Report

Second plenary of the WHO civil society task force on antimicrobial resistance

Hybrid- Geneva and online | 19 May 2026

Executive summary

The second plenary of the WHO Civil Society Task Force on Antimicrobial Resistance (AMR) was held in a hybrid format on 19 May 2026, coinciding with the 79th World Health Assembly in Geneva. The meeting brought together Task Force members in person at WHO Headquarters and online, with the dual purpose of reporting progress on the three priority workstreams established since the first plenary and agreeing on strategic next steps for the remainder of 2026.

The overarching message was clear: the Task Force must move decisively from discussion to action. Following a Steering Committee meeting in Brussels in March 2026, consensus emerged around the need for outcome-driven, coordinated civil society engagement, with fewer but higher-impact deliverables, given the severe resource constraints facing member organizations and WHO.

Three workstreams presented their progress:
Workstream 1 is developing a Global Civil Society Campaign on Access to Penicillins, anchored around a penicillin access scorecard and patient story bank, with the Fleming Centenary in 2028 as a key advocacy milestone.
Workstream 2 is co-designing a Community-Led Monitoring (CLM) toolkit with 14 civil society organizations from across the Global South, aimed at converting community AMR experiences into advocacy evidence.
Workstream 3 is focused on mapping the civil society AMR landscape, building a clear civil society value proposition, supporting donor engagement, and strengthening civil society visibility at upcoming AMR governance moments.

The strategic discussion identified significant emerging risks including geopolitical disruption, shrinking civic space, WHO reform processes and declining funding. The opportunities identified were the 2026 fifth Ministerial Meeting on AMR, World Health Assembly events, World AMR Awareness Week 2026, and the path to the 2029 UNGA High-Level Meeting.

Background

The WHO Civil Society Task Force on AMR is a WHO-managed network established to strengthen WHO's engagement with civil society on AMR, foster collaboration, build capacity, and amplify the voices of affected communities. It brings together 80+ civil society organizations from all WHO regions, coordinated by a 12-member Steering Committee, and is guided by principles of inclusiveness, diversity, transparency, and alignment with WHO norms and standards.

The second plenary took place on 19 May 2026, during World Health Assembly week, in a hybrid format at WHO Headquarters in Geneva (Room Lac 814). It followed an in-person Steering Committee meeting in Brussels, which had already shaped the three priority workstreams presented at the plenary.

Objectives of the 2nd plenary

- Re-ground the Task Force on its purpose, current context, and intended outcomes for 2026.

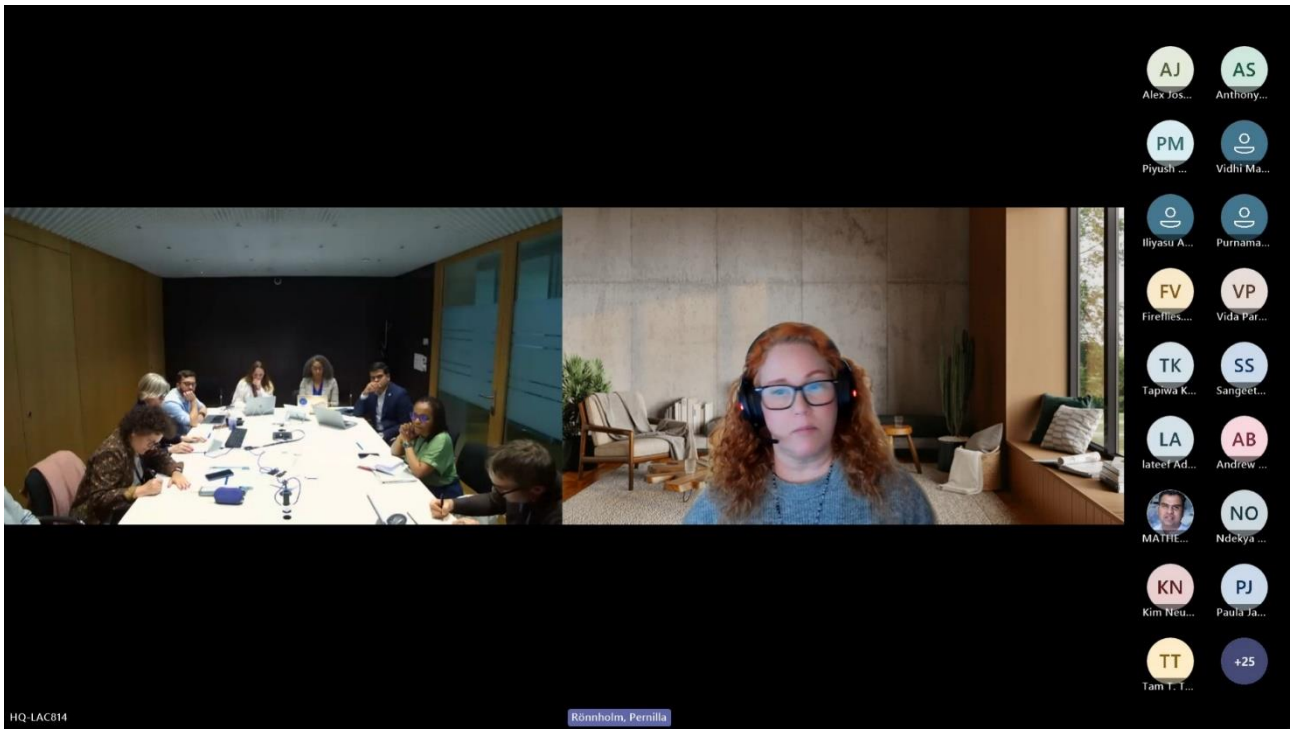
- Present updates and respond to questions across the three priority workstreams.
- Get strategic directions on priorities and agree on immediate next steps.

Opening session

The Co-chair of the task force, Katherine Urbáez, opened the session. The key takeaways from the Brussels Steering Committee meeting were presented, emphasizing that the Task Force must shift from discussion to action and avoid becoming another talk shop. Core messages included:

- Strong consensus on harmonized, coordinated civil society voices that frame AMR as a development, equity, and justice issue, moving beyond the biomedical narrative.
- The role of civil society must evolve from consultation to co-design and co-implementation.
- Funding constraints are the most critical challenge: with high ambition but limited resources, the Task Force must ruthlessly prioritize fewer, higher-impact deliverables.

Three workstreams have taken shape after the last plenary meeting, and the in-person Steering Committee meeting has refined the deliverables.



Workstream 1: Global Civil Society Campaign on Access to Penicillins

Rationale and framing

Prof. Anthony So (Johns Hopkins IDEA Initiative, Workstream 1 lead) presented the case for a flagship campaign on penicillin access. Penicillin, the world's oldest antibiotic, is a first-line drug recommended by WHO for several indications and still access challenges persist and the global supply chain is critically fragile.

- Benzathine penicillin G (BPG), used for treatment of syphilis and rheumatic heart disease prophylaxis has only 3–4 API manufacturers globally, predominantly in China, and a single WHO pre-qualified finished-product manufacturer.
- A supply-demand gap of approximately 50% exists for aqueous BPG which is easier to administer and more stable.
- More than 40 finished-dose manufacturers and six API producers have exited the BPG market since the early 2000s.
- Paediatric amoxicillin shortages in 2022 demonstrated that access failures are not confined to low- and middle-income countries.

The 2028 Fleming Centenary, 100 years since the discovery of penicillin, was identified as a compelling public advocacy milestone recalling how governments, scientists, and communities once collaborated to make penicillin universally accessible.

Proposed flagship outputs

The workstream is developing two complementary deliverables:

1. **Penicillin access scorecard**: a civil society instrument to track whether commitments are being implemented, covering manufacturing resilience, regulatory access, procurement practice, stockout documentation, and financing and political commitment.
2. **Patient story bank**: a structured advocacy tool pairing community narratives of access denial with specific formulations, failure points in the pharmaceutical value chain, and accountable institutional actors, giving testimony both magnitude and direction to convert it into advocacy outcomes.

The working group called on Task Force members to anchor story collection by geography and archetype, and to provide guidance on priority scorecard metrics.

Workstream 2: Community-Led Monitoring and Accountability for AMR

Rationale and framing

Geminn Apostol (ATNEO Center for Research and Innovation, Philippines, Workstream 2 lead) presented the community-led monitoring (CLM) working group. The core problem is that communities experience AMR daily through treatment failures, antibiotic stockouts, poor WASH conditions, informal dispensing etc., but are almost entirely absent from national systems designed to monitor and respond to it. The working group is building a CLM guide and toolkit co-designed with CSOs and end users, built on proven models from HIV and NCD programs, accessible without internet or technical expertise, and designed to take communities from awareness through monitoring to advocacy and policy change. Five critical design principles emerged:

- The toolkit must serve three functions: awareness-building, monitoring, and advocacy/policy influence. Data collection tools that stop short of advocacy will not be effective.
- Who it centres matters as much as who uses it: community health workers, AMR survivors, caregivers, and animal/environmental sector counterparts should all be reflected.
- A minimum core indicator set will be defined, balancing quantitative baselines (antibiotic availability, stockout frequency) with qualitative narratives.
- Data must travel: every indicator must specify who receives it, at what level, through what channel, and what response can be demanded.
- The toolkit must be co-designed with communities from the start, not retrofitted.

Next steps

Members were invited to volunteer as 'early adopter' organizations for design sprint and prototyping sessions. Convergence with Workstream 1 was noted: the story bank and CLM toolkit share infrastructure needs for community-level data collection and ethical consent frameworks.

Workstream 3: Coordinated Civil Society Engagement in Global AMR Processes

Rationale and framing

Milka Sokolovic (European Public Health Alliance, Workstream 3 lead) opened with a key observation that civil society is being asked to do more on AMR (from awareness, community engagement, accountability, implementation, advocacy) at exactly the moment when civic space and funding are shrinking. The workstream 3 identified three core concerns:

- Fragmentation: many organizations work towards similar goals without sufficient visibility of each other's efforts, creating duplication and a weaker collective voice.
- Resourcing: AMR-specific funding is limited, with uneven donor access especially for LMIC organizations.
- Value proposition: civil society is too often seen only as an implementer, not as a strategic partner with accountability, community trust, lived experience, and policy intelligence.

Proposed work architecture

Four tracks were agreed for the workstream:

1. **Mapping and shared intelligence**: who is doing what, where, and around which policy processes.
2. **Civil society value proposition**: a concise statement explaining what civil society contributes to AMR, what support it needs, and why it must be resourced, serving as a basis for donor engagement and political positioning.
3. **Resourcing and donor engagement**: an initial scan of funding opportunities including non-traditional funders, and identification of entry points.
4. **Political visibility**: preparing coordinated, purposeful civil society engagement at the World Health Assembly, Abuja Ministerial, and future UNGA high-level meetings.

Discussion

The members had suggestions on improving the work of the task force and the three workstreams:

- WHO country offices were identified as valuable partners for anchoring story collection in LMICs, given their connections to ministries of health and civil society.
- The WHO AMR Survivors Task Force (established 2023) and the 'AMR is Invisible. I Am Not' campaign ahead of UNGA 2024 were cited as complementary, high-impact storytelling resources.
- Some members suggested that the task force should call on Quadripartite agencies to declare their AMR staffing levels and budgets, so that the civil society can apply pressure on member states to provide more resources to the organizations leading the implementation of UN General Assembly high-level meeting commitments.
- A pre-Abuja civil society briefing in June was proposed to prepare Task Force members and finalize collective asks ahead of the ministerial.
- The connection between AMR and conflict zones was raised as an important, under-resourced area.
- Parliamentary engagement was highlighted as a near-term opportunity: a side event at Abuja will focus on parliamentary engagement in Africa, building on the Quadripartite's policy brief on parliamentarians and the European MEP Interest Group on AMR.
- A joint session between the Task Force Steering Committee and the WHO Civil Society Commission Steering Committee was proposed to align on financing, engagement strategy, and avoid duplication.
- Language and narrative: participants called for retiring the 'silent pandemic' framing ('There is nothing silent about AMR') in favour of language that connects AMR to out-of-pocket costs, governance failures, and justice.

Strategic discussion: risks and opportunities

Emerging risks

- Geopolitical disruption and political fatigue, including WHO reform processes that may not adequately protect AMR programming.
- Severe funding constraints across all civil society organizations, with voluntary contributions already stretched to their limits.
- Fragmentation: without coordination, civil society's energy is dispersed and its credibility weakened.
- Misinformation and competing narratives, including difficulty engaging actors beyond the health sector.

Emerging opportunities

- The 2026 Abuja Ministerial Meeting on AMR (Nigeria, June 2026) as an immediate window for civil society influence, including on the outcome declaration and through a parliamentary side event.
- The World Health Assembly 79 (May 2026), with multiple civil society networking events linked to the WHO Civil Society Commission.
- World AMR Awareness Week 2026: an opportunity to move from awareness to measurable action, potentially anchored by community monitoring activities.
- The Fleming Centenary in 2028 as a sustained public communication opportunity on the history and politics of antibiotic access.
- The 2029 UNGA High-Level Meeting on AMR as the horizon for longer-term political engagement, requiring early coordinated preparation.

Closing remarks

Benedikt Huttner (Unit Head, AMR/RSA, WHO) thanked participants and offered several reflections: the penicillin campaign was welcomed as compelling and publicly accessible; he encouraged broadening the frame beyond AMR-specific resistance to the wider challenge of infection prevention/management; he acknowledged the WHO Secretariat's own capacity constraints; and he expressed confidence in the Task Force's value while urging pragmatic prioritization.

Cross-cutting themes

From talk to action: the Task Force must prioritize tangible, measurable deliverables. With limited voluntary resources, doing fewer things well is essential.

Civil society as co-designer, not just an implementer: across all three workstreams, the call was consistent, civil society should be engaged from the design stage of interventions, not brought in to execute pre-specified projects.

One Health coherence: AMR cannot be addressed without genuinely engaging veterinary, food system, and environmental civil society organizations. The current human-health focus of most engagement can provide specificity to our messaging and outputs, but constant communication with other civil society should be prioritized to overcome this structural constraint.

Stories as the currency of advocacy: from the penicillin story bank to Pernilla Rönnholm's testimony about losing a twin to neonatal sepsis, the plenary underscored that lived experience is the most powerful advocacy tool civil society possesses.

Coordination before creation: across all workstreams, the consistent principle was to map and build on existing networks and initiatives before creating new ones.

Sustainable resourcing as an existential issue: the Task Force cannot fulfill its mandate without dedicated, ring-fenced funding. Making the civil society value proposition legible to donors is not peripheral, it is foundational.

Annex: Second plenary of the WHO civil society task force on antimicrobial resistance

Time (CEST)	Agenda item	Lead
14:00–14:10	Welcome and setting the scene: objectives, agenda walkthrough, context, and decisions needed today	Tracie Muraya Co-chair
14:10–14:35	Workstream 1 presentation + Q&A: Global Civil Society Campaign on Access to Penicillins	Anthony So Workstream 1 lead
14:35–15:00	Workstream 2 presentation + Q&A: Community-Led Monitoring (CLM) and Accountability for AMR	Geminn Apostol Workstream 2 lead
15:00–15:25	Workstream 3 presentation + Q&A: Coordinated Civil Society Engagement in Global AMR Processes	Milka Sokolovic Workstream 3 lead
15:25–15:55	Strategic discussion: emerging risks/opportunities, civil society mobilization strategies and coordination asks	Katherine Urbaez Co-chair
15:55–16:00	Closing remarks	Benedikt Huttner Unit Head, AMR/RSA, WHO