PHM daily briefing of the 78th World Health Assembly Meeting
Days 7 and8 (Monday-Tuesday, May 26 & 27th, 2025)

Report prepared by PHM's WHO Watch team

Committee A (Monday Morning)

The morning of the penultimate day of the assembly started with the adoption of the draft 6th report which contained six resolutions

- Strengthening national capacities in evidence-based decision making for the uptake and impact of norms and standards
- Rare diseases: a global health priority for equity and inclusion
- Strengthening health financing globally
- Strengthening medical imaging capacity
- Accelerating the eradication of dracunculiasis
- Skin diseases as a global public health priority

Committee A considered items 13.5 (Substandard and falsified medical products), 13.6 (Standardization of medical devices nomenclature), and 13.7 (Health and care workforce).

13.5 Substandard and falsified medical products

Documents A78/4 and EB156/2025/REC/1, decision EB156(25)

The issue of Agenda Item 13.5 substandard and falsified medical products stems from Resolution WHA65.19 (2012), which established the Member State Mechanism on Substandard and Falsified Medicines to improve collaboration among Member States and WHO to prevent and control substandard and falsified medical products from a public health perspective. It is the primary intergovernmental mechanism for member states to convene, make policy recommendations, exchange knowledge, support mutual efforts and coordinate actions to address the challenge of substandard and falsified medical products.

Rwanda (on behalf of Africa), Namibia, Ethiopia, Chad, Kenya, Malawi, Senegal emphasised the **disproportionate burden in Africa**. The region welcomed the work of the mechanism as an important step towards access to safe medicine and welcomed the 5

recommendation from the independent evaluation, stating recommendations 2-4 to be straightforward and to be actioned while recommendation 1 on format and recommendation 5 on external engagement needs further discussion. **India** and **Ethiopia** wanted to opt for option B under recommendation 1, using the existing member state mechanism format. With respect to recommendations 2 to 5, **India** was open to participation and engagement with external stakeholders, including informal meetings. **Australia** specified support for the mechanisms but proposed to defer the decision making on the recommendations until after 2025 giving more time to consider recommendation 1 and 5, while the **Philippines** concurred with the five recommendations underscoring recommendation 1 as the most fundamental.

Colombia, Russia, India, Brazil, Philippines, Thailand, Australia, Ethiopia, Namibia, Senegal, Bahamas, Indonesia welcomed the report and supported the mechanism. **Micronesia, Bangladesh** and **Ethiopia** called country-specific or context-tailored implementation. **Israel** urged for bigger collaboration with private industry like pharmaceutical companies. **Pakistan**, and **Oman** highlighted the difficulty to track online sales of medicines while **Paraguay** emphasized the importance of traceability. **Tanzania, Malaysia, China, Zambia, Egypt, Indonesia** and the **Bahamas** called for improved detection and tracking systems, including early warning and post-market monitoring.

The session closed by noting the report as contained in WHA78/4 and approval of decision EB156/25.

Agenda Item 13.6 on the standardization of medical devices nomenclature

This agenda item refers to the importance of a standardized international classification, coding and nomenclature for medical devices which supports technology assessment, regulation (standard setting, marketing approval), patient safety (adverse event reporting), procurement (discoverability, ordering), and quality of health care (efficacy, cost-effectiveness).

During the discussion on medical device nomenclature, many countries expressed strong support for the global harmonization and standardization of systems. The **Eastern Mediterranean Region** noted that countries in the region use different systems and lack a formal nomenclature format. They urged WHO to promote coordination among countries to strengthen patient safety.

Support for harmonized systems was echoed by countries across all regions. **Tanzania** supported global harmonization and recommended integration of MeDeVis into national systems. **Burkina Faso** highlighted national harmonization efforts and training programs for certification. **Thailand** viewed harmonization as vital due to evolving technologies and urged continued collaboration to ensure patient safety. **Brazil** underscored cooperation between WHO and the

Global Medical Device Nomenclature (GMDN), noting that while registration is required, access is free. **Philippines, Malaysia, Indonesia,** and **Pakistan** expressed strong support for the WHO-led efforts and emphasized the importance of widespread adoption and integration of GMDN codes. The **Bahamas** commended the WHO for its leadership and acknowledged the role of MeDevIS .

Several countries called for WHO technical support and capacity building. **India** requested technical guidance for using MeDevIS. **Bahamas** requested WHO's assistance in national framework implementation. **Niger** noted a lack of expertise in international nomenclature and called on WHO for help. **Cameroon**, also aligning with the **African group**, stressed that resource-limited countries need collective resources and support to enhance international cooperation and interoperability.

Countries also highlighted progress at the regional and national levels. **Saudi Arabia** described its ongoing development of a national nomenclature system and database, and offered to share expertise through its FDA. **Pakistan** fully integrated MeDevIS and GMDN codes into its digital systems. **Malaysia** has adopted GMDN under its Medical Device Act and links the captured data to device tracking systems. **South Korea** is developing its own nomenclature system and emphasized the importance of regular WHO updates. **El Salvador** commended WHO's efforts to improve availability, accessibility, and affordability of devices, and called for standardization to ensure equitable healthcare. **Kenya**, aligning with the African group, stressed the importance of an effective nomenclature system to match technological advancements.

The importance of information sharing, transparency, and open access was emphasized by several Member States. **Russia** acknowledged the value of MeDevIS and called for a balance between national and international requirements, with principles of free access and transparency. **Brazil** and **Bahamas** similarly called for regular updates and open access. Israel recognized WHO's transparency and stakeholder engagement in the development of nomenclature systems and recommended that inclusive participation continue.

Finally, several countries emphasized patient safety as the primary goal of nomenclature harmonization. **Bahrain** linked lack of nomenclature coordination to delays in safety implementation and called for improved digital systems and information sharing. **Panama** reported legal and regulatory improvements to support patients, particularly those with cardiovascular conditions. **China** stressed that medical devices should be used as intended and encouraged further stakeholder engagement to ensure coordination. **Philippines, South Korea** and **Malaysia** also tied nomenclature improvements to enhanced regulatory response and public health outcomes.

Agenda Item 13.7 on health and care workforce

Under Agenda Item 13.7 two documents were deliberated. Firstly the WHO Global Code of Practice on the International Recruitment of Health Personnel was discussed (Documents A78/4 and EB156/2025/REC/1, decision EB156(26)).

The WHO global code of practice facilitates national, regional and global responses on ethical migration of health workers and health systems strengthening and includes provisions for Member States to provide regular reports on its implementation and for the Director-General to maintain the Code as a dynamic text. In February the EB noted the report and in EB156(26) decided to recommend that the Assembly call for regional consultations regarding the interim findings of the Expert Advisory Group and review outcomes at WHA79 through EB158.

The second document is the Global strategy on human resources for health: workforce 2030 (Documents A78/4 and EB156/2025/REC/1, decision EB156(27)). In February the EB noted the report and decided to recommend the Assembly to adopt the draft resolution (in EB156(27)) which is directed to accelerating action on the Global Strategy on human resources for health: workforce 2030.

In the debate, a key divide emerged between **Global South countries**, which emphasized structural injustices and urgent support needs, and **Global North countries**, which largely focused on frameworks, ethics, and technical enhancements. **African and small island states**—including **Ghana (on behalf of 47 AFRO states), Ethiopia, Namibia, Zimbabwe, Barbados, Micronesia, Samoa,** and **Comoros**—voiced consistent concerns about brain drain, underinvestment, and inequity. They called for financial and technical support, with Zimbabwe notably proposing a global health fund to offset the damaging effects of workforce migration.

Colombia struck one of the strongest ethical tones, declaring: *"We call for an end to the genocide in Palestine and to protect health workers we need peace in Palestine,"*reminding the Assembly that health workers should be "treated as workers with rights, rather than commodities." Similarly, **Palestine** described the severe trauma and direct violence facing its health professionals in Gaza, underscoring how political conflict and occupation fundamentally obstruct health service delivery.

In contrast, countries from the **Global North**—such as **Germany, France, Ireland, the UK, Spain, and Poland (on behalf of the EU)**—voiced broad support for ethical recruitment, gender-sensitive approaches, and digital upskilling. Germany, aligning with the EU, acknowledged the North's dependency on foreign health workers, stressing the importance of *"ethical, fair and transparent recruitment."* However, while **Global North** statements often emphasized systems development, digital innovation, and long-term planning, they were less likely to directly address

the power asymmetries or the extractive dynamics of health worker migration highlighted by countries in the Global South. **Barbados**, for instance, bluntly pointed out that LMIC are "*subject to aggressive recruitment from the Global North*," and **Jamaica** urged WHO to advocate more strongly on the migration impact.

The Assembly underscored a consensus on the need to implement the WHO Global Code of Practice and the Global Strategy on Human Resources for Health 2030. Countries like **India**, **Pakistan**, **Sudan**, and the **Philippines** emphasized domestic capacity-building through community health worker training, midwife frameworks, and gender-equal scholarship schemes. Meanwhile, **Costa Rica** and **Guyana** focused on monitoring and regulating bilateral and multilateral recruitment agreements. Several LMICs, including **Bangladesh**, **Lebanon**, and **Malawi**, criticized the lack of enforcement mechanisms in the Code and urged for real-world-aligned data collection and enforceable international solidarity. Despite these challenges, many countries, both North and South, supported the resolution and strategy, reflecting a shared recognition that without decisive, ethical, and redistributive action, the projected 11 million global health worker shortfall by 2030 will continue to undermine universal health coverage.

The session closed with the approval of decision contained in EB156/26 on the interim report of the expert advisory group on the WHO global code of practice and the recruitment of health personnel and the approval of the resolution to accelerate action on the Global strategy on human resources for health: workforce 2030 as contained in EB156/27.

Committee A (Monday Afternoon)

In the afternoon, Committee A took up items 13.8 (Draft global traditional medicine strategy 2025–2034) and 13.9 (Global strategy for Women's, Children's and Adolescents' Health).

13.8 Draft global traditional medicine strategy 2025–2034

With respect to 13.8, the document EB156/16 presents the draft Global Strategy on traditional medicine (2025-34). At the Executive Board, in decision EB156(28), the EB decided to recommend that the 78th World Health Assembly adopt the strategy and request reports to WHA83 and WHA87.

WHA78 revealed key geopolitical dynamics between the **Global South's** push for integration, recognition, and cultural respect, and the **Global North**'s prioritization of safety, regulation, and evidence-based validation. Countries across the African region, led by **Zimbabwe**, emphasized that traditional medicine is an essential component of public healthcare for the majority of populations. **Ethiopia**, **Kenya**, **South Africa**, and **Burkina Faso** reinforced this view,

highlighting their national policies and legislative frameworks aiming to integrate TM into primary health systems. Countries like **Thailand** and **Honduras**, speaking for their respective regions, echoed calls for WHO support in developing context-specific methodologies that protect indigenous knowledge while strengthening scientific validation. **India**, **China**, and **Vietnam** underlined the integration of TM in national insurance and policy systems, asserting it as a key pillar of health equity and community trust.

In contrast, the **EU region** focused on scientific rigor, safety, and regulation, often raising caution over commercial exploitation and potential health risks of unproven traditional remedies. While the EU acknowledged the cultural roots of TM, it stressed that WHO must remain a "*normative voice*" and guard against harmful products disguised as traditional medicine. **Germany**, **France**, and **Japan** supported regulation but emphasized the coexistence of modern and traditional systems, where applicable. The **Netherlands** linked TM with the One Health approach, citing biodiversity and animal health risks—highlighting a shift towards global environmental and safety frameworks. The **Global North'**s emphasis on due diligence, though valid, appeared less attentive to the colonial legacies and epistemic injustice that have historically marginalized traditional practices.

A unifying theme, however, emerged in the calls for equitable benefit-sharing and knowledge exchange, particularly around genetic and biological materials. Countries like **Brazil**, **Mexico**, **Bolivia**, and **Haiti** framed TM not merely as ancestral heritage but as complementary resources to modern systems, requiring legal protections, technical support, and cultural preservation. **South Africa** and **Cuba** stressed the importance of intellectual property rights and local production, while **Samoa**, **Comoros**, and **Malawi** called for solidarity with small island states in safeguarding TM practices.

The session closed with approval of the draft decision on the WHO traditional medecines strategy 2025-2034 as contained in EB156/28.

13.9 Global strategy for Women's, Children's and Adolescents' Health

Committee A moved on to discuss item 13.9 on **Women's, Children's and Adolescents' health**. Pursuant to resolution WHA69.2 (2016), in which the Health Assembly requested the Director-General to report regularly on progress towards women's, children's and adolescents' health, the document EB156/17 provides a summary of recent trends and data and outline the Organization's efforts to accelerate progress towards women's, children's and adolescents' health.

Member States universally commended the Secretariat for the reporting on women's, children's and adolescents' health and enthusiastically supported the objectives and implementation of the Global Strategy. They also backed the creation of World Prematurity Day.

Discussions on the Global Strategy for Women's, Children's, and Adolescents' Health showcased distinct regional emphases. Countries such as **Angola** (on behalf of the African region), **Kenya**, **Chad**, **Ethiopia**, and **Mozambique** reported notable reductions in maternal and child mortality but stressed persistent challenges in equity, premature birth care, and financing. **Angola** cited a 40% reduction in maternal mortality and 55% in infant mortality, crediting co-financing and WHO-supported monitoring. **Kenya** supported the inclusion of World Prematurity Day in the WHO calendar and called for regulation of digital breastmilk marketing, as did **Ethiopia**, **Malawi**, **Dominican Republic**, **Barbados**, **Central African Republic**, **Thailand**, **Honduras**, and **Maldives**. **Brazil** strongly supported the regulation of breastmilk substitute marketing, stating:

> *"such marketing – especially in digital environments – can undermine infant and children feeding practices." and that "robust regulation is key to protecting caregivers and health workers from inappropriate promotion*."

This view was echoed by **Mexico**, **Colombia**, **UK**, **Spain**, **Belgium**, **Sri Lanka**, **Samoa**, **Bahamas**, and **Bahrain**, among others.

On sexual and reproductive health and rights (SRHR), only **Germany** and **Finland** explicitly referenced abortion. **Germany** called for access to contraception, safe abortion, and post-abortion care**,** while **Finland** stated it supports **access to abortion** and emphasized young people's bodily autonomy. **Poland**, speaking for the EU, did not use the word "abortion" but supported SRHR, comprehensive sexuality education, and addressing gender-based violence and FGM. **France** aligned with the EU statement and highlighted the need to protect women's rights and promote social norm change but did not specifically mention abortion. These statements contrasted with the emphasis from countries like **Iraq**, **Panama**, and **Vietnam**, which focused on institutional capacity-building and prenatal service delivery without referencing SRHR rights frameworks.

Other areas of consensus included broad support for WHO's strategic leadership and technical support. **Colombia**, **Panama**, and **Mexico** co-sponsored the resolutions; **South Africa**, **India**, **Bangladesh**, and **Senegal** expressed alignment with the strategy. Several countries, including **Singapore**, **Sri Lanka**, and **Philippines**, outlined national programs to support maternal health, breastfeeding, and care for premature infants. **Iran** called for region-specific maternal and child health strategies, while **China** requested WHO to increase targeted support to developing countries. **Ireland** and **El Salvador** highlighted their investments in contraception and breastfeeding, respectively. Overall, the assembly approved both **EB156(29)** and **EB156(30)**, reflecting wide, though varied, commitment to improving outcomes for women, children, and adolescents — whether through legal protections, service delivery, or normative health governance.

Committee A (Tuesday)

Morning session in Committee A focused on Agenda items 14(Pillar 1) Health in the 2030 Agenda for Sustainable Development and Item 15 (Pillar 1) on Antimicrobial resistance based on Document A78/7 Rev. 1, Documents A78/8 and A78/8 Add.1. Universal Health Coverage (UHC) and Primary Health Care (PHC) were dominant themes, with countries emphasizing the need for stronger health systems that ensure equitable access and financial protection.

Many countries commended WHO for the efforts and progress yet challenges such as climate change, ongoing humanitarian crises, economic vulnerabilities, burden of NCDs and mental health have delayed the achievement of the SDG in health by 2030. Spain commented ⅔ of these goals are not achieved.

Countries such as **Australia**, **Spain**, **France** and **Ireland** emphasised the importance to avoid duplicated efforts and fragmentation and need for cost effectiveness during the financial restrictions the organisation is facing.

The **African region** shared the progress towards UHC and their support to countries through key programs and surveillance.

The **Bahamas**, **Barbados**, **Micronesia**, and **Samoa** urged WHO to ensure tailored strategies and inclusion in global initiatives, noting the unique challenges they face due to geography, resource limitations, and climate vulnerability. They emphasized equitable data representation, targeted funding, and support for national capacities as crucial steps to ensure that no one is left behind.

Data systems, digital health, and surveillance were also highly prioritized. Countries like **Australia, Jamaica, Panama, the Philippines, Austria, Lebanon, Thailand**, and **Ireland** stressed the importance of robust, disaggregated health data to support evidence-based decision-making. **Saudi Arabia, El Salvador, Cuba, India, Honduras, Russia,** and **Mexico** showcased efforts in digital health transformation, including AI integration, real-time monitoring systems, and public health data hubs to enhance tracking and policy response.

Health workforce development and technical support were highlighted by **Iraq**, **Ethiopia**, **Saudi Arabia, Zambia, Namibia, Iran**, and **Israel**. These nations stressed the importance of ongoing staff training, technical guidance from WHO, and building national capacities. Israel specifically proposed training AMR professionals as part of institutional leadership, while others called for broader investment in local human resources for sustainable health system improvements. In general the member states highlighted the importance of UHC as a major pillar in the WHO, probably with the most universal support for any topic discussed in this years assembly.

Antimicrobial Resistance (AMR) was a major agenda item, with widespread support for updating the Global Action Plan. African countries (e.g., **Kenya, Nigeria, Ethiopia**), EU members (led by **Poland** and **Austria**), and EMRO states (represented by **Saudi Arabia**) all underscored the urgency of combating AMR. With several countries calling for AI to support in surveillance. Countries such as **Colombia**, **India**, **Brazil**, **Germany**, the **UK**, **Ireland**, **Japan**, **Thailand**, **Malaysia**, and others emphasized the One Health approach, national action plans, surveillance improvements, and the need for international coordination. Calls for sustainable funding, capacity building, and inclusion of low- and middle-income countries (LMICs) were repeated.

Committee B

The symbolic value of flags

In Committee B, Member States debated a draft resolution for WHO to fly the flags of observer states – which would have meant raising the flag of Palestine at WHO Headquarters. Israel was obviously opposed to the draft resolution, arguing that allowing non-member flags undermines the UN's rule-based order and sovereignty principles. They warned against bending rules for political symbolism, calling for a vote.

Palestine urged support, framing the flag as a step toward full UN membership and condemning Israel's actions in Gaza. Multiple states echoed this, citing solidarity, self-determination, and the urgency of addressing health crises under occupation.

Pro-Flag States (**Kuwait, South Africa, Egypt, Algeria, China, Spain, Norway, Brazil, Nicaragua, Cuba, Malaysia, Turkiye**, etc.) emphasized moral, legal, and symbolic reasons, aligning with UN precedents. Many co-sponsored the resolution, calling it a corrective to historical injustice and a message of hope.

Neutral/Technical Focus (**Switzerland, Tunisia'**s initial remarks) stressed UN collaboration on health priorities (e.g., UHC, climate) but did not explicitly oppose the flag. Regional Blocs (**EMRO, Arab Group**) unanimously supported the resolution, linking it to broader peace efforts.

Outcome: Strong majority support for the resolution. The vote passed with Abstained: 27, Present and voting: 99 Against: 4 In Favour: 95**. Australia** was the sole member state to take the floor to explain their vote on the decision, taking pains to reassure the assembly that their "*vote for this resolution is not bilateral recognition of Palestinian statehood*."

The health effects of nuclear war

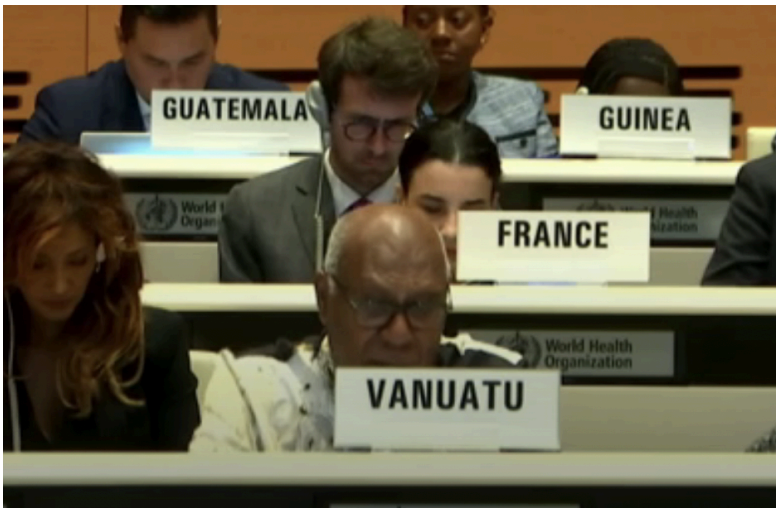
Under **item 18.1**, an extensive debate raged over a draft resolution empowering WHO to conduct an updated study on the public health effects of nuclear war.

The resolution's supporters delivered strongly-worded, sobering statements on the existential threat of nuclear weapons in a world increasingly at conflict. Speaking for the resolution's co-sponsors, **Vanuatu** said that "*nuclear war is not an issue to be politicised, as it is far too important, posing an existential threat*."

Arguments against the draft resolution – made principally but not exclusively by nuclear-armed states and NATO members – included that an update to previous reports on the subject are not needed, the suggestion that the resolution is outside WHO's mandate, and concerns about financial resources.

Some member states argued that the WHA was not the appropriate venue for this discussion, and that it is beyond the scope of WHO's mandate to conduct the proposed work. The **Democratic People's Republic of Korea (DPRK)**'s view was that "*the intention of [the resolution] goes far beyond the mandate of this organization*" and that "*WHO [should] focus on the global health challenges rather than spending precious resources on repeating work that has already been done*."

Critics also argued that the report was a waste of money (notwithstanding it's miniscule financial implications for WHO), with **Russia** saying that "*the WHO secretariat asked for a half a million dollars for an update of this report that's been lying on a shelf for 40 years*" and **DPRK** arguing that, given the organization's financial crisis, "*all precautions need to be taken in using human and financial resources.*"



"Nuclear weapons are an abomination that threaten the health of all people." –Vanuatu

The resolution was ultimately adopted 86-14 with 28 member states abstaining from the vote.

Drama and backroom dealing over climate change and health

Under 18.3, member states considered the topic of climate change and health. At last year's assembly, WHA77 approved a landmark resolution on climate change and health. Prior to the item being taken up at WHA78, the fate of the WHO Action Plan on Climate Change and Health became uncertain. Late on Sunday, a motion to delay the implementation of the proposed action plan by one year – proposed by EMRO region members – was posted on the WHO website. Reports indicate that the initiative to postpone the action plan was principally driven by **Saudi Arabia** with support from the **Russian Federation**, and that the countries spent the morning lobbying African region members to support the postponement.

Asserting that "*urgent and transformative action is required, along with the UNFCCC and the Paris agreement*" **Fiji** (speaking on behalf of the Pacific island countries) "*call[ed] for robust global partnership, multisectoral cooperation, and mobilization of resources, capacity building, and tailored support for small remote island nations*" to ensure the effective implementation of the action plan.

On **Tuesday afternoon**, discussion continued in Committee B.

"We're really testing the rules of procedure today." – Derek Walton, Legal Counsel

Following the strong rejection of their motion proposing to postpone the action plan, **Russia** put forward a proposed amendment from the floor (what the chair referred to as a "*friendly amendment*") which would modify draft decision EB156(40) by adding a paragraph reading:

> "*...request the Director-General to consolidate reporting on the progress achieved on climate change, environment and health through streamlined reporting to the eightieth World Health Assembly and the eighty-second World Health Assembly, in line with existing reporting requirements and timelines*."

This proposed amendment would have had the effect of replacing a specific paragraph in the original draft decision asking the DG to "prepare a progress report on the implementation of the Global Action Plan" with a request to consolidate this reporting with more general reports already required on progress on climate, environment and health.

France expressed a preference for considering the initial decision – rather than the amended version – in part, they claimed, because members hadn't had the opportunity to consult with capitals prior to the amended version being considered. Raising a point of order, France said that "*we would have liked there to be a reconsideration of the decision to* consider *this amendment because the amendment was submitted so late*." France raised an appeal, which required a vote of the committee on the question of whether the amendment proposed by the **Russian Federation** should even be considered. Subsequently, in a vote of 62-47, the committee rejected the proposal to consider Russia's amendments, therefore leaving only the initial, unamended decision on the table. Under Rule 61 of the rules of debate, **Peru** proposed a motion to close debate on the topic, on the grounds that "*we are all very tired today and [...] it has been a long week of negotiations*" which would permit the committee to move directly to a vote on the draft decision. The motion passed 94-20, and the debate was therefore closed.

"Delegates, please stay focused" – Committee B Chair

Following an incomprehensibly long period of silence, "*clarifications*" on the part of **Egypt** (on behalf of **EMRO**), who simultaneously claimed they neither wanted to adopt the decision by

consensus, nor request a vote, and repetitive back-and-forth between the Chair and the Legal Counsel Derek Walton, the draft decision was finally brought to a vote. The voting results were recorded at EMRO's request.

The decision passed without a single vote against, by a vote of 109-0, with 19 abstentions.