PHM daily briefing of the WHO 79th WHA Meeting: Day 5 (May 22, 2026)
Report prepared by PHM's WHO Watch Team

Committee A, morning session (9:00-12:30)

Item 12.4 Universal health coverage (continued)

On the 5th day of the 79th World Health Assembly, Committee A continued discussions under the **Universal Health Coverage agenda** (A79/5), focusing on the draft global strategy for integrated emergency, critical and operative care (2026–2035) (EB158/4), ethical access and oversight of transplantation of human cells, tissues and organs, and recognition of rare diseases as a global health priority for equity and inclusion.

Debate on the draft global strategy for integrated emergency, critical and operative care (2026–2035) centered on the need to move emergency and surgical care out of isolated hospital settings and integrate them into primary healthcare and national health systems. **Togo**, speaking on behalf of the African Region, called for *"a universal strategic approach"* that coordinates care throughout the life course, while **Ghana** stressed that emergency and operative care is essential to reducing preventable deaths *"especially in low- and middle-income countries."* **Zambia** linked the issue directly to recent cholera outbreaks, mpox and climate-related flooding, warning that financing and workforce gaps continue to undermine preparedness. **Chad** expressed support for the draft strategy on integrated emergency, critical, and operative care for 2026–2035, particularly in contexts such as the *Lake Chad Basin affected by Boko Haram attacks,* displacement, migration, persistent crises, and shortages of qualified health workers. **Cambodia** argued that operative care is central to reducing *"preventable deaths and disability."*

On transplantation of human cells, tissues and organs, discussions focused heavily on ethics, regulation and health sovereignty. **Togo** called for *"robust legislative frameworks"* to prevent organ trafficking and protect donors and recipients, while **Pakistan**, speaking on behalf of the Eastern Mediterranean Region, warned that transplantation systems remain *"complex and highly heterogeneous,"* requiring *stronger oversight, transplant registries and regional cooperatio*n. **Burkina Faso** highlighted its first kidney transplants as *"a major step"* toward reducing costly medical evacuations abroad and strengthening national health sovereignty. Several countries, including **Qatar** and **Morocco**, supported continued work on a global transplantation strategy, though Member States ultimately agreed to defer its final consideration to WHA80 in 2027 to allow for further consultations and technical refinement.

Rare diseases emerged as one of the most politically resonant discussions under the agenda item, with many delegations framing the issue as a test of equity and inclusion within universal health coverage. **Egypt**, speaking

on behalf of 41 co-sponsoring Member States, described the first-ever resolution on rare diseases as a *"historic step"* for the *"visibility, dignity and equity"* of millions of people living with rare conditions. At the same time, several countries warned that access to diagnostics, treatment and orphan medicines remains deeply unequal. **Sri Lanka** described its rare disease services as *"underdeveloped and fragmented,"* while **Malaysia** called for stronger registries, centres of excellence and sustainable financing mechanisms. **Kenya** welcomed the development of a WHO global action plan and offered to serve as a regional centre of excellence for rare diseases.

Throughout the debate, many delegations linked UHC to broader questions of justice, inequality and political responsibility. **Mexico** stressed that UHC cannot be reduced to insurance schemes alone, but must guarantee *"effective, timely and continued access"* regardless of income or employment status. **Haiti** warned that UHC *"should not be a privilege"* reserved for stable countries. **Palestine** called for comprehensive universal health coverage and strong health systems **"***for all, without exception***,"** invoking the *Astana Declaration* and its vision of health as a pathway to peace. The delegation stressed that conditions in Gaza and across the occupied Palestinian territory, including East Jerusalem and Area C of the West Bank, *remained excluded from any positive health progress* due to the ongoing humanitarian crisis, settler violence, and attacks affecting civilians, Palestinian medical personnel, humanitarian workers, and international solidarity activists.

At the close of the session, Committee A approved the resolutions (resolutions EB158.R2, EB158.R3, EB158.R4, and EB158.R5) under agenda item 12.4, including resolutions on precision medicine, equitable access to diagnostic imaging through teleradiology, reducing the burden of stroke, and smart pharmacovigilance. The Committee also approved the draft global strategy for integrated emergency, critical and operative care 2026–2035 (decision EB158(4)), while consideration of the global transplantation strategy was deferred to WHA80 in 2027.

Committee B Morning Session (9:00-12:00)

Item 20.1 Reform of the global health architecture and the UN80 Initiative (continued)

During the morning session, Member States discussed report A79/23, outlining WHO's collaboration with the United Nations system and other intergovernmental organizations in 2025. Under agenda item 20.1, Member States discussed report A79/24 on the proposed joint process for reforming the global health architecture and the UN80 Initiative, alongside the financial and administrative implications of the proposal (A79/24 Add.1) and the related report of the Programme, Budget and Administration Committee of the Executive Board (A79/31).

A dominant theme throughout the debate was that the process must remain firmly *Member State-led.* This position was echoed by **Pakistan, Panama, Indonesia, Nepal, Mexico, China** and **Saudi Arabia**. **South Africa** strongly emphasized that "*ownership can only rest with Member States*," warning that while inclusivity was important, final authority must remain with governments. Pakistan insisted that Geneva-based consultations remain central to the process, arguing that Permanent Missions are the "*authoritative voice of Member States.*" Indonesia stressed that the process "*should be visible to Member States at all time*," and Nepal emphasized that consultations in Geneva must remain accessible and inclusive for LMICs. Beyond Member State participation, **Lebanon** highlighted the importance of involving *civil society* in the reform discussions.

Several delegations, including **Norway, Canada, Slovakia and Indonesia,** underlined the need for a *lean*, *efficient* and *practical* reform process. Slovakia called for a "*lean process*" with "*no additional financial burden*,".

The issue of **official development assistance (ODA)** and declining health financing emerged repeatedly throughout the debate. In a sweeping intervention, **Pakistan** reminded the floor that reform "*must not translate into reduced ODA, weakened WHO country presence or diminished support for developing countries.*" Warning against austerity-driven reform, the delegation stressed that "*lean must not become synonymous with less.*" Pakistan further argued that "*genuine reform demands sustained and predictable financing, accelerated transfer of innovative technologies to build long-term self-sufficiency, while keeping national health system strengthening at its core*."

Colombia delivered one of the most politically substantive interventions, questioning the very basis of the reform process. "*Information on the architecture reform is not sufficient,*" the delegation stated, arguing that discussions focused heavily on "*methodology and organisation, but not substantive matters*." Colombia asked directly: "*What is being reformed, and why?*", warning that the process could have a "*massive impact on WHO as a specialized UN agency*." Referring to previous WHO reform efforts under Brundtland, Chan and Tedros, Colombia stressed that any new reform must clearly define its purpose. The delegation further insisted that "*any reform needs to protect the public multilateral character of the UN organization,"* warning against *"interference of private commercial interests.*"

South Africa also cautioned against "*undue influence*" in the reform process and stressed the importance of protecting equity principles, "*especially as we entrench equity in the Pandemic Agreement.*" The delegation linked the reform debate to the need for greater resilience against future public health shocks.

In its final intervention, **Pakistan** requested that interim and final reports be shared with Member States before broader circulation. The **Chef de Cabinet** confirmed that **Pakistan's** comments would be reflected in the WHA summary records and taken forward in the implementation process.

Closing the discussion, **Director-General Tedros** brought up WHO's recent financial stabilization efforts, noting that increased assessed contributions approved in 2023 and 2025 had helped decrease the impact of funding cuts and stabilize the Organization during restructuring. He explained that future increases in assessed contributions should eventually represent "50–60%" of WHO's total budget, making WHO "*more resilient*" and "*more independent*." Alluding to various Member States' intervention, Tedros answered that WHO had heard calls for "*transparency, inclusive process, genuine division of labour,*" and concluded that "*the rule of this game is together*."

The Assembly noted reports A79/23 and A79/24.

Committee A Afternoon Session (14:00-17:30)

Item 12.5. Primary healthcare & Item 12.8. Report of the Expert Advisory Group on the WHO Global Code of Practice on the International Recruitment of Health Personnel

Under agenda items 12.5 and 12.8, Member States debated the future of primary health care (PHC) (Document A79/5) and the growing crisis around international recruitment of health personnel (Documents A79/5, A79/5

Add.3 and A79/5 Add.5), with discussions exposing clear tensions between source and destination countries. Across the debate, delegations repeatedly framed PHC as the political and financial foundation of universal health coverage, while many countries from Africa, Asia, Latin America and Small Island Developing States warned that workforce migration, underfunding and fragile health systems are undermining progress.

Several countries strongly reaffirmed PHC as the backbone of national health systems. **Ethiopia** explicitly linked its intervention to the *Alma-Ata Declaration of 1978*, describing PHC as the "*cornerstone*" of its health system and noting that *"80% [of the population] receive their services"* through community-based and multisectoral PHC structures. **Cuba** highlighted its longstanding community-led PHC model built by *Fidel Castro,* rooted in equality, prevention and local access to care. **Ghana** stressed that PHC remains *"the foundation of universal health coverage, resilient health systems and health security,"* while pointing to its new free PHC initiative and community-based prevention programs. **Zimbabwe** similarly emphasized a *"people-centred and whole-of-society approach,"* stressing the importance of integrating community health workers into formal systems. **Micronesia** warned that for small island nations, PHC is often *"the first and sometimes the only point of care available to remote communities,"* calling for investment in digital health, transportation and decentralized services.

The sharpest political debate emerged under agenda item 12.8 on international recruitment of health personnel. Source countries repeatedly argued that wealthy destination countries benefit from the migration of health workers without compensating countries that finance their education and training. **Pakistan** delivered one of the strongest interventions of the session, stating: *"We came to these negotiations asking for justice, not charity."* Pakistan stressed that every year it invests heavily in training health professionals only to see them recruited abroad by high-income countries that *"save billions on health professional education they never had to fund."* The delegation linked workforce losses to fragile health systems, climate catastrophes, border conflict and shrinking fiscal space, while criticizing the resolution for lacking binding obligations. *"Lean must not become synonymous with less,"* Pakistan argued that *"the current text does not reflect the scale of the problem, nor the urgency that source countries feel."* Pakistan pushed for "ring-fenced financing," "binding co-investment obligations," and concrete financial mechanisms, including ODA, while warning Member States: *"We will be watching carefully and with long memories."*

Bangladesh raised concerns from a different angle, arguing that the WHO safeguard list, intended to protect vulnerable health systems, can also unfairly limit opportunities for health workers from source countries. The delegation warned that due to inflexible application, the safeguard list has become *"a barrier to the rights of health professionals... to pursue dignified and meaningful work abroad,"* while many remain unemployed or underemployed at home. Bangladesh argued that migration can also help workers gain professional experience that could later strengthen source-country systems, calling for greater "flexibility" and more meaningful co-investment from destination countries.

Several Member States from the African Region echoed concerns over workforce depletion. **Zambia** argued that source countries have *"borne the high cost of educating health professionals"* for too long, while **Zimbabwe** warned that premature removal from WHO's safeguard list could accelerate workforce losses and undermine progress towards UHC. **Ghana** similarly highlighted the growing impact of international recruitment on source-country systems.

Destination countries and European delegations largely defended the voluntary nature of the WHO Code. Speaking on behalf of the EU, **Croatia** emphasized ethical recruitment, stronger data systems and international

cooperation, while **Japan** stressed that *"strengthening domestic health financing systems and promoting cross-country learning remain indispensable."* Japan also highlighted bilateral workforce cooperation through JICA and welcomed recognition of care workers in the revised code. **Norway**, **Ireland**, **Switzerland**, **Australia** and the **United Kingdom** all emphasized partnership approaches, workforce sustainability and mutually beneficial cooperation, though several delegations avoided endorsing binding financial obligations toward source countries.

Throughout the debate, Member States repeatedly linked PHC and workforce migration to broader questions of equity, financing and sovereignty. **Chile** stressed that PHC should not only address clinical needs, but also *"strengthen community links and social connection"* while tackling isolation and exclusion. **Brazil** warned that workforce migration poses *"difficult challenges to the long-term sustainability of health systems within developing countries,"* while **Mexico** emphasized community-based care for rural and Indigenous populations. **Papua New Guinea** stated bluntly that *"the health workforce crisis is not theoretical, it is immediate and deeply felt,"* warning that migration is placing *"significant strain on already fragile health services."* The delegation called for measurable action, ethical recruitment, transparent bilateral agreements and stronger WHO technical support.

At the close of the session, Committee A approved the resolution updating the WHO Global Code of Practice on the International Recruitment of Health Personnel and noted continued implementation of the PHC agenda. The adopted text strengthened language on co-investment, ethical recruitment and workforce sustainability, though many source countries made clear that the final compromise fell short of the binding financial commitments and accountability mechanisms they had sought.

Committee B Afternoon Session (14:00-17:30)

Item 20.2 Communications of the United Nations Secretary-General as depositary of the Constitution of the World Health Organization

Under agenda item 20.2 on communications of the United Nations Secretary-General as depositary of the WHO Constitution, Member States discussed the withdrawal of Argentina from the World Health Organization and the amendments proposed to decision EB158(12).

The **EB158** Decided to recommend the following to the Seventy-ninth World Health Assembly the adoption of the following resolution:

"*The Seventy-ninth World Health Assembly, Taking note of the report by the Director-General;*

Having noted the communication from the Minister of Foreign Affairs, International Trade and Worship of the Argentine Republic, notifying the United Nations Secretary-General that the Argentine Republic withdraws from the World Health Organization, effective as of 17 March 2026,

RESOLVES to acknowledge the withdrawal of the Argentine Republic from the World Health Organization, effective as of 17 March 2026"

Belgium, Brazil, Croatia, France, Germany, Japan, the Netherlands, **Norway** and the **Republic of Korea** proposed an amendment(A79/B/CONF./2) to avoid language explicitly recognizing the withdrawal, instead proposed "*acknowledg[ing] the request of the United Nations Legal Counsel*".

Paraguay further proposed adding language: [the WHA] "*RESOLVES that while the World Health Organization will always welcome the full reintegration of the Argentine Republic into the work of the Organization, no other further action is needed."*

The final text was as follows:

> The Seventy-ninth World Health Assembly,
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> Taking note of **the recommendation contained in decision EB 158 (12)** entitled "Withdrawal of the Argentine Republic from the World Health Organization" and the report by the Director-General;
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> Having noted the communication from the Minister of Foreign Affairs, International Trade and Worship of the Argentine Republic **dated 25 February 2025, and received by the United Nations Secretary General on 17 March 2025, notifying the latter that the Argentine Republic withdraws from the World Health Organization and that the withdrawal would be effective one year after the receipt of that letter**; ~~notifying the United Nations Secretary-General that the Argentine Republic withdraws from the World Health Organization, effective as of 17 March 2026,~~
>
> RESOLVES **that while the World Health Organization will always welcome the Argentine Republic's full co-operation in the work of the Organization, it is not considered that any further action at this stage is desirable**. ~~to acknowledge the withdrawal of the Argentine Republic from the World Health Organization, effective as of 17 March 2026.~~

The amended draft resolution (A79/B/CONF./4) was adopted.

Several Member States delivered broader political statements following the adoption. **China** stressed that WHO remains the "*most authoritative institution in global health,*" arguing that "*global public health is a whole and cannot be divided*." **China** also described Member State withdrawal as a "*sensitive and complex*" matter and called for clearer rules regarding financial obligations, withdrawal procedures and conditions for rejoining WHO. **Bolivia** described the decision as "*vital to the sovereignty of states*," while **Sierra Leone,** speaking on behalf of the African Group, stressed that WHO unity remains "*essential for developing countries*" and reaffirmed the Group's "*unwavering commitment to WHO.*"

Item 15.1 Strengthening rehabilitation in health systems, Item 15.3 The health of Indigenous Peoples, & Item 15.4 Maternal, infant and young child nutrition

The Afternoon session continued discussing agenda item 15.1 Document A79/5, on Strengthening rehabilitation in health systems, agenda Item 15.3 on The health of Indigenous Peoples (A79/5 and EB158/2026/REC/1, decision EB158(10)), and agenda item 15.4 on Maternal, infant and young child nutrition (A79/5).

On rehabilitation in health systems, many member states stressed the need to integrate rehabilitation services into primary healthcare, emergency response and universal health coverage. Member States, including **China, Brazil, Thailand, Panama, Saudi Arabia, the Phillipines**, and **Chile** described rehabilitation as an

"*essential*" component of health systems. **El Salvador** brought up the specific needs of survivors of *mines and explosive remnants of war*, particularly in rural areas. **Zambia, Senegal** and **Morocco** pointed at shortages in the workforce capacity, rehabilitation infrastructure and assistive technologies, calling for stronger WHO support and sustainable financing mechanisms.

The discussion on the health of Indigenous people centered around meaningful participation of indigenous communities and intercultural approaches to health care delivery. **Brazil** stressed that Indigenous health "*cannot be separated from the land and the culture",* reaffirming its commitment to the intercultural health approaches. Similarly, **Colombia** emphasized the intercultural intercultural models of care as essential for building equitable health systems; **Ecuador** highlighted the importance of integrating family and community based approaches into care for Indigenous populations. Panama stressed the importance of "*hearing the voices and learning from the knowledge of Indigenous people,*" and **Angola** welcomed the integration of Indigenous medicine and traditional knowledge systems into healthcare.

Under maternal, infant and young child nutrition, Member States shared their concern on the progress on towards the global nutrition targets. **Burkina Faso** highlighted national progress in reducing malnutrition from 25% to 17% between 2019 and 2025, alongside increased breastfeeding rates. **Sri Lanka** mentioned that the economic crisis and climate disaster are worsening food insecurity.

Many delegations called for stronger regulation of breast milk substitute marketing. **Jamaica** stressed that breast milk substitute marketing "*needs to be regulate*d," while **Thailand** warned that violations linked to cross-border digital marketing had "*nearly tripled*" in 2025. **China**, **Turkey**, **Lesotho** and the **Central African Republic** similarly called for stronger oversight of digital advertising. Across the debate, Member States repeatedly linked nutrition to primary healthcare, equity and long-term health system resilience.