

## **Address by Dr Tedros Adhanom Ghebreyesus, Director-General**

### **High-level welcome (First plenary session, 18 May 2026)**

Your Excellency John Mahama, President of Ghana, your Excellency Elisabeth Baume-Schneider, Federal Councillor of the Swiss Confederation, President of the Seventy-ninth World Health Assembly, Dr Victor Atallah Lajam, United Nations Office at Geneva Director-General Tatiana Valovaya, Excellencies, honourable ministers and heads of delegation, dear colleagues and friends, good morning and welcome.

My thanks to Your Excellency Councillor Baume-Schneider for your warm welcome, and for Switzerland's continued hospitality in hosting WHO and the World Health Assembly. My thanks also to Your Excellency President Mahama for honouring us with your presence, and for your inspiring message today. Thank you for your leadership over the past year, especially in launching the Accra Reset at the Africa Health Sovereignty Summit in August 2025 – where I was honoured to join you. I would also like to thank the President of the Syrian Arab Republic, the Prime Minister of Barbados and the United Nations Secretary-General for their messages today.

This time last week I was in Spain, where we had just completed the successful disembarkation and repatriation of the passengers aboard the MV Hondius. I thank His Excellency Prime Minister Pedro Sánchez and Minister Mónica García Gómez, who is with us today, for their outstanding leadership and partnership in response to the hantavirus outbreak. *Muchas gracias*, Minister. His Excellency Prime Minister Sánchez will join us this afternoon, and I look forward to welcoming him.

And as you know, yesterday I declared a public health emergency of international concern over the Ebola virus disease outbreak in the Democratic Republic of the Congo that has already spread to Uganda. I will say more about both outbreaks – hantavirus and Ebola – in my address to Member States this afternoon, which is the technical report. They are just the latest crises in our troubled world. From conflicts to economic crises to climate change and aid cuts, we live in difficult, dangerous and divisive times.

As you all know, WHO has itself been through a difficult period as a result of sudden and steep cuts to our funding. Many people have questions about the impact of those cuts for the future of WHO. They want to know what is going on. Today, I want to address those concerns by telling you what we have done, what we are doing, and what we will do to build a stable and resilient WHO, and secure its future.

In fact, that work did not begin last year. It began nine years ago, when we started the WHO transformation – the most ambitious reform agenda in the Organization’s history, because we knew such a scenario could happen. There are dozens of ways in which WHO has transformed, and continues to transform, to meet the changing needs of Member States.

Today I would like to highlight just three, among a long list of changes we are trying to make: the changes we made to our core normative and technical functions; the changes we made to our work in emergencies; and the changes we made to our financial model. I will also update you on our restructuring and our work on reform of the global health architecture.

First, our core mandate – science, data, norms and standards. As some say, WHO’s bread and butter. Prior to 2019, the way WHO developed normative products was fragmented, with limited quality control or overview. So, for the first time in the Organization’s history, we established a new Science Division – led by the Chief Scientist as a new executive position – to consolidate and strengthen WHO’s normative and technical work. By the way, this work is going to help the Organization, because we are saying – and many of you are saying – that WHO should focus on its core mandate, and this is our core mandate.

We have strengthened our evidence-generation processes, and aligned prequalification of medical products with the introduction of living guidelines. For example, in the past, WHO would prequalify medicines and only then develop guidelines on their use. The process was disjointed and could take years. Last year, WHO prequalified the groundbreaking drug lenacapavir for HIV prevention at the same time as we developed the guidelines, in just eight months.

But we also want to make sure that WHO does not just produce technical products that sit on a shelf, but that are put to use. So, in 2024, we opened the WHO Academy in Lyon, France, which now offers over 400 courses in 23 languages, reaching over 120 000 learners so far. We are also leveraging the network of over 800 WHO collaborating centres, as the Federal Councillor said earlier. We established the World Health Data Hub to consolidate our fragmented data and analytics capacities. We are investing in a modern data backbone, including an artificial intelligence-powered single point of discovery for data, statistics and knowledge products. We continue to modernize interoperability standards, including the eleventh revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-11), which is accessed four million times daily in 15 languages. And to support countries to harness the power of digital technologies and artificial intelligence for health, we established a dedicated department at headquarters, with focal points across all six regions.

The second major area of change came with the coronavirus disease (COVID-19) pandemic, which exposed many gaps in global health security, and taught us all many lessons. Based on the gaps we identified – I will focus on six today – we are changing.

First, we saw that the world needed enhanced capabilities to identify and respond to threats faster. So with support from Germany, we established the WHO Hub for Pandemic and Epidemic Intelligence in Berlin.

Second, the pandemic exposed deep inequities in access to vaccines, diagnostics and therapeutics. So we established the Access to COVID-19 Tools (ACT) Accelerator, including COVAX, the ACT-Accelerator vaccines pillar, followed by the interim Medical Countermeasures Network. We also set up the mRNA Technology Transfer Hub in Cape Town, South Africa, which is now sharing technology with research centres in 15 countries; and the WHO Biomanufacturing

Workforce Training Initiative in the Republic of Korea, which is supporting countries to build the workforce they need, with the skills they need, for local manufacturing.

Third, to strengthen national capacity, together with the World Bank, we established the Pandemic Fund – which has so far disbursed US\$ 1.4 billion in grants to 128 countries. We also established the Universal Health and Preparedness Review, a peer review mechanism to build national capacity and enhance accountability.

Fourth, to improve coordinated global sharing of pathogen materials we established the WHO BioHub here in Switzerland, again as the Federal Councillor said, which has now shared 165 samples.

Fifth, to enhance emergency workforce capacity, we established the Global Health Emergency Corps, which recently ran its second simulation exercise, involving 600 health emergency experts and 25 partner organizations from 26 countries and territories.

And sixth, we recognized that we needed to reform the governance of global health security, to bring everything together into a cohesive whole.

At this Assembly two years ago, Member States adopted a set of amendments to the International Health Regulations (2005), and last year, you adopted the WHO Pandemic Agreement, a landmark instrument of international health law.

The final remaining piece of the puzzle is the Pathogen Access and Benefit-Sharing system, as was said earlier by previous speakers – the PABS Annex. Of course, we had all hoped that negotiations would be completed in time for the PABS Annex to be adopted at this Assembly. It has not happened yet, but I am confident it will, and I thank Member States for their commitment to continuing negotiations and seeking consensus – which I have no doubt you will find, and address the last piece of the puzzle.

The third major area of transformation – and arguably the most significant – is the historic change we are making to the way WHO is financed. They say, “The economy, stupid”. In terms of independence and preventing shocks, it is the financing model, stupid. When WHO was established in 1948, its only source of funding was from assessed contributions – the membership fees that countries pay. Voluntary contributions were introduced in the 1950s but initially represented only about 20% of WHO’s base budget. By 2017, that proportion had flipped: assessed contributions accounted for only 20% of the base budget, and voluntary contributions accounted for 80%. What is more, the majority of voluntary contributions were – and remain – tightly earmarked for specific projects and programmes selected by donors, making WHO vulnerable to shifting donor priorities and geopolitical winds.

We recognized this overreliance on inflexible, voluntary contributions from a handful of donors as a major risk. It undermined the Organization’s independence, impeded its agility and exposed it to shocks if a major donor were to withdraw or reduce its funding significantly. So together with Member States, we designed a set of proposals to broaden our donor base – the revenue source – and make our funding more predictable and sustainable. Several Member States reduced earmarking and committed to higher levels of flexible and voluntary funding – and we thank those countries for their trust and support. We also established the WHO Foundation, to tap sources of funding that we had not accessed before. Most significantly, we proposed a plan to increase assessed contributions from 20% of the base budget to 50%. In 2022, here at the World Health Assembly, Member States approved it – a plan to increase assessed contributions to 50% of

the base budget. Subsequently, they agreed to achieve that target in five instalments. The first two have already happened, and the remaining three are due in 2027, 2029 and 2031.

We cannot overstate just how transformational this change has been – and will continue to be – for safeguarding WHO's institutional independence, and for protecting the Organization against shocks, like the shock that happened last year. If the first two instalments had not happened, the impact of last year's funding cut would have been much worse, as you can imagine.

Excellencies, honourable ministers, dear colleagues and friends. These are the three key areas in which WHO has transformed: science, emergencies and finance, among others. Now I would like to update you briefly on the comprehensive process of prioritization and realignment that we have undergone in the past 16 months.

Although the first two increases in assessed contributions cushioned the impact of the funding cuts we faced, they could not insulate us fully. In close consultation with Member States, we reduced our programme budget and undertook a rigorous analysis of every office and every programme. Unfortunately, we were left with no choice but to say goodbye to a large number of dedicated, hardworking colleagues – and I would like to place on record my deep gratitude to all of them for their commitment and service. We have now completed the restructuring process. We have reached a position of stability and are moving forward, with purpose and confidence.

The crisis actually brought clarity and confirmed that what we have been doing over the past nine years is the right road to stability. We project that for the current biennium, 90% of the base budget is funded. However, we recognize that in the current environment, the remaining 10% will not be easy to mobilize. And because the majority of voluntary contributions remain earmarked, we continue to see pockets of poverty in many areas of our work. That makes it essential that Member States fulfil their commitment to approving the remaining three increases in assessed contributions and to fully honouring the commitments you made in the Investment Round. At the same time, the work of reforming WHO to make it leaner and more effective and efficient, focused on its core mandate, will continue.

There is always room for improvement. There are always lessons to learn. There are always things we can do better, should do better and will do better. For us, I would like to assure you that change is a constant, and we will continue to change – not for the sake of change, but for the sake of the countries and people we serve. In some areas, this will require stepping back from work that others are better placed to perform. Because after all, WHO is only one part of the global health architecture. Over time, that architecture has become increasingly crowded, complex and fragmented. It is time for a renovation, to build a new global health architecture fit for the future.

At this Assembly, Member States will consider a proposal for a Member State-led, WHO-hosted joint process to reform the global health architecture. Our purpose is not to launch a new initiative but to bring together the many existing initiatives that have proposed reforms of the global health architecture, in part or in whole. That is why we have chosen as the theme for this year's World Health Assembly, "Reshaping global health: a shared responsibility". And this is where the leadership of His Excellency President Mahama has been so decisive, in launching the Accra Reset last year.

In the past year, many countries have experienced severe disruptions due to sudden and steep cuts in development assistance. Those disruptions, and the damage they caused to the health of individuals, families and communities, were regrettable and avoidable. But they had an unintended benefit: they prompted many leaders to say now is the moment to leave behind the

era of donor dependency and open a new era of health sovereignty. That is the message of the Accra Reset, and the echoes of Accra are now resounding in Geneva, and around the world.

Thank you, Your Excellency, for your leadership in this. You were very clear in your message today. Every country should be able to depend on other countries. For friendship. For solidarity. For support when needed. But no country wants to be dependent. Every country wants equity. Every country wants sovereignty. It is a cliché to say we are at a turning point – a fork in the road. In this case, it is true.

This is the moment for change. This is the opportunity to take the road that leads to sovereignty; the road that leads to solidarity; the road that leads to equity. That is the road down which many countries are now walking – and that is the road that WHO is walking with you, every step of the way. It is the road that leads to the destination that our founders set 78 years ago: the highest attainable standard of health, not as a luxury for some but a right for all.

I visited Malaysia this year, and I had a meeting with His Excellency the Prime Minister. One thing I picked up was, “Malaysia *boleh boleh*”. It means “Malaysia can”. All countries can. That’s what President Mahama showed us. So *boleh boleh*. It is possible, we can.

I thank you.

## Opening address (Third plenary session, 19 May 2026)

President of the Seventy-ninth World Health Assembly, Dr Victor Atallah Lajam, Excellencies, honourable ministers and heads of delegation, dear colleagues and friends,

Early on Sunday, I declared a public health emergency of international concern over an epidemic of Ebola virus disease in the Democratic Republic of the Congo and Uganda. This is the first time a Director-General has declared a public health emergency of international concern before convening an Emergency Committee.

I did not do this lightly. I did it in accordance with Article 12 of the International Health Regulations (2005), after consulting the ministers of health of both countries, and because I am deeply concerned about the scale and speed of the epidemic. We will convene the Emergency Committee today to advise us on temporary recommendations.

So far, 30 cases have been confirmed in the Democratic Republic of the Congo, from the north-eastern province of Ituri. Uganda has also informed WHO of two confirmed cases in the capital Kampala – including one death – among two individuals who travelled from the Democratic Republic of the Congo. A national of the United States of America has also been confirmed positive and has been transferred to Germany, as reported by the United States. We’re working with the Democratic Republic of the Congo, Uganda and the United States.

There are several factors that make us concerned about the potential for further spread and further deaths. First, beyond the confirmed cases, there are more than 500 suspected cases and 130 suspected deaths. These numbers will change as field operations are scaling up, including strengthening surveillance, contact tracing and laboratory testing. Second, cases have been reported in urban areas, including Kampala and the city of Goma in the Democratic Republic of the Congo. Third, deaths have been reported among health workers, indicating healthcare-associated transmission.

Fourth, there is significant population movement in the area. The province of Ituri is highly insecure, as you may know. Conflict has intensified since late 2025, and fighting has escalated significantly over the past two months, resulting in civilian deaths. Over 100 000 people have been newly displaced – and in Ebola outbreaks, you know what displacement means. The area is also a mining zone, with high levels of population movement that increase the risk of further spread.

And fifth, this epidemic is caused by Bundibugyo virus, a species of Ebola virus for which there are no vaccines or therapeutics. In the absence of a vaccine, there are many other measures countries can take to stop the spread of the virus and save lives, even without medical countermeasures, including risk communication and community engagement. I thank the Government of Uganda for postponing the annual Martyrs' Day celebrations, which can attract up to 2 million people, because of the risk posed by the epidemic.

WHO has a team on the ground supporting national authorities to respond. We have deployed people, supplies, equipment and funds. I have approved an additional US\$ 3.4 million from the WHO Contingency Fund for Emergencies, bringing the total to US\$ 3.9 million. I would like to use this opportunity to thank all countries who contribute to the Contingency Fund for Emergencies, and we will continue to keep all Member States informed.

As you know, WHO is also responding to the outbreak of hantavirus among passengers and crew on the MV Hondius cruise ship. The passengers have all been repatriated and will be monitored until the quarantine period ends on 21 June. Yesterday, the MV Hondius arrived in Rotterdam, Kingdom of the Netherlands, where the crew disembarked and will be quarantined until 29 June.

For the past two weeks, I have been in regular contact with the captain of the ship, Captain Jan Dobrogowski of Poland, and I would like to thank him for everything he has done for the passengers and crew under his care. I'm sure Poland is proud of Jan.

WHO's assessment continues to be that the risk of hantavirus globally is low. So far, there are 11 reported cases, including three deaths, and no deaths have been reported since 2 May, when WHO was first informed of the outbreak on the ship. Those numbers have changed little since the outbreak was first reported to WHO two weeks ago. As things stand, there is no sign that we are seeing the start of a larger outbreak. But of course, that could change, and we urge all affected countries to continue monitoring the passengers and crew carefully.

I thank the many countries involved in the response. Spain not only met its legal duty under the International Health Regulations (2005), but also its moral duty to the passengers and crew. I would especially like to thank Prime Minister Pedro Sánchez for his leadership, and for his inspiring message at this Assembly yesterday. Spain handled the situation with compassion and kindness to the passengers and crew, and not just legal obligation.

I also thank South Africa, which was the first to confirm hantavirus at the National Institute for Communicable Diseases in Johannesburg, after the first patient was evacuated there. I thank the United Kingdom of Great Britain and Northern Ireland for notifying WHO and all countries through the International Health Regulations (2005). I thank Cabo Verde for helping with the evacuation of the three symptomatic patients. I thank the Kingdom of the Netherlands, which has been actively involved through every stage of the outbreak and has received the evacuees from the ship. And I thank Argentina and Chile for sharing their expertise and support in the epidemiological investigations and for donating reference material for polymerase chain reaction and serologic testing to five reference laboratories involved in the response.

The outbreaks of Ebola and hantavirus in the past two weeks show why international threats need an international response. They show why the world needs the International Health Regulations (2005) and why it needs WHO.

Despite the challenges we faced last year, there were many achievements to celebrate. The WHO results report contains a comprehensive and interactive account of those achievements, with scorecards and country stories that demonstrate our impact on the ground. I urge you to use it.

In one speech, I cannot do justice to the length, breadth and depth of my colleagues' work. But allow me to highlight a few key achievements, according to each of the three key priorities of the Fourteenth General Programme of Work, 2025–2028: to promote, provide and protect health.

Let me begin with our work to promote health and prevent disease by addressing its root causes. This year marks the fortieth anniversary of the Ottawa Charter for Health Promotion – a landmark declaration that reminds us that health is created in the places where people live, learn, work and play. I would like to pay tribute to the architect of the Ottawa Charter, Professor Ilona Kickbusch, and the then Director-General, the late Dr Halfdan Mahler.

In the past year, WHO has worked to promote health and prevent disease in six key areas.

First, tobacco. Last year, the WHO Framework Convention on Tobacco Control celebrated its twentieth anniversary. Since the Convention entered into force, tobacco use has dropped by one third globally, and it continues to decline in 140 countries. With support from WHO, Maldives became the first country to adopt a generational tobacco ban for people born from 2007, and this year the United Kingdom followed suit, banning the sale of tobacco to anyone born from 2009 onwards. Just last week, Zambia's parliament approved a landmark comprehensive tobacco control bill, after years of work and strong support from WHO.

Despite progress against traditional tobacco products, we face a rapidly changing market of new and emerging nicotine products, including e-cigarettes and nicotine pouches. Last week, WHO published a new global report exposing the marketing tactics and strategies driving the global growth of nicotine pouches.

Second, health taxes. Last year WHO launched the 3 by 35 Initiative, calling on all countries to raise the real prices of tobacco, alcohol and sugary drinks by at least 50% by 2035. In the past 12 months, India, Jamaica, Malaysia, Mauritius, Mexico, Montenegro, Saudi Arabia, Sierra Leone, Viet Nam and Zambia were among countries that either announced, introduced or increased taxes on one or more of these products.

Third, nutrition. At this Assembly last year, Member States approved the extension of the six WHO global nutrition targets to 2030. Two of the targets, on exclusive breastfeeding and childhood overweight, were almost met, so Member States increased them. Almost 50% of children worldwide are now breastfed for at least six months, and 146 Member States now have legal measures in place to protect breastfeeding, covering 91% of all births globally.

Although obesity continues to rise in many low- and middle-income countries, recent analyses show that obesity rates are plateauing in some high-income countries. Also last year, WHO verified Portugal and the United Arab Emirates for the elimination of trans-fats, a leading driver of cardiovascular disease. We will recognize both countries for their achievements later today.

Fourth, climate and environment. In the past 12 months, the WHO Alliance for Transformative Action on Climate and Health grew to more than 100 countries, supporting them to build climate-resilient, low carbon health systems. Member States also endorsed an updated global road map on air pollution and health, including a commitment to halve health impacts by 2040. And new data from the WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene showed that one billion more people now have access to safely managed drinking water than a decade ago, saving millions of lives.

Fifth, violence, injuries and drowning. In the past year, 68 countries have reported progress on violence against children, based on the pledges they made at the first Global Ministerial Conference on Ending Violence Against Children in Colombia in 2024. For example, Benin is rolling out a national plan of action on child marriage, while Mongolia is introducing a nationwide child protection workforce. With partners, we launched the first Global Strategy for Drowning Prevention, with a target to reduce drowning deaths by 35% by 2030. WHO also supported 15 more countries to strengthen legislation and action on road safety. For example, Ghana adopted new safety standards for child restraints in vehicles and for motorcycle helmets. We urge countries to agree a strong political declaration at the United Nations high-level meeting on improving global road safety, to be held in July.

And sixth, cities. Over the past 12 months, almost 140 cities in 24 different countries joined the regional Healthy Cities Networks – including 69 cities in Saudi Arabia alone – and WHO's Urban health capacities assessment and response resource kit was implemented in 14 cities, collectively home to approximately 33 million inhabitants. Participating cities have improved food safety, housing affordability and quality, and indoor air quality.

Now to our work supporting countries to provide health, by strengthening health systems and primary healthcare on the road to universal health coverage. Here are four areas where we're doing that:

First, health financing. Following deep cuts to official development assistance last year, WHO developed guidance on responding to the health financing emergency, supporting countries including Cambodia, Ethiopia, Mozambique and Uganda. We're also supporting Sierra Leone, under the leadership of the Vice-President, to navigate the impact of the cuts while also launching an ambitious health system reform. And with the World Bank and the Government of Japan, we established the UHC Knowledge Hub in Tokyo, which is now supporting the first eight countries with capacity-building and knowledge sharing and by bringing ministries of health and finance together, especially to increase fiscal space.

Second, health workforce. The world is facing a shortage of 11 million health workers by 2030, with the biggest gaps in the African and Eastern Mediterranean Regions. More than half the gap is a shortage of nurses, as last year's landmark State of the World's Nursing Report showed. In the past 12 months, WHO supported 11 countries facing the most acute shortages to strengthen their national workforce strategies, contributing to commitments for nearly 100 000 new health worker jobs. With WHO support, 38 countries have more than doubled their health workforce over the past 10 years. This Assembly will consider important additions to the WHO Global Code of Practice on the International Recruitment of Health Personnel.

Building the capacity of the global health workforce was one of the main reasons for establishing the WHO Academy in Lyon, France, with the support of the Government of France. Following the restructuring, the Academy brings together WHO's work on health workforce strengthening, alongside its learning function. The Academy now offers more than 400 courses

free of charge, in 23 languages, with more than 120 000 enrolments so far. I urge all Member States to make use of this resource; it is there for you. One of the courses offered by the Academy is the Basic Emergency Care programme, which has now been implemented in over 100 countries. Four African countries are now bringing it to scale in 846 health centres and hospitals over the next two years, saving tens of thousands of lives.

Third, health products. In the past 12 months, WHO prequalified 50 medicines, six vaccines, 15 in vitro diagnostics, 41 medical devices and six vector control products and performed 198 inspections of manufacturing sites. We also updated the WHO Model List of Essential Medicines to include new medicines for cancer and glucagon-like peptide-1 medicines (GLP-1s) for diabetes in people with obesity.

To expedite prequalification and procurement, we designated regulatory agencies in five more countries as WHO listed authorities: Australia, Canada, Indonesia, Japan and the United Kingdom. In addition, we recognized Ethiopia and Kazakhstan for reaching maturity level 3 for regulatory oversight of medicines and vaccines, and Singapore for reaching maturity level 4 for medical devices. And just three weeks ago, we designated regional training centres for biomanufacturing in countries in each region – in Brazil, China, Egypt, India, Ireland, Senegal and South Africa. This is a major step forward in strengthening the global workforce needed to support local manufacturing, based on the coronavirus disease (COVID-19) lessons, as you remember.

On antimicrobial resistance, the Global Antimicrobial Resistance and Use Surveillance System, GLASS, showed that one in six bacterial infections globally are now resistant to antibiotics, and the trend is increasing. To enhance the pipeline of new antibiotics, in March we published three new target product profiles for treating some of the most severe drug-resistant infections in at-risk populations worldwide. We also launched the Traditional Medicine Global Library, with almost 2 million scientific records.

Fourth, health data systems and digital technologies. Of the estimated 61 million deaths that occurred globally in 2023, fewer than one in five were reported to WHO with sufficient cause-of-death information for reliable public health analysis. Strengthening health data systems is vital to enable countries to generate and use their own data to guide public health action.

In the past 12 months, WHO expanded the Global Digital Health Certification Network to 82 countries, enabling 2 billion people to access their health records on national digital health wallets. I would like to thank the European Union for its great support for this new department we have in digital health.

We have now rolled out the eleventh revision of the International Classification of Diseases (ICD-11) to 132 Member States. Every day, our International Classification of Diseases systems receive around 4 million requests for information, enabling analysis of national and global health trends.

All of this work is supporting countries to strengthen the foundations of their health systems and to help them progress towards universal health coverage. At the same time, we're supporting countries to address specific health threats in five areas.

First, maternal and child mortality. Last year, WHO released updated estimates that more than 55 high-burden countries are using to prioritize and refocus. With partners, we issued the first consolidated guideline on postpartum haemorrhage, creating a single global clinical standard for the leading cause of maternal death that is saving lives when applied consistently. We also

issued our first global guideline on infertility and published updated global estimates on violence against women, which unfortunately show little progress in 20 years. We supported policy change in 50 countries to reduce unintended pregnancy, expand sexually transmitted infection and HIV self-testing, and accelerate screening coverage for cervical cancer.

This year, with partners, we published new global estimates on newborn, child and adolescent mortality, showing that in 2024, 4.9 million children died before their fifth birthday. Of course, there is significant progress compared to 30 years ago, when it was 11 million deaths a year, but we have to continue to strengthen our efforts. Although under-five deaths have fallen by more than half since the year 2000, progress has slowed dramatically. Reinvigorating it must be a global health priority.

Second, vaccine-preventable disease. In March, we concluded the Big Catch-Up initiative, an historic effort with Gavi, the Vaccine Alliance and UNICEF to reach children who missed out on one or all routine vaccines, partly due to the disruptions caused by the coronavirus disease (COVID-19) pandemic. Over the past three years, together we delivered more than 100 million vaccine doses to an estimated 18.3 million children in 36 countries. We also supported seven new countries to introduce malaria vaccines, bringing the total to 25 and targeting 10 million children every year, and we supported 15 more countries to introduce human papillomavirus vaccination to prevent cervical cancer. Since we launched the global call for action to eliminate cervical cancer in 2018, almost 75 countries have introduced human papillomavirus vaccination, meaning 65% of girls globally now live in a country with routine human papillomavirus vaccination. But of course, we need to do more.

Despite funding cuts, the Global Measles and Rubella Laboratory Network processed more than 700 000 tests to detect and respond to measles outbreaks globally. And we conducted an analysis of 31 studies in multiple countries over 15 years that showed once again that vaccines, including those containing thiomersal and aluminium adjuvants, do not cause autism.

Third, disease elimination. In the past 12 months, WHO has confirmed the elimination of seven different diseases in 17 countries. Algeria, Australia, Burundi, Egypt, Fiji, Libya, Senegal and Tunisia have all eliminated trachoma, Kenya eliminated sleeping sickness, and Chile eliminated leprosy. In addition, The Bahamas, Brazil, Denmark, Maldives and Turks and Caicos all eliminated mother-to-child transmission of HIV, and Botswana reached gold tier status on the path to elimination. Some of these countries also eliminated mother-to-child transmission of hepatitis B or syphilis or, in the case of Maldives, all three – the first country to achieve triple elimination. Congratulations to Maldives.

In addition, five countries have been validated for maintaining elimination status – Anguilla, Cuba, Montserrat, Oman and Sri Lanka – and WHO certified Suriname and Timor-Leste as malaria-free. Congratulations to all countries. The UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, TDR, contributed to Suriname's achievement through research that helped to reach hard-to-reach populations. We will recognize all these countries today.

I would also like to recognize the leadership of Mr Yohei Sasakawa, who is celebrating 25 years as a WHO Goodwill Ambassador for Leprosy Elimination – our longest-serving Goodwill Ambassador, and still running strong. *Arigato gozaimasu*, Mr Sasakawa.

Fourth, communicable diseases. On HIV, we took an important step forward by prequalifying lenacapavir in tandem with guidelines on its use, supporting the first 14 countries to roll it out.

Lenacapavir is one of the most powerful and promising tools in the history of HIV: a long acting injectable given every six months, it's the next best thing to an HIV vaccine.

On tuberculosis, WHO supported countries to expand access to rapid tuberculosis diagnostics, including new tests that can be used near the point of care. We also accelerated the roll-out of shorter, safer and more effective treatment regimens. The Tuberculosis Vaccine Accelerator is working with countries to prepare for the rapid integration of new tuberculosis vaccines into health systems, should they succeed in phase III trials.

On malaria, WHO prequalified the first treatment developed specifically for newborns and infants, as well as three new rapid diagnostic tests that can detect strains of malaria that other tests miss. On hepatitis, the WHO Global hepatitis report published just last month shows that since 2015, the annual number of new hepatitis B infections has dropped by 32% and hepatitis C-related deaths have fallen by 12% globally. On sexually transmitted infections, WHO issued a first recommendation for the use of doxycycline post-exposure prophylaxis to help prevent infections among key populations.

And fifth, noncommunicable diseases and mental health. The United Nations General Assembly adopted the most ambitious political declaration yet, with concrete targets on tobacco, hypertension and mental health. WHO also issued new guidelines on the use of GLP-1s for the treatment of obesity in adults, and WHO initiatives on cervical, breast and childhood cancer are now benefiting over 1 million people in more than 100 countries.

In partnership with St Jude Children's Research Hospital, we delivered 1.5 million cancer medicines, supporting treatment for 2400 children in five countries. I would like to use this opportunity to thank St Jude for their cooperation and leadership in this area.

We also supported 14 more countries to strengthen mental health services for children and young people. Since it launched in 2020, WHO's Special Initiative for Mental Health has expanded mental health services to over 90 million people and enabled first-time treatment for more than 1.5 million children and adults. WHO is supporting 13 countries in the African Region to improve access to neurological medicines for epilepsy and Parkinson's disease, where the treatment gap is more than 75%.

Now to WHO's work to support Member States to prevent, prepare for and respond to health emergencies. Most notably last year, Member States adopted the WHO Pandemic Agreement, and the amended International Health Regulations (2005) entered into force. Although Member States have not yet reached consensus on the Pathogen Access and Benefit-Sharing System, the PABS annex, they have committed to continuing negotiations, and I have every confidence that they will – you will – finalize it.

WHO took many other steps last year to strengthen health emergency preparedness and response in two key areas.

First, prevention and preparedness. Through the Pandemic Fund, with the World Bank, WHO supported 70 countries to develop and implement 41 projects to strengthen surveillance, laboratory networks, workforce capacity and multisectoral coordination. Twenty-one countries completed joint external evaluations, 195 States parties submitted their annual International Health Regulations (2005) reports, and 25 countries completed their national action plans for health security.

The Global Health Emergency Corps ran its second simulation exercise – Exercise Polaris II – involving 600 health emergency experts and 25 partner organizations from 26 countries and territories. And just this weekend, we launched our global health emergency strategy, with a target to have 10% of the world's health workforce ready to respond to emergencies by 2030.

The WHO R&D Blueprint for action to prevent epidemics brought together global expertise to prioritize research and close preparedness gaps for high-risk pathogens, including avian influenza, Rift Valley fever, Oropouche virus disease and Ebola. The WHO Hub for Pandemic and Epidemic Intelligence launched an update of the Epidemic Intelligence from Open Sources (EIOS) initiative, which harnesses the power of artificial intelligence to support more than 120 countries who use the platform every day to quickly identify new threats. Through the International Pathogen Surveillance Network, over 309 partners across 101 countries are also strengthening genomic surveillance to better track pathogens, detect new variants and guide faster responses to emerging threats.

In the past year, the WHO Global Influenza Surveillance and Response System, GISRS – a network of 165 institutions in 136 countries – tested more than 11 million clinical specimens and shared 65 000 virus samples with WHO collaborating centres. Through the Pandemic Influenza Preparedness Framework, the PIP Framework, WHO signed eight new agreements, giving us access to more than 940 million vaccine doses in the event of an influenza pandemic, as well as antivirals, syringes and diagnostics. The WHO BioHub System coordinated 17 sample shipments to laboratories in 10 countries to guide research and development of countermeasures.

We were also on the ground, supporting countries to prevent outbreaks of high-threat diseases. We supported preventive vaccination for Ebola for approximately 170 000 frontline workers in the Central African Republic, the Democratic Republic of the Congo, Guinea-Bissau, Sierra Leone and Uganda. We also established a new stockpile for a monoclonal antibody against Ebola, with hundreds of treatment courses ready to be shipped in 24 hours if an outbreak is confirmed.

After a three-year break, we re-established preventive cholera vaccination, allocating 50 million doses to Bangladesh, the Democratic Republic of the Congo and Mozambique, thanks in part to a doubling of supply. To protect against outbreaks of yellow fever, we supported the vaccination of more than 38 million people in the Democratic Republic of the Congo, Guinea-Bissau, the Niger and Uganda.

Second, response. In addition to the outbreaks of Ebola and hantavirus that we are responding to now, in the past 12 months, WHO detected 4.2 million signals and supported countries to respond to 50 emergencies in 82 countries, preventing disease spread and saving lives. We released almost US\$ 30 million from the WHO Contingency Fund for Emergencies to support the rapid response to emergencies in 40 countries. And through the Global Outbreak Alert and Response Network, GOARN, we coordinated 58 deployments to support emergency response in 16 countries. As you know, conflict is on the rise in our world, and that's why you see a rise in deployments.

Last year, we supported the Democratic Republic of the Congo to respond to an outbreak of Ebola, which it controlled within six weeks, deploying more than 100 experts and 150 tonnes of supplies, and vaccinating 47 000 people. In 2025, we also supported the United Republic of Tanzania and Ethiopia to control outbreaks of Marburg virus disease. And in September, I declared an end to mpox as a public health emergency of international concern.

We also continued to respond to the global resurgence of cholera, deploying more than 50 million doses of oral cholera vaccine from the global stockpile. And we launched the first WHO guidelines for the diagnosis and treatment of meningitis, and supported the response to meningitis outbreaks with 4 million doses of vaccine.

We also continue to work with partners towards our long-held dream of eradicating polio. Last year, 52 cases of wild poliovirus were reported from just 24 districts in Pakistan and Afghanistan – a 50% decline from 2024. So far this year, six cases have been reported. In addition, countries around Lake Chad mounted a joint vaccination campaign that reached more than 83 million children. And with partners, WHO vaccinated over 600 000 children in the Gaza Strip, controlling the Strip's first recorded polio outbreak in 25 years.

In addition to outbreak response, we also responded to the health needs of millions of people affected by humanitarian emergencies. That included dispatching US\$ 150 million of supplies to 97 countries and territories. In the Gaza Strip, together with our partners, we organized the transport and shipment of 515 trucks of life-saving emergency health supplies, coordinated more than 82 Health Cluster partners, and supported over 2700 medical evacuations. In Sudan, since the start of the conflict in 2023, we have delivered more than 3000 metric tonnes of medical supplies, responded to outbreaks of cholera, dengue and malaria, and we are providing direct support to hundreds of health facilities. And in Ukraine, we provided almost 20 000 health consultations, supported the medical evacuation of more than 1200 patients, and provided training to more than 3000 health workers.

In all these places, we continue to see attacks on healthcare as the alarming and illegal new normal of conflict. In 2025, WHO verified 1385 attacks on healthcare in 19 countries and territories, causing 1984 deaths and 1187 injuries among health workers and patients.

Of course, WHO does not work alone. As the Health Cluster lead of the United Nations Inter-Agency Standing Committee, we coordinate over 1500 partners. We also coordinated the deployment of more than 100 international emergency medical teams who, together with their national counterparts, provided over 1.8 million medical consultations in more than 17 countries.

Excellencies, honourable ministers, Mr President, this summarizes WHO's work to promote, provide and protect health. It's a glimpse. As you can see, it's a lot, and I have barely scratched the surface. Supporting all of this work are the Secretariat's efforts on the fourth 'P' of the Fourteenth General Programme of Work: to power for health through science, data and digital technology.

As WHO moves forward following last year's prioritization and realignment, one of our priorities is to make better use of our network of collaborating centres, which includes over 800 research institutes in 80 countries. That's why in April this year we convened the first Global Forum of WHO Collaborating Centres in Lyon, France, which involved 577 collaborating centres from all six regions, and almost 1200 participants. I would like to take this opportunity to thank His Excellency President Macron of France for his support and presence during that conference.

To strengthen our core mandate on norms and standards, we also launched a three-year project to modernize the way WHO prioritizes, develops and disseminates our highest-priority guidelines. Also last year, we launched a new global action plan and a new global network to strengthen clinical trials, involving 34 major research institutions. This year, we are celebrating 25 years of Research4Life and the Hinari Access to Research for Health programme, which makes scientific publications available for free or at very low cost in low- and middle-income countries, helping to address inequities in access to scientific publications and strengthening trust in science.

Finally, we continue to take steps to make WHO more accountable, transparent, efficient and effective, under the fifth 'P' of the Fourteenth General Programme of Work: perform for health.

We continue to prioritize WHO's support to countries by preserving our country presence. Through the work of the Action for Results Group, we have implemented the core country office model, which is helping to achieve an effective, efficient, empowered and results-focused country presence.

We also expanded our evaluation function and improved completion rates. In the past 12 months, WHO's Office of Internal Oversight Services completed 19 audits, with no unsatisfactory conclusions. Our investigations function handled 1174 cases and closed 636 cases. The year-end caseload fell to 656, which is the lowest in three years.

For the first time, Member States agreed to include a gender equality indicator in the results framework in the Fourteenth General Programme of Work, and the Global Risk Management Committee continues to assess the risks to WHO's success. The number one risk on its list is tightly earmarked, unpredictable and non-diversified financing, alongside significant reductions in financing. That is why it is essential that Member States approve the remaining increases in assessed contributions, to make WHO more stable, resilient and independent, as I said in my welcome speech yesterday.

Excellencies, honourable Ministers, Mr President, there is no denying that for WHO, and the countries we serve, the past year was a difficult one. I would like to place on record my deep respect and gratitude to the WHO colleagues who are no longer with us, and to those who still are and who continue to serve the Organization and Member States with dedication. I likewise thank Member States for your support and trust throughout.

This week, you will consider many significant challenges in global health – antimicrobial resistance, malaria, emergencies and more – as well as the proposal for a Member State-led joint process on reform of the global health architecture.

For 78 years, this Assembly has been where the world meets to confront shared threats with a shared response. Multilateralism is not easy. But it is worth it. National sovereignty and international cooperation are not mutually exclusive; they are mutually reinforcing.

When I was in Tenerife last week, supporting the disembarkment of passengers from the MV Hondius, under the leadership of Spain, the Prime Minister and Minister Monica García Gómez – who is here with us – it occurred to me that the cruise ship is a lot like our world. The passengers on the ship were from many different countries, but they faced a shared threat. Our mission was just to keep everyone safe and to get everyone home, because that is what we do as WHO.

It is the same with our world. We are all in the same boat. We are stronger and safer together – as one world. That's why WHO was created in 1948. That's why it remains relevant today. And that's why its vision must remain our driving force this week: the highest attainable standard of health – not as a luxury for some, but a right for all. As Prime Minister Sánchez said yesterday, we need a contagion of solidarity, because solidarity is our best immunity.

I wish you all a very productive Seventy-ninth World Health Assembly.

I thank you.