PHM daily briefing of the WHO 79th WHA Meeting: Day 2 (May 19, 2026)
Report prepared by PHM's WHO Watch Team

Third Plenary meetings — General Discussion (09:00 - 13:00)

In his opening remarks to the plenary, **Dr Tedros Adhanom Ghebreyesus** reported that on 17 May, he declared a public health emergency of international concern (PHEIC) under Article 12 of the International Health Regulations, convening an emergency committee on 19 May to advise. He noted that this marked the first time a WHO Director-General has declared a PHEIC before convening an emergency committee.

On Ebola, the Director-General confirmed 30 cases in the northern province of the Democratic Republic of the Congo, two confirmed cases and one death in Uganda among individuals who had travelled from the DRC, and one confirmed case in a United States citizen who has been transported to Germany. Uganda, he said, postponed the annual Martyrs' Day celebration, an event that could have attracted two million people. The province of Ituri remains highly insecure; conflicts have displaced over 100,000 people, posing a risk of further spread. The Ebola virus strain involved is one for which no vaccines have yet been developed. WHO has deployed a team to support national authorities, along with personnel and funds, approving an additional 3.4 million USD from the Contingency Fund for Emergencies, bringing the total to 3.9 million USD.

On the Hantavirus outbreak, Dr Tedros said WHO has supported repatriation and monitoring efforts, with quarantine in place until 29 June 2026. He assessed the risk of global spread as low. Since WHO first reported the outbreak, 11 cases and three deaths have been recorded, with no additional deaths reported as of 11 May. While there are no signs of a larger outbreak, WHO continues to monitor the crew and passengers closely.

The Director-General thanked the many countries involved in the response. He specifically acknowledged Spain, which supported not only out of legal duty under international law but also out of moral duty to the crew and passengers, and thanked Prime Minister Sánchez for his inspirational speech yesterday. He thanked the United Kingdom for notifying WHO and all countries through the IHR. He thanked Argentina and Chile for sharing expertise and supporting the donation of reference materials for PCR and serological testing, and for identifying laboratories involved in the response. He thanked South Africa for being the first to confirm Hantavirus at the National Institute of Communicable Disease (NICD) in Johannesburg. He also noted that the Netherlands has been actively involved at every step.

Dr Tedros explained why the IHR and WHO remain essential. He noted that in one speech, he could not do justice to the length, breadth and depth of his colleagues' work. He then highlighted three key priorities of the 14th General Programme of Work: promote, provide, protect.

He reported over 500 suspected cases and over 130 suspected deaths. He announced the elimination of trachoma in Algeria, Australia, Burundi, Fiji, Libya, Senegal, Tunisia, and Egypt; elimination of leprosy in Chile; elimination of trichomoniasis in Kenya and Timor-Leste; elimination of mother-to-child transmission of HIV and hepatitis; and elimination of trans fats in Portugal and the United Arab Emirates. He also noted that ICD-11 coding has been rolled out to 132 Member States.

Turning to emergencies, Dr Tedros reported that in Gaza, 515 trucks of emergency supplies and 2,700 medical evacuations have been carried out. In Sudan, 3,000 metric tonnes of medical supplies have been delivered. In Ukraine, 1,200 medical evacuations have taken place. He noted persistent attacks on health workers.

On organizational priorities, the DG highlighted the use of a network of 577 collaborating centres. He confirmed that 90 audits of country offices have been completed without any unsatisfactory conclusions. He stated that the number one risk is undiversified financing and reduction in financing, calling on countries to approve an increase in assessed contributions.

Dr Tedros reminded delegates that for 78 years, the World Health Assembly is where countries have met. He stressed that national sovereignty and international sovereignty are not mutually exclusive. Drawing a parallel to the patients in the Hantavirus outbreak, he said: *"We are all in the same boat. We are all stronger and safer as one world."* He echoed the Prime Minister's words: *"We need a contagion of solidarity."*

Committee A (10:00 - 13:30)

Following the plenary, the second meeting of Committee A commenced with the consideration of agenda items 13.1 and 13.2, focused respectively on the WHO Emergency Programme's Independent Oversight and Advisory Committee and on International Health Regulations (IHR 2005) implementation.

Under item 13.1, the Committee discussed the report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (IOAC), contained in document A79/6. Under item 13.2, the Assembly considered the Director-General's annual report on the implementation of the International Health Regulations (2005), contained in document A79/7. Notably, the Assembly's membership continues to report on IHR implementation under the IHR (2005) instrument, in its form before the post-Covid-19 revisions that were approved by the Assembly two years ago.

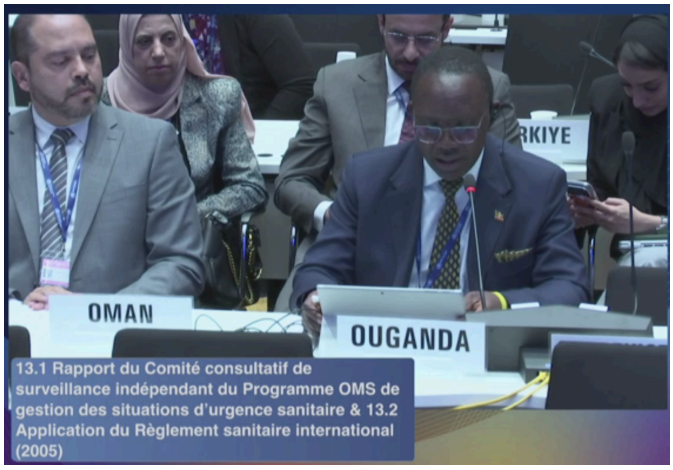
Several countries referenced the evolving and increasingly complex landscape for health emergencies, driven by climate, increasing zoonoses, higher rates of migration, war and conflict, and economic strife. **Namibia** and **Micronesia** argued this creates conditions in which the IHR and its proper implementation are all the more important. **Angola** reinforced its support for the IHRs, *"recognizing its fundamental role in maintaining global health security."* **Togo** proudly reported on the launch of its health security action plan designed to meet the minimum requirements of the IHRs. **The Central African Republic** described the IHRs as an *"important pillar of global health security."* **China** called for the *"upholding of global health security for all."*

The need for funding to achieve health emergency preparedness and response goals was repeatedly raised by countries, particularly developing countries. **Angola** underlined the importance of sustainable and equitable financing to achieve shared goals in health emergency response.

Colombia commended WHO for its work on health emergencies amidst *"more and more complex health issues,"* arguing that WHO's leadership is still vital, especially in relation to the regulatory function of the organization and establishing and enforcing standards. Colombia reinforced its support for *"a strong and technically robust WHO."*

India pointed out that, while WHO has demonstrated commendable leadership on facilitating progress on the IHRs and health emergencies more generally, persistent gaps remain, especially in sustainable financing and the promotion of country-level capability to meet expectations for IHR core capacities. **Ecuador** similarly called for further strengthening of capacities and the availability of sustainable resources to ensure reliable surveillance and response capacities. **Uganda**, commenting amidst its own emergency response to an Ebola virus outbreak, called for predictable financing, global collaboration and support, and strong country ownership to ensure the smooth implementation of the IHR (2005) and rollout of the new IHR (2024) instrument.

Indonesia highlighted that this is a cross-cutting issue, arguing that preparedness for health emergencies needs to be included under multiple agenda items related to health system strengthening, not just "a standalone agenda item" on health emergencies. The agenda items were concluded with the noting of the reports under consideration by consensus.



"Uganda is currently managing an Ebola outbreak, which is currently under control, reflecting the importance of preparedness and rapid reaction."
–Delegate from Uganda

Committee A (14:30 - 18:00)

Committee A continued by considering agenda items 14.1 and 14.2. Item 14.1 addresses WHO work in health emergencies (Documents A79/9 and A79/9 Add.1), while item 14.2 concerns Strengthening the evidence base for public health and social measures (Document A79/5).

With respect to WHO's work on health emergencies, the Committee considered two reports. The report contained in document A79/9 (WHO's work in health emergencies) is the standard Director-General's report on Health Emergencies routinely presented to the Assembly on an annual basis. Reporting on calendar year 2025, the report provides information on all WHO-graded acute and protracted emergencies and on public

health emergencies of international concern that required a response by WHO. The report also provides some information about health emergency trends, challenges and short- and medium-term outlooks.

The second report, contained in document A79/9 Add.1, is subtitled "Update on strengthening health emergency prevention, preparedness, response and resilience" and serves in part as a response to Assembly resolution WHA77.8 on health emergencies arising from natural disasters, which was passed two years ago.

Many countries expressed support for providing additional and sustainable financing for the WHO Health Emergencies Programme (WHE). Countries making strong statements in this respect included **Angola**. The importance of a One Health approach was repeatedly endorsed, including by the **Bahamas**. The **Philippines** strongly emphasized the importance of WHO's coordinating role in health emergency response and called for the strengthening and sustaining of ongoing initiatives, including expansion of the international pathogen surveillance network.

Most countries commended WHO's ongoing work on coordinating and contributing to preparedness for and response to health emergencies, and asked for continued strengthening of these efforts. Some countries, especially from the global south, made mostly implicit connections between health emergency prevention and response and aspects of comprehensive primary health care and the Alma Ata vision. The **Philippines**, for example, advocated for *"sustained investment in resilient primary care"* and *"equitable access to medical countermeasures"* as core features of global health collaboration on health emergencies.

Under item 14.2, the Committee took up the topic of taking action to strengthen the evidence base for public health and social measures. The item refers to the report considered by the Executive Board in January and February of this year (contained in document EB158/21), which itself arose from a resolution approved by the Assembly at WHA78 in 2025. That resolution instructed the Secretariat, among other things, to work to strengthen social science and behavioural research capacities at national and international levels. During discussion of the item at EB158, special emphasis was placed on the importance of evidence for public health and social measures to facilitate decision-making during emergencies, hence the grouping of this item with 14.1 on health emergencies.

With regard to the topic of evidence for public health and social measures, most countries who referred to it spoke positively.

The debate was anchored by coordinated regional statements that highlighted the specific vulnerabilities of their member states. **Cyprus**, speaking on behalf of the **European Union**, **Albania**, and **Moldova**, expressed deep alarm regarding the global landscape of health crises. The statement condemned all deliberate attacks on civilians, health care workers and aid workers, and reminded parties to armed conflicts that they are required to facilitate the functioning of medical establishments and protect them from harm. Cyprus noted that ten years of the WHO Health Emergencies Programme have been a success but warned that it is in our common interest to ensure the functioning of the programme through flexible and predictable funding. The bloc also expressed deep concern regarding the rapid spread of the Ebola virus disease in the Democratic Republic of the Congo and Uganda, while welcoming the swift release of funds from the Contingency Fund for Emergencies.

Similarly, **Lesotho, speaking on behalf of the 47 member states of the African Region**, highlighted the intersection of climate, migration, and crisis. The statement noted that nearly half of all people in need of humanitarian assistance worldwide are in the region. Lesotho expressed severe concern about the funding

reductions that have disrupted services in over 6,000 health facilities, impeding access to services for 50 million people. The region called for the protection of health workers in conflict zones and condemned attacks on health facilities, emphasizing that the growing problem of cholera outbreaks and humanitarian crises requires long-term intervention.

In the Eastern Mediterranean, a strong, unified bloc of nations aligned with Lebanon and Egypt to address the erosion of medical neutrality. **Egypt** stated that attacks on hospitals should be considered as attacks on the right to health and stressed the need for a moral and ethical commitment not to attack health infrastructure. **Jordan**, speaking on behalf of global humanitarian personnel, highlighted 284 attacks on WHO facilities and the killing of peacekeepers, urging the upholding of International Humanitarian Law. L**ebanon** provided the most detailed account, stating that attacks on health care numbered 169 according to WHO surveillance, which killed 110 health workers and injured 200, damaged transport and medical supplies, and closed three hospitals.

Nations from the Pacific and Caribbean regions formed a distinct cluster, emphasizing the existential threat of climate change and the lack of financial capacity to respond independently. **Barbados** noted that member states such as Barbados do not have the financial capacity to respond to emergencies like hurricanes, Mpox, and Ebola, and called for the Emergency Fund to support them within 24 hours. **Maldives** underscored that for smaller states, emergencies affect industry and called for strengthened health solidarity for essential services including maternal and child care. The **Dominican Republic** highlighted the value of cross-border cooperation in areas with high mobility, such as the Caribbean. The **Philippines**, noting their status as a climate-vulnerable archipelago, called for sustained investment in resilient primary care.

Beyond these regional blocs, individual member states grouped their interventions around three primary themes: the protection of health infrastructure in conflict, the necessity of sustainable financing, and the strengthening of evidence-based responses.

On the issue of protecting health infrastructure in conflict, Cuba strongly condemned aggression, stating that no political difference should put the right to health at risk. **Cuba** specifically addressed the situations in Iran and Lebanon, asserting that illegal attacks have damaged Iran's healthcare infrastructure and that Israel's ongoing attacks on Lebanon have killed 1,800 Lebanese and led to the closure of primary healthcare centres and hospitals. **Iran** detailed the impact of recent hostilities, noting that eight hospitals were damaged and services were temporarily halted, and that vaccine centres, labs, and equipment have suffered significantly. **China** urged aggressors to cease military operations in line with humanitarian law. **Monaco** paid tribute to those risking their lives on a daily basis working in such extremely difficult conditions. **Switzerland** recalled that International Humanitarian Law must be respected under all circumstances. **South Africa** condemned attacks on the Pasteur Institute in Iran, stating that such attacks are becoming the norm and must never be continued.

Regarding sustainable financing and resilience, **Angola** highlighted its own 2025 cholera outbreak affecting 18 of 21 provinces and noted that predictable and sustainable financing is crucial in response, especially for vulnerable countries. **India** called for a stronger, adequately funded WHO at the centre of global health governance. **Thailand** stated that sustainable financing is vital and advocated for a One Health approach. **Sri Lanka** underscored the urgency of sustaining the HEPRR framework, noting that global evidence clearly shows reduced financing has always disrupted services for millions, with disproportionate impacts on maternal and neonatal health, nutrition, and gender-based violence response. **Malaysia** showcased its Resilient Healthcare Facilities Toolkit and announced it would be hosting the fourth International Economic Conference on Disaster

Health Management in 2027. The **United Kingdom**, as the largest flexible funder, recommended flexible and predictable funding to enable WHO to maintain rapid response capacity.

Finally, on evidence, surveillance, and One Health, the **Philippines** called to deepen behavioural and social science research and build capacities for implementation research, especially in resource-poor and fragile settings. **Oman** underscored the importance of surveillance and health data, noting that analysing metadata is important for early warning systems. **Bulgaria** noted a significant gap in the capacity to apply findings and suggested that social listening could be a feature of the Secretariat's approach on this issue moving forward. **Morocco** welcomed the rigorous evidence in the 50 emergencies analysis. **Ethiopia** cited the successful containment of a Marburg outbreak in 2025 as proof of the need for early risk readiness, preparedness, and response. **Singapore** encouraged member states to strengthen systems, noting that the Hantavirus shows the need to strengthen research. Bahrain stated that they value scientific knowledge that will help us deal with health emergencies.

The debate concluded with a vote on two draft resolutions, revealing known deep geopolitical divisions. The first, A79/A/Conf./2, proposed by Iran regarding the protection of healthcare in conflict settings with reference to attacks on Iran, was rejected in a recorded vote: 19 in favour, 30 against, 58 abstentions. Canada, the United Kingdom, Belgium, and New Zealand voted against or abstained, citing Iran's destabilizing actions and the inclusion of political language. Conversely, Indonesia and Oman voted in favour, recognizing the humanitarian situation, while Singapore voted in favour but placed on record reservations that the text veers into political territory.

The second resolution, A79/A/Conf./3, concerning the health emergency in Lebanon, was approved by a wide margin: 95 in favour, 2 against, 18 abstentions. This resolution garnered broad support from the Arab League, the African Group, and Western nations including France, Spain, and Portugal, who aligned with the European Union's condemnation of attacks on Lebanese healthcare. Israel voted against. Explanations of vote will be given at the start of the session on Wednesday.

"WHO's work in health emergencies must be defended, strengthened, and sustainably financed. Its coordination of health clusters, support to ministries of health, documentation of attacks on health care, and delivery of essential services remain indispensable. Yet emergencies cannot be reduced to detection, grading, and response. War, occupation, forced displacement, climate breakdown, austerity, debt, weakened public systems, and unequal access to health technologies are producing avoidable crises. We call on Member States to reject the normalization of humanitarian rationing, protect health care in conflict, replenish WHO's emergency funds, and move from health

security to health solidarity. Emergency preparedness must mean peace, public health systems, climate justice, social protection, community participation, and equitable access for all."

- MMI and PHM Statement on Agenda 14.1 and 14.2 -

Side event — Economics of Health for All: Taking Action (evening)

PHM Watchers attended an official side event in the evening discussing WHA79's agenda item on the Economics of Health for All. This topic has been foundational to PHM's political economy of health work for more than 20 years. It was again emphasized that a fair and just global economic and financial system is critical to advancing health and social equity.

The panel brought together an interesting mix of civil society organizations, academia, and member states from both the Global South and Global North. Some panelists observed that the draft strategy has diluted certain parts of the vision of the Council on the Economics of Health for All. Others noted that key conversations, such as tackling the intellectual property regime, have disappeared within the WHO. The issue of debt and the financialization of health and society also arose. Participants identified a need to explore the relationship between these issues and declining trust in public institutions, including the WHO.

Those in attendance and the panelists agreed that this is a very important agenda that must be kept within WHO's work, but acknowledged that difficulties and more work lie ahead. They expressed a desire to continue collaborating as they move forward.

Disclaimer: The summarizing of this daily brief was aided by DeepSeek based on the notes of PHM WHO-Watchers. Translation into French and Spanish was done fully by DeepL.