



# Health for All Now! People's Health Movement

PHM daily briefing of the WHO 79th WHA Meeting: Day 6 (May 23, 2026)

Report prepared by PHM's WHO Watch Team

## Committee A (Morning)

### **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 (Continued)**

At the start of Committee A, non-state actors were given the opportunity to deliver statements under items 12.5 and 12.8, following the abrupt adjournment of the committee in the previous afternoon session, which cut off several NSAs from speaking on these topics. Item 12.8 covered the 'report of the Expert Advisory Group on the WHO Global Code of Practice on the International Recruitment of Health Personnel.' The report in question (contained in document [EB158/17](#)) was communicated via the Consolidated DG's report (document [A79/5](#)), and the Committee was asked to consider draft Decision [EB158\(7\)](#). Reports were noted and the draft resolution on "WHO Global Code of Practice on the International Recruitment of Health Personnel" ([A79/5 Add.3](#)) was approved.

### **Item 12.7 Substandard and falsified medical products & Item 12.9 Draft updated global action plan on antimicrobial resistance**

The committee moved on to discuss item 12.9 'Draft updated global action plan (GAP) on antimicrobial resistance'. The committee considered the draft updated global action plan on antimicrobial resistance 2026–2036) (contained in document Document [A79/5 Add.2](#)), which is an updated version of document document [EB158/18](#), which was considered by the 158th Executive Board earlier this year. On the table was a draft decision ([EB158\(6\)](#)) recommending the WHA to adopt the updated global action plan on antimicrobial resistance and requesting the DG to report biennially on progress to WHAs in 2027, 2029 and 2031.

The wide-ranging debate saw many member states zero in on technology transfer, while discussions were also punctuated by the recurring themes of conflict, war, and limited resources, as well as the need for cooperation and solidarity.

**New Zealand** and other member states of the global north and those hosting the headquarters of pharmaceutical companies advocated for a technology transfer strategy based on 'voluntary and mutually agreed' terms. **Cyprus, speaking on behalf of the European Union and its 27 member states**, welcomed the draft updated global action plan (GAP) as a deliverable from the 2024 UN high-level meeting. Cyprus noted

that the environmental sector is now a strong component of the GAP and stressed the importance of respecting international intellectual property rules and voluntary technology transfer on mutually agreed terms. **The United Kingdom** called for clearer measures on monitoring and evaluation and explicit guidance on AMR in conflict settings. On technology transfer, the UK stated that it interprets the GAP to specifically encourage promotion of technology transfer by member states and remains committed to voluntary, mutually agreed partnerships. **The Philippines** underscored the importance of technology transfer, knowledge sharing, and scientific cooperation. **Brazil** cautioned that regulatory frameworks must be precise and risk-proportionate to avoid stiffening legitimate, affordable generic medicines. **Nauru**, as a small island state, encouraged WHO and partners to ensure that AMR action is operationally realistic for countries with limited resources and workforce capacity.

**Japan** appreciated the revised draft's broader One Health approach and welcomed the establishment of the independent panel on evidence for action against AMR. Japan, echoed by **Sweden**, requested the Secretariat to proceed with thorough preparations and consult with member states on the panel at an appropriate timing. **France**, aligned with the EU, welcomed the strengthening of the environmental dimension and social and behavioural sciences, and announced an international pact launched at the One Health Summit in Lyon to promote appropriate antibiotic use and ban antimicrobials as growth promoters in livestock. **Italy**, aligned with the EU, highlighted the need to integrate environmental dimensions of AMR, and reiterated the importance of sustainable financing for disadvantaged and vulnerable populations. **India** stressed that cross-sectoral actions in the environment sector should be evidence-based, phased, and proportionate while prioritising reduction of the human health burden of AMR. **China** called for a dedicated financing window for One Health, uniform technical standards for environmental surveillance, and a fair technology transfer mechanism. China added that *"The secretariat should develop a diversified and sustainable funding model, expedite developing guidance on coordinated regulation of cross-border sale via the internet, and strengthen targeted technical support for low-income countries."* **Nepal** urged WHO to strengthen One Health governance, bacteriology capacity, digital surveillance, and predictable long-term financing. **Iran** reaffirmed commitment to One Health, noted that conflict and sanctions disrupt supply chains and laboratory capacity, and called for stronger international cooperation, regulatory harmonisation, and technology transfer.

**Thailand** emphasised the need to strengthen global governance mechanisms for AMR as a means of reinforcing sustained national efforts, particularly during periods of policy transition or leadership change. Thailand stated: *"Strong global mechanisms can help maintain political commitment, accountability, multisectoral coordination, and sustainable financing."* **Libya** called for international cooperation to reduce medicine costs and improve detection mechanisms, and reported an active surveillance programme for drug-resistant bacteria. **Togo** noted recurring challenges with financing the mechanism, and invited member states to prioritise strengthening regulations and cleaning up supply chains nationally and regionally. **Cuba** reported updating its national action plan to incorporate new GAP targets, but noted financial limitations that make implementation and sustainability difficult. **The Central African Republic**, reflecting on AMR in a resource-limited context, called on WHO and financial partners to step up support for capacity building and national regulatory systems. **Chad** called for stronger international solidarity and sustainable financing mechanisms. **Ethiopia** called for sustained investment, research and innovation, and support for local manufacturing. **Mexico** noted that only 10% of countries have specific financing for national AMR plans and encouraged member states to guarantee such financing. **Ukraine**, despite Russia's full-scale war, reported that it continues to strengthen AMR work. Ukraine noted that war creates serious additional risks including more infections, higher antimicrobial use, and pressure on the health system, and called for sustainable financing and technical support for conflict-affected

countries. **Sudan**, facing war and a severe humanitarian supply chain crisis, stated: “*Sudan cannot confront AMR alone while simultaneously responding to displacement epidemics and health system collapse,*” and called for continued global support for war-affected settings.

**Colombia** stated that AMR is a global threat comparable in magnitude to climate change and that technology transfer cannot be left only to voluntary mechanisms because “*it’s a challenge that affects everybody.*” **Netherlands** emphasised that AMR is not just a future threat but a crisis unfolding today, stating: “*Framing it solely as impacting us in the future is not only outdated but also dangerous.*” **Mali** said that “*This decade that is opening should not be one of repeated promises, but one that will lead to real equity in combating this silent pandemic.*”

**Germany** announced an additional €25 million for WHO this year with €1 million for AMR, specifically for underfunded functions of surveillance, diagnostic capacities, and stewardship, along with a note of concern: “*We remain concerned that the AMR department has several underfunded functions ... this must be urgently addressed by WHO.*”

**Nigeria** announced that the fifth high-level ministerial conference on AMR would take place in Abuja in June and extended an invitation to all.

The Committee noted the reports contained in document A79/5 and approved the draft decision entitled “Draft Updated Global Action Plan on Antimicrobial Resistance” contained in decision [EB158\(6\)](#). No objections were raised.

#### **Committee A (Afternoon)**

#### ***Item 12.6 Health in the 2030 Agenda for Sustainable Development & Item 12.10 Harmonization of regulatory approaches, governance and standards for data, digital health and artificial intelligence in the health sector***

To begin the afternoon, Committee A began discussing Items 12.6 and 12.10 together, referring respectively to ‘Health in the 2030 Agenda for Sustainable Development’ (Document [A79/5](#)) and the ‘Harmonization of regulatory approaches, governance and standards for data, digital health and artificial intelligence in the health sector’ (Document A79/5).

Under item 12.6 (2030 Agenda for Sustainable Development), **Iran, speaking on behalf of EMRO**, stated that health is a prerequisite for and an outcome of sustainable development. The region requested WHO to continue supporting member states in advancing UHC, strengthening health emergency preparedness and response, and health information systems. Persistent challenges include financial constraints, conflicts, environmental threats, and disrupted health services. **Maldives, speaking on behalf of the SEARO**, stated that digital transformation must be guided by trust, equity, and strong governance. Challenges include interoperability, data protection, cybersecurity, ethical oversight, and unequal infrastructure. Harmonization must remain flexible and adaptable to national priorities and digital maturity.

**Democratic Republic of Congo, speaking on behalf of AFRO**, stated that sustainable development needs robust health systems based on primary healthcare, but the region faces underfinancing and access challenges. Mpox demonstrated the need to strengthen primary healthcare services.

**Barbados** and **Chile** aligned with the assessment that the world remains significantly off track to achieve health-related SDGs by 2030. For small island developing states, consequences are felt in limited health budgets and workforce pressures. **Japan** also expressed concern that many health-related SDG targets remain off track and called for returning to the principle of “*leave no one behind.*” **Norway** expressed concern about lack of progress on UHC, PHC, financial protection, and basic services like vaccination and reproductive, maternal and child health. **The Philippines** affirmed the urgent need for stronger health systems, wider PHC access, sustainable financing, and better use of data. For countries with decentralised health systems, aligning national priorities with local implementation remains a key challenge.

**Nigeria** noted that 4.5 billion people still lack access to essential health services, while official development assistance fell by about 23% in 2025; the largest annual decline on record. Nigeria called for “*renewed acceleration towards health-related goals anchored in PHC and UHC, stronger domestic financing, and leaving no one behind.*” **Brazil** stated that further progress depends on predictable financing, structured knowledge sharing, and resilient information systems.

**Panama** stated that health is both a goal and a motor for sustainable development. Coverage of essential services, primary care, and data systems is essential. **Malaysia** underscored the need to strengthen PHC as the foundation of health promotion, prevention, early detection, and integrated person-centred care, alongside intensified action on NCD risk factors. Malaysia requested WHO’s assistance in developing structured platforms for sharing best practices. **Gambia** urged acceleration towards UHC through strengthening PHC, health workforce investments, and domestic resource mobilisation. **Morocco** reiterated that health is a key pillar for sustainable development.

**Papua New Guinea, speaking on behalf of the Pacific States**, recalled the adoption of the UN General Assembly resolution endorsing the ICJ advisory opinion on climate change on 20 May 2026, stating that “*climate change is a direct and unprecedented threat to health, human dignity, and survival, and States have moral and legal obligations to act. For the Pacific, climate change is the single greatest threat to health and sustainable development*”. The Multidimensional Vulnerability Index reinforces the need for global systems to recognise structural vulnerabilities of SIDS (Small Island Developing States) to improve access to sustainable financing for climate-resilient health systems. Pacific states called on WHO and development partners to provide predictable, accessible, and sustainable financing for climate-resilient health systems consistent with the 2050 Strategy for the Blue Pacific Continent and the Healthy Islands Vision 2050. **Vanuatu**, aligned with the Pacific States statement, stated that climate change continues to erode development gains, and called on WHO and partners to scale up predictable financing, technical assistance, technology transfer, and capacity building for SIDS.

*“...for small island states, vulnerability persists even as we graduate to high-income status. Our remoteness, size, and exposure to shocks do not disappear with the statistics. If the 2030 agenda is truly to leave no one behind, financing for health must reflect vulnerability, not just GDP. For Nauru, progress on the SDGs depends on resilient health systems that can deliver despite geographic isolation, limited resources, and climate pressures.”*

- **Nauru** -

Under item 12.10, the report contained in document [EB158/19](#) (Harmonization of regulatory approaches, governance and standards for data, digital health and artificial intelligence in the health sector) was delivered by the Secretariat pursuant to Decision [WHA78\(22\)](#), which extended the global strategy on digital health (originally of 2020-2025) to 2027, and asked the DG to develop a draft global strategy on digital health for 2028–2033. The report notes that some member states highlighted three key areas in the aftermath of WHA78 – precision medicine; regulatory and ethical governance of data and artificial intelligence in the health sector; and digital health transformation for resilient health systems. It was subsequently decided to consolidate the items under one agenda item.

**Maldives, on behalf of SEARO**, stated that digital transformation must be guided by trust, equity, and strong governance. Challenges include interoperability, data protection, cybersecurity, ethical oversight, and unequal infrastructure. Harmonization must remain flexible and adaptable to national priorities and digital maturity. **Iran, on behalf of EMRO**, urged member states to mandate private sector data integration through legal frameworks and develop interoperable digital health architecture blueprints. **Poland** stated that digital technologies shape care decisions and trust, but technology alone is never the answer. For Poland, health data and robust health information systems are the foundation, while AI must remain a tool built on reliable, interoperable data governed by clear ethical and legal frameworks. Poland strongly supported human-centred, transparent, and safe use of AI with strong data protection and meaningful human oversight.



*“It is important that digital transformation remains people-focused and is understood from a perspective based on human rights. The conversation cannot just simply be about what technologies we use, but who can access them, who benefits, and under what principles it is governed. The future of health cannot consist in replacing old-fashioned inequalities with digital inequalities. The innovation is only making sense when the benefits reach all people and communities.”*

- Delegate of **Colombia** -

**Brazil** stated that the proposed global digital health strategy must treat data, information systems, and AI as interconnected pillars guided by systemic governance rather than isolated technological adoption. The strategy should advance inclusive financing, shared standards, and meaningful participation from the global south. **China** stated that efforts should be made to promote innovation in AI application scenarios, strengthen digital health infrastructure, regulatory standards, data resources, and security safeguards, and advance cross-border sharing of AI. China is ready to engage in international cooperation on AI in pharmaceutical regulation to build a global regulatory framework balancing safety and innovation. **Japan** underscored the importance of promoting digitalisation in health, including AI. In SIDS and rural areas, AI supported by robust data infrastructure has significant potential to improve health system efficiency. **Burkina Faso** has implemented reforms to strengthen health data governance, interoperability, and responsible use of AI, but challenges in connectivity, cybersecurity, technical capacities, and sovereign hosting of health data remained. **The Republic of Korea** called for offline-first solutions for environments with limited communication infrastructure such as island nations.

**Chile** stated that digital transformation of health is a facilitating condition for people-centred, resilient health systems. Health data interoperability, digital health, and AI must contribute to strengthening primary care, continuity of care, and health surveillance. **Zambia** emphasised three priorities: interoperability and standards at the core of the next global digital health strategy; ethical and safe AI governance that is globally harmonised but locally adaptable; and sustainable financing for digital public infrastructure. **Ethiopia** called on WHO to provide practical, context-adapted guidance on AI benchmarking, transparency, accountability, and data protection. **Togo** called for common standards for interoperability, shared benchmarks on data quality, ethical frameworks for AI, and robust cybersecurity mechanisms.

*“We need to develop a harmonised global framework for health data to ensure data quality, complementarity, and trustworthiness. We also need an AI governance system in the field of health with a focus on safe and responsible use.”*

*- Sultanate of Oman -*

Switzerland noted the close link between health data, interoperable systems, and AI, stressed the need for AI readiness and trusted data to counter misinformation, and announced it will host the Global AI Summit in Geneva in 2027.

Reports on items 12.6 and 12.10 as contained in document A79/5 were noted.



PHM WHO-Watchers gifted the 7th edition of Global Health Watch series to Dr. Tedros.

## **Committee B**

### **Item 20.1 Reform of the global health architecture and the UN80 Initiative & Item 20.2 Communications of the United Nations Secretary-General as depositary of the Constitution of the World Health Organization (continued)**

At the start of the session, Committee B read and adopted its third draft report ([A79/40](#)) as read by the rapporteur. The report covered agenda items 20.1 and 20.2 (UN system collaboration, UNAIDS, and communications of the UN Secretary-General). The Committee recommended the attached decision and resolution to the plenary. No objections were raised.

**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 (continued)**

The Committee then resumed discussions on sub-items 15.1, 15.3, and 15.4 under “Promote Health” (Documents [A79/5](#) and [EB158/2026/REC/1](#), and decision [EB158\(10\)](#)).

Under item 15.3 (Indigenous Peoples), **Mexico** reaffirmed commitment to intercultural health models, noting 364 linguistic variations in Mexico and that *“linguistic barriers are still a structural barrier to social inclusion.”* Mexico carried out a national consultation for a law on Indigenous Peoples and is driving comprehensive approaches in the first 1,000 days of life. **Suriname** described efforts to improve healthcare access for Indigenous communities in interior regions, and stated: *“Effectively protecting their health requires not only medical intervention but also the active safeguarding of their traditional knowledge, cultures, and environments.”* **Eswatini** noted that culturally grounded care and community participation should be integrated into national frameworks.

Under item 15.1 (Rehabilitation), **Nigeria, Ethiopia, Tanzania, Nepal,** and **Brunei Darussalam** called for rehabilitation to be embedded in national health information systems and the WHO UHC Service Coverage Index. **Ethiopia** requested WHO to disseminate the rehabilitation indicator set. **Nigeria** noted that *“the focus on chronic primary low back pain ... provides a practical framework for monitoring rehabilitation performance.”* **Tanzania** reported integration of a Rehab HMIS system into electronic medical records and inclusion of rehabilitation in health insurance schemes, stating that *“rehabilitation services at the community level are provided mostly by community-based rehabilitation centres.”* **Nepal** emphasised community-based and decentralised services. Multiple delegations called for workforce development, financing and integration into primary healthcare.

Under item 15.4 (Nutrition), countries stated that they still faced challenges in tackling stunting, wasting, chronic malnutrition, anemia in pregnancy, and implementation of exclusive breastfeeding. **Nigeria** underscored that *“Primary healthcare must be the organising principle for nutrition action. Nutrition should be fully integrated ... not treated as a vertical programme.”* **Pakistan** warned: that *“The lack of nutrition financing is threatening the hard-won gains and also the lives of millions of women and children,”* and called on the international community to maintain and grow nutrition investments. **Nepal** warned that climate change and food insecurity threaten progress. **Ukraine** noted the double burden of malnutrition where nutrient deficiencies and childhood obesity coexist, despite their efforts in reforming school nutrition programs which included updating standards and free meals in frontline regions, stating that *“Essential nutrition intervention must remain accessible even during emergencies and disruption, especially for vulnerable women and children.”* **Palestine** described extreme food insecurity in Gaza, stating that *“Over 90% of young children and pregnant breastfeeding women face severe food poverty with minimal and extremely limited dietary diversity. ... Approximately 126,000 children under 5 are at risk of failing to meet their full developmental potential due to starvation.”* Palestine conveyed that the Israeli aggression has disrupted health systems and restricted access to antenatal and postnatal care. Many delegations requested WHO technical support for country adaptation, capacity building, and tailored measures for emergency and fragile contexts.

***Item 15.2 Well-being and health promotion & Item 15.5 Draft strategy on the economics of health for all***

Subsequently, Committee B moved on to item Item 15.2 Well-being and health promotion Documents [A79/5](#), [EB158/28](#), and [EB158/2026/REC/1](#), decision [EB158\(9\)](#) and item 15.5, in which the new draft strategy on the economics of health for all was discussed (Documents A79/5, [A79/5 Add.1](#) and EB158/2026/REC/1, decision [EB158\(8\)](#)).

*Item 15.2 Well-being and health promotion*

**Colombia, speaking on behalf of an interregional group of 61 member states**, stated that the slogan “*Together for Health, Let’s Support Science*” is a powerful reminder of the role of WHO. A comprehensive approach to sexual and reproductive rights improves wellbeing and health. Colombia stated that with science at the centre of work, the organisation and global health architecture can be strengthened through cooperation, mutual respect, and evidence-based solutions. **Burundi, speaking on behalf of the Africa Group (47 member states)**, welcomed the report of the WHO Commission on Social Connection. Loneliness and social isolation have a significant impact on physical and mental health, aggravating chronic diseases and weakening social cohesion among young people, the elderly, and vulnerable groups. The Africa Group sees strengthening social connection as a strategic investment to build more inclusive, resilient, and healthier societies. The Group supports the integration of social connection into public health policies, sustainable development programmes, and community initiatives. **Thailand, speaking on behalf of SEARO**, stated that member states are advancing healthy and active living through whole-of-government and whole-of-society approaches. Universal health coverage is recognised as an investment in human capital and sustainable development. Social connection is fundamental to holistic health across the life cycle. Thailand requested WHO to revitalise the agenda on healthy and active cities, health in all policies, and healthy settings including schools, workplaces, and health facilities. **Pakistan, speaking on behalf of EMRO**, stated that the region faces unique challenges including conflict, mass displacement, and economic instability, which place vulnerable groups at severe risk of social disconnection. Loneliness and isolation are significant risk factors for early death, cardiovascular disease, and diabetes. Pakistan recommended that member states formally include social connections in national health strategies. The region advocates the Healthy Cities Programme as a sustainable multisectoral platform.

**France** stated that wellbeing should be considered an objective of public policy beyond traditional economic indicators. Social connection is a key determinant of health; loneliness and isolation have a huge impact on mental and physical health and social cohesion. Fighting social isolation is an important lever for preventing poor health. **Singapore** stated that as populations age worldwide, addressing loneliness and social isolation becomes increasingly critical for health system sustainability and individual wellbeing. Their active ageing centres offer programmes across five key domains: social, physical, health, cognitive, learning, and voluntarism. **Sweden** stated that loneliness and social isolation are both deeply personal and a concern for society as a whole. If we truly want to improve public health, we must prioritise social connection; it is just as important as diet and exercise. **Austria** stated that to truly promote health and wellbeing for all, all determinants of health must be addressed, including social, economic, commercial, and environmental determinants. **Japan** stated that loneliness and social isolation are important determinants of health. In Japan, [a minister in charge of loneliness and social isolation](#) has been appointed, and comprehensive legislation to promote measures against these issues has been enacted as the first of its kind in the world.

**Ethiopia**, as a country with a long history of social structure that bonds communities through solidarity and social protection, continues to leverage community engagement platforms. **Iran** stated that its health programmes are grounded in three decades of community-based whole-of-government and whole-of-society approaches. Iran called for enhanced political commitment, multisectoral resource mobilisation, and expanded WHO-facilitated exchange of regional experience. **Ireland** stated that wellbeing must be embedded across public policy and that social connection is a fundamental determinant of both physical and mental health. Through its “Ireland Healthy” framework, Ireland is advancing cross-sectoral action to improve population health and reduce inequalities, including strengthening community-based initiatives, supporting social connection, and integrating wellbeing into decision-making across sectors. **Italy** stated that social prescribing offers a promising way to turn recommendations into practice. In Italy, this is gaining traction through grassroots initiatives in primary care, mental health services, and community welfare. **Nepal** has a strong network of basic health service centres at community level and more than 50,000 female community health volunteers, and is implementing school health programmes, health promotion campaigns including yoga and traditional medicine, psychosocial counselling, and health screening.

**Slovenia** stated that the Ottawa and Geneva Charters are now more important than ever. They provide a basis for tackling health inequities, commercial pressures, and challenges posed by AI, and enable a focus on empowerment, inclusivity, equity, and meaningful participation. **Egypt** stated that social isolation and weak community ties are increasingly recognised as determinants of poor health outcomes. Addressing these challenges requires multisectoral action that integrates social connection into primary healthcare, urban planning, education systems, and digital inclusion policies. **The Republic of Korea** stated that embedding wellbeing into national governance requires a solid legal and statistical foundation. Korea also launched an AI Welfare and Care Innovation Task Force to apply AI in social security responsibly.

**Ukraine** stated that wellbeing and health promotion are directly linked to resilience during war and recovery. It affects mental health, education, employment, and long-term human capital.

#### *Item 15.5 Draft strategy on the economics of health for all*

The item has its roots in resolution [WHA77.13](#) (2024), which called on the Secretariat to develop guidance, mobilize resources, provide technical support to country offices and member states, and generally to advance a strategy and program of work for the realization of an “economics of health for all.” On the table was the Director-General’s report ‘Economics of Health for All’ (contained in document [EB158/31](#)), which was forwarded from the 158th Executive Board, and draft decision [EB158\(8\)](#), which in essence asked the WHA to adopt the report, and would mandate biennial Secretariat reporting to the assembly on the strategy’s implementation.

All countries generally supported the draft strategy and its vision of health as a strategic investment and a driver of inclusive prosperity, sustainable development, and resilience. They recommended whole-of-government action, equity, social participation, gender equality, and increased investment in health, aligned with frameworks such as the SDGs and Agenda 2063. **Finland, speaking on behalf of a group of countries including Belgium, Canada, Ecuador, Estonia, Ethiopia, Latvia, Singapore, Spain, Sri Lanka, and Sweden**, emphasised the whole-of-government approach, country leadership, and guiding principles such as social participation, equity, and gender equality. Strengthened dialogue across ministries and with civil society is critical. WHO has a crucial role in supporting member states through normative guidance, technical assistance,

and facilitating exchange of experience. **Austria** stated that access to healthcare is a right, not a privilege, and should not depend on income, social status, or personal networks, and embraces the wellbeing economies approach. **France** further recommended that health and wellbeing be fully integrated into economic decisions and global public policies, supported by cross-cutting policy approaches and harmonised assessment tools. **Iceland**, reiterating their commitment to a wellbeing economy, emphasised three priorities: whole-of-government and whole-of-society action; practical implementation including tools and evidence; and equity and long-term value. **Ireland** also supports an approach to economic policy that places health and wellbeing at its centre, recognising that traditional economic indicators alone do not capture the full determinants of societal progress. **Saudi Arabia** noted the importance of including digital technologies and public-private partnerships. **South Africa** stated that domestic resource mobilisation requires urgent structural action. Progress taxation must be placed at the centre of the global and national strategies. Implementing wealth tax and financing transition tax can unlock the billions needed to finance health for all. Conversely, relying on blended and private financing is not a viable solution. Evidence consistently shows that these mechanisms harm the poor and exacerbate healthcare inequities.

**The Dominican Republic** stated that progress of societies cannot be measured only by traditional economic indicators. **Bhutan** stated that the draft Global Strategy on Economics of Health for All is a landmark initiative that redefines health not as a cost but as the foundation of sustainable and inclusive development. For Bhutan, this vision aligns closely with the development philosophy of gross national happiness, which places people's wellbeing at the centre of development. **Senegal** invited the Secretariat to strengthen support to member states, notably through strengthening structured dialogue between ministers responsible for finance and health, networking of national expert units, and sharing good practice. **The Republic of Korea** stated that securing credible evidence on the economic returns of health investments should be a primary condition; proceeding without clear evidence could lead to varying policy acceptance among member states. Recommendations should respect the domestic policies and autonomy of member states and avoid excessive regulations. Policies on taxation, trade, and industry should maintain sufficient flexibility to reflect each nation's unique economic conditions. **Iran** stated that a transformative approach should respect national ownership and community-led implementation. **The Philippines** encouraged the WHO Secretariat to support implementation through practical tools, capacity building, and knowledge exchange while ensuring alignment with UHC and SDG workstreams.



*“For South Africa, economic justice is not just an abstract concept; it is a literal prerequisite of achieving health for all. We cannot separate historical structural economic inequities from public health outcomes. [...] We’d like to raise the issue that the Alma-Ata vision of a new international economic order remains unfinished, and South Africa is ready to take this forward. And South Africa stands ready to build the institutional foothold necessary to finish the project of economic transformation that is true health justice.”*

*- South Africa -*

**Pakistan, on behalf of EMRO**, stated that the region faces structural challenges including constrained fiscal space, debt vulnerabilities, large informal sectors, and repeated shocks from conflict, displacement, and climate change. Pakistan called for adoption of the strategy with strong implementation support for fragile and middle-income countries, systematic engagement with finance and planning authorities, and sustained WHO financial, normative, and technical support. **Ethiopia** affirmed the call for strengthened domestic resource mobilisation, improved coordination between external and domestic funding as advanced by the Lusaka Agenda, and alignment with the “*One Plan, One Budget, One Report*” approach.

The Committee noted the reports contained in document A79/5. No objection was raised.

The Committee approved the draft decision entitled “Economics of Health for All” contained in decision EB158(8). No objection was raised.

The Chair declared Committee B closed.