-being. Geneva: WHO; 2024 Apr 10.

Background

The WHO's draft Traditional Medicine Strategy (2025-2034) represents an important but flawed attempt to bring traditional and Indigenous healing systems into global health policy. While the extension of this work through decision WHA76(20) demonstrates growing recognition of traditional medicine's value, the current draft remains trapped in colonial paradigms that privilege modernist medical science frameworks over Indigenous ways of knowing. By centering "evidence-based" approaches as the primary validation method, the strategy inadvertently continues the historical pattern of dismissing Indigenous knowledge systems that don't conform to Cartesian rationality. The draft's uncritical endorsement of the One Health approach is particularly concerning, as this framework is increasingly being co-opted to suggest that sustainability and biodiversity protection can be reconciled with growth-obsessed capitalism. A dangerous fallacy that ignores how capitalist expansion itself drives the ecological crises threatening traditional medicine systems. More troubling still is the Draft Strategy's failure to address how ongoing extractivism, land dispossession, and climate injustice fundamentally threaten both Indigenous health sovereignty and the very ecosystems that sustain traditional healing practices. The proposal's treatment of "integration" risks reducing centuries-old healing traditions to subordinate components of allopathic systems, while its inadequate intellectual property protections leave Indigenous knowledge vulnerable to biopiracy under TRIPS .

What is missing is the genuine respect for Indigenous self-determination; the understanding that traditional medicine cannot be separated from land, spirituality, and cultural context. For this strategy to fulfil its promise of "health for all", it must undergo fundamental revision to center Indigenous leadership, protect collective knowledge rights, and acknowledge how health justice is inextricably linked to environmental and decolonial justice. The WHO and Member States have an opportunity to model true epistemic pluralism in global health, but only if it addresses these critical gaps before the strategy's adoption.

PHM Position

1. Acknowledging the roots and organization of traditional knowledge and its communication with populations is essential in building the scientific evidence base . Validation of traditional knowledge through Western norms and modernity risks stripping indigenous knowledge and practices from their cultural context, including their spirituality. Hence, the report needs to **integrate "Land justice" and "measures against extractivism"** to highlight the interdependence of health and ecosystems. We recommend shifting language to reflect its **broader meaning and lived practices of Indigenous communities.** And explore **alternative forms of** evidence beyond Western scientific frameworks.

2. COVID-19 unveiled the weaknesses of the health systems all over the world and showed that privatization and commercialization, which prioritize profit over public health, have worsened health outcomes. Big pharma's focus on lucrative research rather than public health needs further deepens inequities. A transformative strategy must confront the legacies of **colonization** and **monocultural health systems** that marginalize Indigenous and traditional healing practices. A decolonising strategy should demand transparent and equitable access to collectively owned knowledge, now threatened by corporate privatization under profit-driven and militarized models. **Building national manufacturing capacity** through **publicly owned pharmaceutical production**, with **Indigenous communities empowered to shape policies governing their knowledge**, could safeguard TCIM from harmful and profit-driven motives.
3. A truly **"knowledge-based policy"** must embrace a **holistic perspective**, an allopathic-dominated notion of **"full integration"**. We emphasize **mutual learning** between health systems, and modern medical science stands to learn much from traditional cultures of health and healing. The enduring presence of these healing practices in the modern era proves that **balanced lifestyle interventions, spiritual values, and sustainable relationships of human society and nature** cannot be reduced to a superficial integration of Traditional Complementary Integrative Medicine (TCIM) into biomedical health systems.
4. TCIM and modern medicine must coexist as complementary forces in public health promotion. Historically, Indigenous and traditional healers have met primary healthcare needs, including maternal and child care, especially in underserved rural areas. However, rigid registration systems risk excluding them rather than leveraging their vital contributions to community health. **Support for traditional healers in registration systems and formal mechanisms to connect knowledge systems** are essential. We urge policies that respect Indigenous sovereignty and TCIM's ties to nature and lifestyles, as well as recognize autonomous healthcare choices. The current draft ignores these connections and intersecting crises (conflict, migration, climate change) that disproportionately affect these communities. A meaningful policy framework must address these gaps to ensure health strategies are both culturally grounded and crisis-responsive. **Member states need to protect Indigenous knowledge from extraction and need to ensure ethical governance and benefit sharing.**
5. Centuries-long survival of Indigenous communities stands as the strongest evidence of TCIM's effectiveness, achieved without advanced technologies or diagnostics. **The aggregation of data on TCIM must be handled with respect and protected from knowledge theft.** We are cautious about integrating AI tools to mine data on the invaluable knowledge of the indigenous communities that risks commodification under capitalist-allopathic frameworks. We reject multistakeholder approaches that dilute WHO's "Health for All" through engagement with stakeholders that have conflicts of interest, and highlight **WHA53.10's mandate for** MS **to preserve Indigenous healing knowledge and ensure communities retain its benefits.** While the draft strategy acknowledges the need for collective efforts by the WHO, WIPO, and WTO on Agenda 13.8, corporate-driven trade agreements such as TRIPS remain a hindrance to equitable access to publicly funded health products. We welcome calls for MS to align with CBD, Kunming-Montreal GBF, and UNDRIP, which are critical frameworks for protecting traditional knowledge, Indigenous rights, territorial sovereignty, and biodiversity conservation. We call on WTO Member States to remove must release the TCIM products from the TRIPS agreement.

6. he draft must **explicitly prioritize CBD, Kunming-Montreal GBF, Nagoya protocol, and UNDRIP over WTO/TRIPS rules where conflicts arise**. Only by addressing the root causes of health inequities, including corporate power and polycrisis, can the draft earn our cautious support.

Call to Action

- Recognition of the importance of Indigenous land rights and sacred traditions while linking health policies to anti-extractivism and climate justice.
- Maximize the benefits of TCIM while ensuring Indigenous and local communities lead policies, research, and benefits, not passive participation.
- Build TCIM evidence while protecting Indigenous knowledge from marginalization by Western biomedical frameworks.
- Ensure quality and safety of and TCIM through appropriate regulatory mechanisms.
- Recognize and incorporate TCIM within primary health care systems to advance UHC while respecting and preserving indigenous healing traditions.

Agenda Item 16.1

Strengthening the global architecture for health emergency prevention, preparedness, response and resilience

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Relevant Documents

Document A78/9

Background

WHO document A78/9 reviews the implementation of the Health Emergency Prevention, Preparedness, Response and Resilience (HEPR) framework. While the report presents operational progress across surveillance, countermeasures, and emergency coordination, it reproduces the failings of a technocratic, market-oriented model of global health governance. **This brief evaluates A78/9 through a Public Pharma lens**, as defined by the People's Health Movement (PHM) , advocating for a paradigm shift toward **health sovereignty, public ownership, and the decommodification of health technologies.** A78/9 represents progress in operational capacities but fails to challenge the economic and political roots of pharmaceutical injustice. Public Pharma offers a transformative alternative centered on justice, equity, and health sovereignty. WHO must realign its pandemic preparedness strategy to serve public, not corporate, interests.

What are the issues?

1. **Privatized infrastructure over public ownership** - A78/9 lacks any call for state-owned pharmaceutical infrastructure. References to regional manufacturing and the WHO BioHub system avoid questions of ownership, access, or transparency. Without a move toward Public Pharma, the HEPR framework reinforces corporate monopolies over life-saving technologies.
2. **Bio-surveillance replaces true prevention** - The document's emphasis on biosurveillance platforms (e.g., EIOS, GISRS) overshadows the ecological and socioeconomic roots of pandemics. This reflects a biomedical, market-friendly model that excludes prevention strategies based on planetary health, agroecology, and community medicine.
3. **False equity and conditional access** - A78/9 describes mpox vaccine donations and data-sharing as equitable responses but lacks structural guarantees for Global South autonomy in pharmaceutical production. Equity rhetoric in A78/9 masks the absence of binding benefit-sharing, technology transfer, or IP reform. Vaccine and diagnostic allocation remains donor-dependent, without democratic governance. It also does not acknowledge failures of COVAX during the COVID pandemic.
4. **No role for civil society or communities** - A78/9 mentions community platforms but avoids real democratic engagement. There are no mechanisms for community-led governance, nor any recognition of civil society's watchdog role. This undermines trust and accountability.
5. **Voluntary, market-driven financing** - The report celebrates the Pandemic Fund and Impact Investment Platform - both donor-dependent and aligned with market principles. There is no strategy for publicly controlled, progressive, redistributive financing to sustain HEPR systems.

Call to Action

PHM calls on Member States to:

- Commit to **building, protecting and expanding Public Pharma institutions** in each region with public ownership and democratic governance.
- **Integrate pandemic prevention** into agroecological, environmental, and public health systems, not just surveillance.
- Ensure binding provisions for **IP waivers, open-source R&D, and mandatory tech transfer** during emergencies.
- Create **binding channels for civil society and community co-governance** in HEPR mechanisms.
- **Replace donor logic with public financing** linked to the right to health and fiscal justice.

For more information: www.publicpharmaforeurope.org

Agenda Item 16.2

Intergovernmental Negotiating Body to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response

Relevant Documents

Document A78/10

Document 78/19. Add1

Background

The INB process was launched with the aim of creating a new legal instrument with "comprehensive and coherent approach" for governing future pandemics. The "World Together" decision specified that the new instrument should "prioritize the need for equity" and stressed that Member States "should guide their efforts to develop such an instrument by the principle of solidarity with all people and countries, that should frame practical actions to deal with both causes and consequences of pandemics and other health emergencies."

The first INB meeting (INB1) was held in February 2022, and the 13th INB meeting concluded its work on 15 April 2025. A draft annotated outline of a WHO convention, agreement or other international legal instrument on pandemic prevention, preparedness and response (PPPR) was published in June 2022, and a working draft released in July 2022. A Zero Draft CA+ of the proposed text was published in February 2023, and was based on a Conceptual Zero Draft published in December 2022. However, the Draft Negotiating Text of the accord was only released to Member States in March 2024, meaning that text-based negotiations only commenced at the 9th meeting of the INB, using the Revised Draft of the Negotiating Text released at the start of that meeting.

On 16 April 2025 the INB Bureau released the "greened" onscreen text that Member States had agreed upon during the 13th meeting of the INB. This text is expected to be adopted at WHA78. As the Draft Resolution on the Pandemic Accord, is to be submitted for consideration of Member States at WHA78, modalities are mostly proposed for an Intergovernmental Working Group (IGWG) which will be established to negotiate an Annex to the Pandemic Accord on a Pathogen Access and Benefit Sharing (PABS) instrument.

Action Points

We welcome affirmation of the parties' "**right to use, to the full,** the TRIPS Agreement and the **Doha Declaration on the TRIPS Agreement and Public Health of 2001, which provide flexibility** to protect public health including in future pandemics" (Article 11(4)).

  - In this regard, we urge Member States to domesticate TRIPS flexibilities as a matter of urgency as well as use them promptly and timely to address concerns relating to equitable access. It is the responsibility of the States that rights and instruments accorded internationally are used appropriately domestically to protect people's lives.

- Encouraging state parties to "promot[e] access to safe and effective products that result from [clinical] trials for such trial populations **and for populations at risk in their communities**" (Article 9(3)) and to develop and implement national or regional policies that

could facilitate **timely and equitable access to pandemic-related products that are developed using public funding** (Article 9(5)).

- We urge Member Sates to concretise their commitment to this Article by developing national legislation to ensure national public institutions (e.g. Universities and public research agencies) adopt regulations that ensure post-trial access and benefit sharing conditions are included in all clinical trials protocols prior to trials commencing.

- Encouraging parties to "**take measures, to provide support, and/or strengthen existing or newly created production facilities of relevant health products, at national and regional levels, particularly in developing countries**, with a view to promoting the sustainability of such geographically diversified production facilities" as appropriately."
  - We urge Member States to call on WHO to assist them in this endeavour by requesting WHO to develop an evidence base detailing historical and contemporary case studies and best-practices on Public Pharma initiatives, so as to support and advance Member States' efforts to invest in Public Pharma in line with the work presented by the WHO Council on the Economics of Health for All, the Social Determinants of Health Equity Report (2025), and the Pandemic Agreement.
  - Public Pharma refers to a state-owned infrastructure dedicated to researching, developing, manufacturing, and distributing pharmaceutical products or other health technologies. It encompasses all institutional arrangements in which the state has genuine decision-making power and can establish governance driven by public health needs. It does not include, for example, Public-Private Partnerships (PPPs) or any other arrangement where the state uses public resources to de-risk private enterprises.

- Committing to negotiating a Pathogen Access and Benefit Sharing mechanism, as an annex to this Agreement, that places pathogen sharing and benefits resulting from this on an equal footing.
  - The PABS instrument should not uncouple access to pathogens and sequence information from benefit sharing measures. We urge the IGWG tasked with negotiating the annex to create a mechanism that honours the Right to Enjoy the Benefits of Scientific Progress, recognised in the Universal Declaration of Human Rights (UDHR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR).
  - We call upon all Member States to ensure health products, such as vaccines, therapeutics, and diagnostics developed using shared pathogens and sequences are shared expeditiously with countries and communities affected by disease outbreaks through WHO. Priority access to affected countries not only during pandemic stage but also during PHEIC as well as immediately after outbreaks must remain a key benefit.
  - We call on all Member States to ensure that contributions from non-state actors, including technical experts, honours the spirit of the Resolution on Social Participation for Universal Health Coverage, Health and Well-being (WHA77.2) which notes the "need to prevent, manage and mitigate conflicts of interest to uphold the **integrity of social participation through legitimate representation and ensure that private and personal interests do not override public health goals**" (emphasis added).

Agenda Item 17.1

WHO's work in health emergencies

Relevant Documents

Documents A78/13
EB156/2025/REC/1, decision EB156(31)

Background

Multiple crises have pushed the WHO into an overwhelming state, exacerbated by shrinking funding and ongoing threats of defunding. In the face of escalating global crises - including armed conflict, disease outbreaks, and climate change - WHO's role in health emergency response has become increasingly vital. Over the past year, WHO addressed 51 emergencies across 89 countries, including 21 high-level Grade 3 events that required maximum support. These emergencies included Mpox and Ebola outbreaks in Africa and conflict-related crises in Gaza, Sudan, and Ukraine. Despite a $478 million funding shortfall and challenges like limited surveillance and vaccine production, WHO supported health responses for 89.4 million people in need, partnering with over 900 organizations across 30 health clusters.

Reports EB156/18 and A78.13 highlight these efforts and track global trends, outlining WHO's leadership in emergency response under the International Health Regulations. importantly, the reports emphasize the Surveillance System for Attacks on Health Care and call for stronger protections in fragile humanitarian settings. Despite global funding cuts and rising humanitarian needs - approaching 300 million people in 2024 - WHO maintained a strong country-level focus, allocating over 90% of its Health Emergencies Programme budget to frontline operations and launching new investment strategies for 2025–2028.

PHM Position

PHM acknowledges that **war, conflicts, and relentless militarization** are fueling global health emergencies , undermining equity, dismantling life-protecting systems, and further weakening the global capacity to respond effectively to the health needs of all. The increasing frequency of attacks on health care facilities and workers in crisis settings further exacerbates these challenges, leading to unnecessary suffering and prolonged health disparities

PHM is further concerned about the **aggressive commercialization of health**, driven by profit-focused big pharma giants. This has led to medicine hoarding and vaccine apartheid as seen during COVID-19, leaving countries like Uganda waiting months for access. Corporate control in pharmaceutical industry is exacerbating inequality and weakening global emergency responses.

PHM additionally, expresses significant concern over WHO's ability to effectively respond to the growing scale and complexity of global health emergencies due to threats of **Member States' withdrawal from the WHO and geopolitical constraints**. Although WHO has maintained important global leadership in addressing emergencies like cholera, dengue, and mpox, its efforts are often constrained by delayed funding, fragmented coordination at regional and national levels, and the growing complexity of overlapping crises, suggesting the need for a more agile, better-resourced, and politically insulated emergency response system.

PHM observes that **gender oppression** is deeply connected to other forms of systemic oppression, and their intersection further undermines wellbeing and access to healthcare. Health emergencies including conflicts expose how overlapping oppressions intensify gender inequalities: access to healthcare, particularly reproductive services, became even more limited for marginalized women and sexually and gender diverse individuals in many countries.

Call to Action

- Member states should **increase predictable, flexible, and sustainable funding for WHO's Health Emergencies Programme** and related contingency mechanisms, ensuring that WHO can respond rapidly, independently and effectively, without be restrained by earmarked donor contributions. This includes committing to the **WHO investment round (2025–2028)** and replenishing emergency funds like the Contingency Fund for Emergencies.

- Member states should work collectively to **protect WHO's technical neutrality by minimizing political interference**, ensuring that emergency declarations and response operations are driven by science and health needs, not geopolitical agendas. Reinforcing global solidarity and adherence to the International Health Regulations commitments will be essential to support a more agile, coordinated, and effective WHO-led emergency response system.

- **Global health governance must be decolonized and democratized**, prioritizing the voices of affected communities and frontline health workers over corporate and geopolitical interests.

- Governments must **desist from militarization and war economies** and instead **invest in peace-building.**

- We urge Member States to **invest in public pharmaceutical production** to break the monopoly of capitalistic profit-driven pharma giants and guarantee universal access to essential medicines and vaccines, regardless of borders, ensuring that health interventions are driven by human rights and social justice principles.

- Member states should make efforts to **strengthen national health systems** and **enhance local capacities, including surveillance and early warning systems, infrastructure, and health workforce training**, particularly among high-risk populations, fragile and conflict-affected areas.

- **Strengthening gender-responsive and equity-focused action** across all levels of health emergency response must be prioritized, with particular attention to **safeguarding sexual and reproductive health services for marginalized women and sexually and gender diverse individuals**. An intersectional approach is needed to addresses how gender oppression intersects with other forms of systemic inequality to undermine health and wellbeing.

Agenda Items 17.3 and 20

17.3 Health conditions in the occupied Palestinian Territory, including East Jerusalem

20 Health conditions in the occupied Palestinian Territory, including East Jerusalem, and in the occupied Syrian Golan

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Documents

EB156/20
A78/16

Background

Since 1968—shortly after the Six-Day War and the subsequent displacement of hundreds of thousands of Palestinians (the Nakba)—the World Health Assembly (WHA) has included a standing agenda item addressing health conditions in the occupied Palestinian territory. This item has long been a source of division among Member States: the majority of the Global South generally supports its inclusion, viewing it as vital, while a smaller group led by the United States and Israel consistently opposes it, arguing that it unfairly targets Israel and politicizes the World Health Organization. Despite this controversy, the item is debated annually, based on a report by the WHO Director-General outlining health-related challenges facing Palestinians. The discussions are typically contentious and culminate in a lengthy vote by Member States, ending in a decision that the Director-General should submit a similar report the following year. At the 77th WHA, as Israel's military operations in Gaza entered their eighth month, Palestinian health conditions were addressed under two separate agenda items (i.e. agenda items 17.3 and 20).

The Secretariat documents describe the health conditions in Palestine, noting increased mortality, impediments to access, and attacks on health infrastructure amidst intensifying military violence. While the report provides critical descriptive evidence, it is a sanitized and technocratic document, insufficiently critical of the underlying structures of colonial violence, apartheid, and occupation that are the central drivers of this health crisis. The report also makes excessive use of the passive voice, failing to explicitly identify the Israeli government that is supported by Western governments as the perpetrator of the humanitarian devastation and public health nightmare unfolding before our eyes in Palestine.

Main Problems

For the past 19 months, and as recognised on record by several UN Special Rapporteurs including the Special Rapporteur for Palestine, the Palestinian people in Gaza have been subjected to genocide, mass displacement, and engineered famine by Israeli occupying forces. Over 52,000 Palestinians have been killed, many more remain buried under rubble, and 92% of Gaza's buildings have been destroyed. Since March 2025, no food, water, fuel, or humanitarian aid has been allowed to enter Gaza. The healthcare system has been deliberately dismantled, with only 61% of hospitals partially functioning, over 1,000 attacks on health facilities, the murder of 1,400 health workers, and the complete breakdown of access to clean water, anesthesia, and basic medical supplies (OCHA oPT). To safeguard Palestinian health, it is essential to address these underlying structural and political determinants of health:

1. **Devastation of the Palestinian health system**

   The destruction of health infrastructure, obstruction of medical supplies, and criminalization of healthcare workers are not collateral damages, they are violations of international humanitarian law. The Israeli military's targeting of hospitals and ambulances is a form of collective punishment. A78/25 does not adequately situate these acts as part of a state policy that weaponizes health against a besieged population.

2. **Deliberate starvation as a weapon of war**

   As of May 2025, the Israeli Occupying Force has prevented any food from entering Gaza for over two months, triggering a fully man-made famine. The deliberate obstruction of food, medicine, and fuel constitutes collective punishment and a grave breach of international law (OHCHR, Special Rapporteur on the right to food). This should be explicitly mentioned in the Secretariat documents.

3. **Structural determinants ignored: Settler colonialism, occupation and apartheid**

   WHO fails to name or analyze the occupation as a system of settler colonialism and apartheid while the ICJ advidory opinion classified Israel as an apartheid state. This omission reflects a broader tendency in global health to pathologize crises without naming the political economy that sustains them. The WHO report maintains a neutral tone that avoids naming perpetrators or demanding accountability. WHO's avoidance of naming Israeli actions as violations of IHL undermines its credibility and moral authority. The blockade and occupation of Gaza, forced displacement, land seizures, and movement restrictions constitute an intentional policy infrastructure of domination. Health cannot be restored without dismantling this system**.**

4. **Health Apartheid and Differential Value of Lives**

   The unequal value placed on Palestinian lives is embedded in the political response to the ongoing war. Palestinian deaths are often normalized or justified. WHO must challenge this racialized hierarchy of suffering and ensure equal attention and justice for all people under occupation.

Call to Action: Name the horror

PHM urges Member States and WHO to:

1. **Stop arming the Israeli Occupying forces and call for a permanent and immediate Ceasefire**
   - Cease all arms transfers to Israel immediately, as required under the Arms Trade Treaty and customary international humanitarian law when there is a risk of use in atrocity crimes
   - Demand a permanent and unconditional ceasefire to end the genocidal violence, siege, and mass displacement
   - Call for an end to impunity by supporting international investigations into war crimes, including the targeting of civilians and health infrastructure

2. **End the man made famine in Gaza and Immediate Access for Humanitarian Aid**
    - Acknowledge the deliberate denial of food as a violation of international humanitarian law and a war crime. Hold accountable those responsible for the use of starvation as a method of warfare, explicitly prohibited under international law (Rome Statute, Article 8(2)(b)(xxv)).
    - End the famine and demand immediate, unrestricted humanitarian access to all parts of Gaza and the West Bank and the immediate entry of food and medical supplies.
    - Restore and fully fund UNRWA and other agencies essential to food, shelter, medical care, survival, Palestinian refugee status and the right to return.
    - Ensure the Red Cross has access to all Palestinian detainees in Israeli prisons and detention facilities, and release all illegally detained health workers, under the "unlawful combatant" designation which exists outside of international humanitarian law.

3. **End Impunity for Attacks on Health and help rebuild Palestine's Health Systems**
    - Recognize that attacks on health infrastructure are part of a systematic strategy of war and pursue accountability for the attacks on healthcare workers and infrastructure as well as blockade-induced famine.
    - Demand the protection and rebuilding of hospitals, clinics, ambulances, and health workers in accordance with the Geneva Conventions.
    - Ensure the Red Cross has access to all Palestinian detainees in Israeli prisons and detention facilities.
    - Demand full access for WHO to assess the health status and service conditions of Syrian detainees and civilians in the occupied Golan.

4. **Address the Social Determinants of Health**
    - Member State should **f**ulfil their obligations under international law to stop and prevent genocide by upholding UN resolution, ICJ advisory opinions, ICC arrest warrants and sanctioning Israel. This includes a full arms embargo.
    - End the Israeli occupation, blockade, the system of apartheid, and forced displacement.
    - Ensure all rights of the Palestinian people to be upheld: from the right to health, to the right of self determination and the right of return.

Conclusion

The Secretariat reports reveal an overwhelming crisis, but fall short of confronting its systemic, political roots. Health justice demands an end to occupation, decolonization, accountability, and solidarity with people under occupation.