

Public health emergencies: preparedness and response

Report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme

The Director-General has the honour to transmit to the Seventy-ninth World Health Assembly the report submitted by the Chair of the Independent Oversight and Advisory Committee (see Annex).

Annex

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Part 1. Background

1. The WHO Health Emergencies (WHE) Programme was established at the request of Member States in 2016, following the 2014–2016 outbreak of Ebola virus disease in West Africa.¹ It was founded on the principle of a single programme, with one clear line of sight and authority, one workforce, one budget, one set of rules and processes, one set of standard performance metrics, and one common structure across headquarters, regional offices and country offices.
2. Concurrently with the creation of the WHE Programme in 2016, the Independent Oversight and Advisory Committee for the WHE Programme (IOAC) was established with the agreement of Member States to provide oversight and guidance for the Programme's work. This it has done since its inception, witnessing the Programme's leading role in coordinating WHO's work in emergencies. The IOAC also advises the Director-General on issues within its mandate and reports its findings to the Health Assembly.
3. The IOAC is a permanent committee composed of nine members who serve in their personal capacity in full independence. It uses a combination of teleconferences, in-person meetings, country visits, desk reviews and interviews to carry out its work, and is guided by a monitoring framework that it developed to support its assessments.
4. This fourteenth report to the WHO governing bodies covers the period from May 2025 to April 2026. During this period, the IOAC convened virtually on a monthly basis and held two hybrid meetings: a mid-term review on the outcomes of the prioritization and realignment process in November 2025, and an annual review to draft its annual report in March 2026. In light of financial constraints, the IOAC temporarily paused its country visits during the reporting period and instead met virtually with WHO Representatives.
5. However, 2026 marks the tenth anniversary of the establishment of the WHE Programme. To commemorate this milestone, the IOAC is conducting a ten-year review to assess the progress made since then, examine the extent to which the original reform vision has been realized, and identify persistent structural challenges affecting performance. The review will be conducted throughout 2026; it will examine changes in the WHE Programme since the reform of WHO's work in health emergency management,² including its strategic intent and mandate, its governance and authority, its operational capacities and its financing, and will reflect on whether the expectations of Member States and partners are aligned with the Programme's current authority and capacities.
6. In this report, the IOAC presents its annual findings and observations on the WHO prioritization and realignment process; WHO's leadership in health emergencies; the WHE Programme's financing, budgeting and resource mobilization for emergencies; human resources

¹ Decision WHA69(9).

² See document A69/30.

and workforce management; emergency operations support and enabling functions; partnerships; and Member State leadership and national ownership for health security. While this report draws on preliminary findings from the ten-year review, the IOAC will make the review outcomes public and submit its recommendations to Member States on completion of the review later this year.

Part 2. Findings and observations

7. The global context for health emergencies is characterized by a marked increase in both the frequency and scale of events, alongside a growing convergence of overlapping crises, including conflict, climate-related hazards and infectious disease outbreaks. These compounding risks are further exacerbated by rising levels of global fragility, population displacement and weakened health systems. As a result, health emergencies are becoming structurally embedded within the global landscape, requiring sustained international coordination.

8. At the same time, the multilateral system underpinning global health action is under increasing strain. The IOAC is concerned by the gradual erosion of confidence in multilateral mechanisms, reflected in growing scepticism toward multilateral institutions, increasing fragmentation of global governance, and the impact of political polarization affecting global health cooperation. These trends constrain timely and coordinated action, even as health security remains fundamentally dependent on international cooperation. Evidence of continued engagement, including the adoption of the WHO Pandemic Agreement in 2025, signals that collective approaches remain viable. Where the political will exists, multilateralism remains the most effective and essential mechanism for coordinated, equitable and durable responses to global crises.

9. The financing landscape for global health is becoming more constrained and less predictable. The decline in official development assistance and humanitarian funding, combined with pressure on national budgets and shifts toward defence spending, are reducing resources for health and undermining global preparedness and readiness for future health crises.

WHO prioritization and realignment process

10. The IOAC remains deeply concerned by the dramatic reductions in official development assistance from major donors and the declared intentions of two Member States to withdraw from the Organization in 2026. The IOAC recalls that the 2008 global economic recession prompted decisions to deprioritize the WHO's emergency-related teams and reduce the workforce. The Organization paid a high price for those decisions during the Ebola virus disease outbreak in West Africa, which resulted in over 11 000 lives lost and posed an existential threat to WHO. These shortcomings ultimately catalysed reform of WHO's work in health emergency management and led to the establishment of the WHE Programme in 2016, which provided a clearer mandate and strengthened institutional capacity for emergency operations. Should the Organization reduce the Programme's capacity solely because of financial constraints, it risks repeating these historical failures. It is the IOAC's responsibility to ensure that past weaknesses are not reprised and that WHO's emergency capacities remain safeguarded.

11. As at 13 March 2026, provisional data subject to final validation show that 2507 staff separations will have been managed between January 2025 and June 2026 (including projected separations through June 2026). Of these, 1232 (49%) were post abolitions and 1275 (51%) were associated with voluntary measures such as natural attrition, retirements and voluntary early retirement programmes. The highest separation rates proportionately were at the D2 grade and

the P2/P1 grades. The highest projected headcount reductions are at headquarters and Global Shared Services (-29%), in the African Region (-25%) and in the European Region (-26%), with a global average reduction of 23% compared to the pre-prioritization baseline. Women represent 50.7% of the post-realignment workforce, and there is an improvement in the proportion of staff from under- and unrepresented countries at global level. The IOAC expresses its solidarity with staff whose positions have been affected, as well as with those who remain and are adjusting workloads to sustain delivery of the Organization's mandate.

12. The Committee observed that WHO adopted a functional approach to workforce decisions, rather than assessing staff based on contract type or source of funding. The approach is guided by whether functions are core to WHO's mandate, whether a partner is better positioned to undertake the work, and by the budget available to each division and department. The IOAC considers this a strategic and disciplined approach.

13. The IOAC notes that strong collaboration with other divisions is critical, since they contribute to upstream work and may provide surge capacity for future emergency responses. The WHE Programme must be able to access and leverage the expertise of other WHO divisions. Clear internal coordination and expectations can help define how other divisions support emergency operations.

WHO leadership in health emergencies

14. The WHE Programme's establishment in 2016 marked a fundamental development for the Organization, complementing WHO's traditional technical and normative role with new operational capacities and capabilities for its work in disease outbreaks and humanitarian emergencies. The WHE Programme was designed to bring speed and predictability to WHO's emergency work, using an all-hazards approach, promoting collective action, and encompassing preparedness, readiness, response and early recovery activities. The Committee notes that these core functions have been preserved across the three levels of the Organization and remain aligned with the initial reform of WHO's work in health emergency management. Over the last decade, the IOAC has observed continued efforts to adopt an all-hazards approach, including its integration into WHO operational guidelines and frameworks, such as the Emergency Response Framework 2.1 and the Health Emergency Prevention, Preparedness, Response and Resilience framework.

15. At the organizational level, the Committee notes the new WHE organization chart at headquarters following the prioritization process, which now comprises five departments: Health Emergency Alert and Response Operations; Health Emergency Intelligence and Surveillance; Health Emergency Preparedness; Humanitarian and Disaster Management; and Epidemic and Pandemic Management. In November 2025, each WHE director at headquarters briefed the IOAC on their departmental vision, revised structure, priority areas and activities being scaled back or stopped. Despite continued adjustments to organizational structures since 2016 to reflect shifting priorities, operational demands and resource constraints, the IOAC considers that core functions have remained intact and that functions are aligned across the three levels. **The IOAC recommends undertaking a regular stock-take of current structures at the end of each biennium to ensure that the "single programme" model continues to function effectively in the various operational environments.**

16. In the context of emergencies, the WHE Programme continues to play a critical normative, technical and operational role. The IOAC believes that WHO must sustain its leadership and coordination role in disease outbreaks and with regard to health in humanitarian crises and

natural disasters. In 2025, WHO responded to 50 emergencies in 82 countries and territories: 20 Grade 3 emergencies (10 acute and 10 protracted) requiring the highest level of Organization-wide support, and 30 Grade 1 and Grade 2 emergencies. As at 3 March 2026, WHO was responding to a total of 38 graded emergencies, of which 14 were graded at level 3 under the Emergency Response Framework. These included global outbreaks of diseases such as cholera, mpox, dengue and COVID-19, outbreaks of diphtheria, Marburg virus disease, Rift Valley fever, yellow fever and Sudan virus disease, and ongoing crises in Afghanistan, the Central African Republic, the Democratic Republic of the Congo, Ethiopia, Haiti, Lebanon, Myanmar, the occupied Palestinian territory, including east Jerusalem, Somalia, South Sudan, Sudan, the Syrian Arab Republic, Ukraine and Yemen. The Committee noted efforts to maximize operational efficiencies, including the use of joint Incident Management Support Teams to combat, for example, Rift Valley fever in Mauritania and Senegal.

17. In the context of humanitarian access and protection of healthcare, the Committee reiterates its call for all parties to uphold international humanitarian law and to ensure humanitarian access. Following the launch of WHO's Surveillance System for Attacks on Health Care³ in December 2019, the Organization has systematically collected and made available data on attacks on healthcare in countries facing emergencies. Since the system's establishment, there has been a significant and alarming escalation in attacks on health facilities and workers, from 1035 reported attacks in 12 countries and territories in 2019 to 1637 attacks in 16 countries and territories in 2024. In 2025, WHO verified 1351 attacks on healthcare, resulting in 925 health facilities damaged or destroyed, 609 medical personnel injured, killed or impeded, and 411 ambulances obstructed or attacked, severely limiting civilians' access to care and undermining already fragile health systems. These figures likely underestimate the true scale of the crisis as reporting is uneven. **The IOAC remains extremely concerned at the increase in attacks against healthcare facilities, workers and services, and recommends that the Director-General and the Regional Directors continue to speak out against these violations.**

18. From a management perspective, the IOAC recalls that the WHE Programme was established with one clear line of authority, one workforce, one budget, one set of rules and processes, and one set of standard performance metrics. The IOAC has observed that the de facto practice has diverged from this model and is particularly concerned by the growing number of delegations of authority to the regional directors regarding decisions, human resources and budgets in emergency operations. **The Committee reiterates its previous recommendation that the Executive Director of the WHE Programme (EXD/WHE) must be equipped with the authority to act across the global health emergency ecosystem, empowered to engage at the appropriate levels, with the mandate, clarity, respect and accountability required for an effective response. It believes that current practice should be realigned with document A69/30.**

19. The Committee notes a significant variance from the reforms established in document A69/30 regarding the leadership of the WHE Programme. Member States originally established the EXD/WHE as a Deputy Director-General level role, recruited through a competitive selection process, to ensure that the WHO's emergency function would not be marginalized within the Organization's hierarchy. However, the role has since been downgraded to the Assistant Director-General level, with the EXD/WHE being appointed directly by the Director-General and no longer serving as a permanent member of the Global Policy Group, led by the Director-General and the Regional Directors. The IOAC views this shift as a substantial erosion of the position's institutional authority. **It emphasizes that the grade, mandate and competitive recruitment**

³ Pursuant to resolution WHA65.20 (2012); see the [database](#) (accessed 29 April 2026).

process of the EXD/WHE are critical to ensuring the Programme's effective leadership, independence and global credibility, and that current practice and decisions in force should be fully aligned and consistently applied.

20. Looking ahead, the IOAC recognizes that the recent prioritization and cost-saving measures have reduced the number of senior leadership roles, including in emergencies. However, strengthening leadership capacity will be essential over time, as it is extremely difficult to manage both the high-level representation and agency-wide coordination role of the EXD/WHE together with the day-to-day obligations of running a large team. **The IOAC recommends the appointment of a deputy EXD/WHE in the near to medium term to ensure sufficient leadership capacity.**

21. At the regional level, regional directors are central to the success and implementation of the WHE Programme. During its mid-term review in November 2025, the IOAC met with the Regional Directors for Africa, Europe, the Eastern Mediterranean and the Western Pacific to review the outcomes of the prioritization process and health emergency management. It notes the regional WHE organization charts and commends efforts to preserve core emergency response capacities. The IOAC also notes the increasing authority of regional directors in emergencies, including their role in allocating flexible Programme funding at the regional level under a joint collaboration model with the EXD/WHE. However, these developments represent a departure from document A69/30, which assigns responsibility for developing the WHE Programme's single budget and staffing plan to the EXD/WHE. The IOAC observes that regional organization charts were developed and approved by Regional Directors and the Director-General, rather than the EXD/WHE, indicating a variance from the original single budget and staffing principle.

22. The IOAC welcomes further progress in strengthening regional leadership reporting lines and arrangements. The implementation of its recommendation that regional emergency directors be jointly recruited by, and have dual reporting lines to, the regional director and the EXD/WHE is now in place across all regional offices. As stated in document A69/30, the Regional Emergency Directors report to their respective Regional Director on a day-to-day basis on the implementation of emergency management activities in their regions and to the EXD/WHE on issues of policy, strategy and operational planning related to those activities. **The IOAC recommends that the EXD/WHE should also be involved in the annual performance management of all regional emergency directors.**

23. With regard to operational frameworks, the IOAC considers that the Emergency Response Framework has been a major success in developing and strengthening WHO's work in emergencies over the past 10 years. The first version, published in April 2013, established roles, responsibilities and core processes guiding WHO's actions in emergency responses. The second version, released in June 2017 following the creation of the WHE Programme and lessons learned from the 2014–2016 Ebola virus disease outbreak, marked a significant shift towards a fully operational emergency management model. The Emergency Response Framework 2.1 version, published in 2024, incorporates experience garnered from the COVID-19 pandemic and other public health emergencies. Despite these advances, the Committee notes that implementation is uneven across the Organization. It encourages strengthening training for WHO Representatives, improving information flows across the three levels, and fully aligning delegations of authority with the Emergency Response Framework 2.1 for senior managers in emergencies, including clear roles for WHO Representatives and incident managers to prevent delays in activating the incident management system. Future revisions could explore additional improvements, such as adding guidance on cross-border or cross-regional collaboration, better data and information sharing between neighbouring countries, greater use of innovative technologies in operations, guidance

for protracted emergencies (including when to end long-standing grades or whether additional grading levels are needed), and standardization of emergency situation reports across countries and regions. The IOAC also welcomes the development and roll-out of the National health emergency alert and response framework (2025), and notes its relevance for countries, including in terms of capacity-building.

Financing, budgeting and resource mobilization for emergencies

24. The Committee congratulates Member States on their historic decision to approve a second 20% increase in assessed contributions for the 2026–2027 biennium.⁴ This follows the 2022 agreement to gradually increase assessed contributions to 50% of WHO's core budget by the 2030–2031 cycle.⁵ **The IOAC urges Member States to honour their commitments to provide these assessed contributions and to agree on the next increase at the Eightieth World Health Assembly. Notwithstanding this important achievement, the IOAC remains profoundly concerned about the severe and persistent shortfall in flexible and sustainable financing, which continues to affect not only the WHE Programme but the Organization as a whole.**

25. The 2026–2027 approved Programme budget in the base budget segment of the WHE Programme has been set at US\$ 918.5 million, of which 51% is for country offices, 22% for regional offices and 27% for headquarters. The 2026–2027 budget for the Pandemic Influenza Preparedness Framework is US\$ 42.7 million, with 70% of partnership contributions directed towards preparedness work at the regional and country levels. Following discussions with the regional committees, the practice in previous bienniums of setting the budget for the Emergency Operations and Appeals segment at US\$ 1 billion was continued for 2026–2027 but, on the basis of detailed operational planning, the 2026 WHO Health Emergencies Funding Appeal was launched for a total requirement of US\$ 965 million for ongoing emergency responses.

26. The WHO Health Emergencies Funding Appeal has mobilized US\$ 3.63 billion since its introduction in 2022 to sustain life-saving health services across the world's most severe emergencies. It functions as a single, predictable financing platform and almost 90% of resources flow directly to WHO country offices, supporting Health Cluster coordination and local partners. The IOAC is concerned that in 2025 only 58% (US\$ 0.95 billion) of the US\$ 1.5 billion requirement was met, a 37% decline from 2024.

27. The Contingency Fund for Emergencies was established by the Health Assembly in May 2015⁶ following a review of WHO's response to the 2014 Ebola virus outbreak in West Africa. It provides funding during the critical gap between the moment the need for an emergency response is identified and the point at which funds from other mechanisms can be released. The Fund is critical for WHO's early response and is cost-effective in preventing the further spread of outbreaks. In 2025, it released US\$ 29.4 million to support WHO's response to 24 emergencies, but it received only US\$ 10.6 million in contributions from 12 donors. As at 7 April 2026, it had a balance of US\$ 17.6 million. **The IOAC reiterates that the Contingency Fund for Emergencies is designed as a replenishment mechanism; if donors do not replenish it, the Fund is forced to be more conservative. This trend risks undermining WHO's ability to respond rapidly to emergencies. The IOAC is deeply concerned that a shrinking Contingency Fund for Emergencies**

⁴ Resolution WHA78.2 (2025).

⁵ Decision WHA75(8) (2022).

⁶ Decision WHA68(10) (2015).

at a time of escalating global needs is both dangerous and alarming, and encourages Member States and donors to contribute as a matter of urgency.

28. The IOAC welcomes WHO's efforts to diversify funding sources and broaden the donor base, including through the WHO Foundation. **The IOAC encourages continued exploration of innovative financing mechanisms and partnership platforms, including engagement with multilateral development banks and international financial institutions, and selective use of trust funds.**

Human resources and workforce management

29. When the global WHE Programme was created in 2016, a total of 1396 positions were planned across the Organization, with a distribution of 50% at country level, 25% across the six regional offices and 25% at headquarters. As at 30 September 2025, the number of full-time equivalent staff contributing to the strategic objective of "One billion more people better protected from health emergencies" stood at 1588, of whom 901 (57%) were located in country offices, 314 (20%) across the six regional offices and 373 (23%) at headquarters. The IOAC understands that these figures will decrease following the prioritization process and is concerned that further reductions in the workforce would affect the WHE Programme's ability to deliver. The IOAC also encourages the systematic use of WHE operational tools and the prioritization of human resource emergency data at the country and regional office levels to improve situational awareness and support reporting requirements.

30. The WHO workforce remains the Organization's most valuable resource. The IOAC notes with concern that the duration of temporary and fixed-term appointments has been reduced to six months and 12 months respectively, in order to limit financial liabilities. While the Committee recognizes the financial rationale, it urges WHO to extend contract lengths as soon as funding allows, as short contracts risk undermining talent retention and operational continuity. Moreover, the IOAC acknowledges that the human resource function is under significant strain, having lost 23% of its staff (192 to 148 positions). Despite this, **the Committee reiterates its previous recommendation that WHO revisit its risk appetite regarding contract modalities. The IOAC considers this a persistent structural issue that requires urgent attention.**

31. The IOAC welcomes implementation of its 2025 recommendation to establish a talent pool comprised of WHO personnel separated as a result of the prioritization and realignment process. As at early March 2026, the talent pool contains 1023 profiles that can be drawn on should additional funding become available. The Committee notes, however, that there is currently no automated technical mechanism to link applicant profiles with documented performance ratings within existing systems. **The IOAC recommends developing such a mechanism to ensure that high-performing staff can be prioritized for re-engagement and that future rehiring decisions are based on performance.**

32. On country leadership, the IOAC reiterates the importance of ensuring WHO Representative positions in emergency-affected countries are filled by individuals with appropriate emergency experience. **The Committee further recommends that WHO strengthen country-level succession planning and provide targeted support to candidates navigating the assessment centre process, with the aim of improving pass rates and expanding the pool of qualified leaders, including for emergency settings.**

33. The Committee appreciates ongoing efforts to maintain mechanisms for emergency deployments, including the Global Outbreak Alert and Response Network, Standby Partners and

internal staff rosters, which help ensure the timely presence of personnel in emergency settings. Having the right people in the right place on the ground is critical to an effective emergency response. **The IOAC also reiterates its previous recommendation on the importance of duty of care for both national and international staff working in emergencies, including careful management of assignment duration to avoid excessively long deployments in hardship duty stations.**

WHE operations support and enabling functions

34. The Committee notes the new organization charts resulting from the prioritization process and the incorporation of the prevention and response to sexual misconduct function into the new Department of Gender, Rights, Equity and Sexual Misconduct Prevention. While recognizing the intent to streamline structures, the IOAC remains concerned about increased workloads and the potential impact on the preservation of essential accountability functions. Ensuring that these functions remain robust and adequately resourced is critical to maintaining organizational integrity and safeguarding WHO's ability to prevent, detect and respond to misconduct.

35. The IOAC welcomes the launch of the new WHO Strategy to Prevent and Respond to Sexual Misconduct (2026–2029), which builds on the strong progress achieved under the 2023–2025 strategy, with 80% of actions implemented. While this progress is encouraging, the IOAC notes that it remains fragile and requires continued consolidation across all levels of the Organization. In 2025, according to the Sexual Misconduct and Abusive Conduct Investigations Dashboard,⁷ 181 cases of abusive conduct, 25 cases of sexual exploitation and abuse, and 25 cases of sexual harassment were reported, with the highest number of reported cases in the African and Eastern Mediterranean Regions. **The IOAC also notes with caution the reduction in reported sexual misconduct cases between 2024 and 2025. Although this decline may reflect strengthened prevention efforts, including the regular publication of disciplinary and managerial action in appropriate cases, it may also signal reduced trust or willingness to report. The Committee therefore underscores the need for sustained monitoring to ensure that reporting channels remain accessible, credible and trusted by personnel and the communities concerned.** The IOAC further observes the shift towards more decentralized accountability for prevention of sexual misconduct and encourages departments and programmes to strengthen their own capacities, establish clear performance indicators and fully institutionalize their responsibilities, including in emergencies. Ownership at all levels is essential to sustaining progress.

36. Regarding efforts to prevent and respond to sexual misconduct in emergency contexts and operations, **the IOAC recommends that emergency programmes receiving voluntary contributions with programme support cost rates below 13% should establish and strengthen cost recovery mechanisms to ensure that all direct costs related to preventing and responding to sexual misconduct are fully and transparently financed. To operationalize this, the WHE Programme, together with the Comptroller, must design and implement a dedicated cost recovery mechanism that secures sustainable financing for the prevention of and response to sexual misconduct in emergency operations, enables clear and transparent reporting to Member States, and ensures donor accountability for the direct costs of sexual misconduct prevention and response when programme support cost rates are reduced. This action is in line with decision EB154(4) (2024) and with WHO's corporate commitment to sound financial practices under the Fourteenth General Programme of Work, 2025–2028.**

⁷ [Sexual Misconduct and Abusive Conduct Investigations Dashboard](#) (accessed 21 April 2026).

37. The IOAC is concerned that the corporate security function has weakened. The former Director of Global Security role has been merged with two other departments, creating the new position of Director of Operational Support, Security Management, and Health and Well-being Services. This consolidation risks undermining WHO's ability to operate in emergency settings, particularly in complex humanitarian environments. During the IOAC mid-term review in November 2025, interviews with the WHO Representatives for Afghanistan and Ukraine highlighted the critical importance of robust security systems. WHO's ability to operate effectively on the frontlines depends on maintaining its own security capacity. The IOAC is deeply worried by the reduction in staff dedicated to security at a time when needs are increasing. **In line with its previous recommendations, the IOAC urges WHO leadership to safeguard the security function and ensure that core resources are allocated to sustain this essential work.**

38. The Committee commends major advances in procurement, stock, transport and warehouse management systems. For the first time, the Organization has full end-to-end visibility of its supply chain, enabling real-time tracking of products and expiry dates to maximize efficiency and ensure timely use. Through the Transport Management System, the Organization has digitized and operationalized Green Light customs clearance processes across 76 active countries, enabling standardized track-and-trace clearance workflows and contributing to a reduction in average customs clearance time from 36 days in 2024 to 22 days in 2025. In parallel, the Warehouse Management System has been implemented in 112 WHO-managed warehouses, providing real-time inventory visibility, improved control over stock movements, and enhanced audit readiness across global supply operations. These system deployments are underpinned by a new Organization-wide Warehouse and Inventory Management Policy, launched in early 2026, which establishes a single framework for warehousing, inventory accountability and end-to-end supply chain visibility.

Partnerships

39. Funding constraints across the humanitarian sector are affecting partners throughout the UN system and may require WHO to reduce its operational footprint in some settings. The Humanitarian Reset and significant reductions in funding have had a tremendous impact on health service provision, coverage delivery and coordination among the health clusters. As at December 2025, of the 24 settings with an activated health cluster, 75% had dedicated, properly trained health cluster coordinators. Of these, 50% were fixed-term staff, 22% were temporary staff and 22% were consultants, whereas in December 2024, of the 28 settings, 86% had dedicated, properly trained health cluster coordinators. By December 2025, 50% of coordinators had been identified as at risk in 2026. **The IOAC is deeply concerned that resource constraints are limiting full implementation and considers this area under high risk.**

40. In this context, strengthened coordination and strategic engagements with partners continue to be essential. WHO works with over 1500 partners through the Global Health Cluster to support national health responses in crisis-affected countries. Its emergency operations rely on partners such as networks, inter-agency mechanisms, academic and research institutions, and nongovernmental organizations, which are central to WHO's work in emergencies. These partnerships are critical to sustaining life-saving activities, including medical evacuations, the coordination of emergency medical teams in contexts such as the Gaza Strip, and efforts to advance community protection, including meaningful engagement with communities as full partners, and emergency preparedness. Going forward, **WHO should more effectively leverage the full extent of its partners' capacities and resources, while establishing clearer expectations and stronger accountability mechanisms to ensure delivery on commitments.**

41. The IOAC welcomes the Director-General's initiative to convene the first Global Forum of WHO Collaborating Centres in April 2026 to identify how best to leverage and strengthen scientific and technical collaboration. There are over 800 institutions (research institutes, universities or academies) in over 80 countries supporting WHO's programmes. Collaborating Centres represent a largely untapped strategic asset that could be more deliberately mobilized to accelerate evidence generation, strengthen country-level capacity, support rapid surges in emergencies, foster innovation, and enhance knowledge translation into policy and practice; this will require clearer roles, predictable engagement modalities and stronger accountability frameworks to maximize the centres' added value to WHO's mandate.

42. The Committee continues to follow discussions on the reform of the global health architecture and the UN80 Initiative, noting their potential implications for the Organization's work. It welcomes decision EB158(20) (2026), in which the Executive Board requested the Director-General to develop, in close consultation with Member States, a transparent, inclusive and time-bound proposal for a WHO-hosted, Member State-led process to strengthen global health coordination and advance reform efforts. In this context, **the Committee underscores the need for UN agencies to enhance efficiency at the country level by streamlining coordination and identifying areas for the rationalization of resources within cluster coordination mechanisms. It reiterates that the highest level of WHO leadership must be actively engaged in and represented throughout these discussions.** The IOAC will keep this matter under review once a proposal on the joint process is submitted.

Member State leadership and national ownership for health security

43. The WHE Programme has had an impact on Member States in different ways. Since its inception in 2016, it has invested in countries to strengthen capacities and has advanced its own skills and knowledge. At the same time, Member States are building national capacities and moving towards vertical integration with one leader accountable in emergencies, reflected in the growing number of national public health agencies, from 53 in 2000 to 94 in 2020 and now 121, either established or being set up. The IOAC underscores that emergency preparedness and response are, first and foremost, the sovereign responsibility of Member States. In this context, the role of WHO and the WHE Programme is not to substitute for national action, but to enable, support and catalyse it, by helping countries mobilize, coordinate and optimize their own domestic resources across government institutions, the private sector and civil society. This includes strengthening national leadership, fostering whole-of-society approaches and ensuring that external support builds on, rather than bypasses, existing national capacities and systems. As countries continue to evolve, WHO and the WHE Programme must also evolve by sustaining the skills required to support them, while recognizing that the same level of expertise is not required in every region and that more agile, horizontal movement of expertise should be explored.

44. The WHE Programme has made a significant contribution to Member State preparedness planning and capacity-building over the past decade. Core health emergency preparedness tools, including the International Health Regulations (2005), the IHR States Parties Self-Assessment Annual Reports, the Joint External Evaluation for both self-evaluations and external validation of IHR-related technical areas, risk and vulnerability assessments, after-action reviews, and national plans for health security, have strengthened country capacities. Implementation of the International Health Regulations Monitoring and Evaluation Framework remains effective and active, with 190 Joint External Evaluations completed in 129 countries and 397 simulation exercises conducted in 124 countries. Based on these assessments, 98 countries have developed

national action plans for health security.⁸ Looking ahead, these instruments should more explicitly serve as levers for countries to identify, mobilize and align their own domestic capacities and resources for emergencies, ensuring that preparedness and response efforts are rooted in sustainable national systems. The IOAC welcomes ongoing efforts to rationalize and streamline these instruments, and encourages further work to enhance their implementation and impact, including by ensuring adaptability to country-specific contexts.

45. The IOAC congratulates Member States on the adoption of the WHO Pandemic Agreement by the Health Assembly in 2025, marking an important achievement for multilateralism. The Committee has closely followed the work of the Intergovernmental Working Group on the WHO Pandemic Agreement (IGWG) and reiterates that the timely conclusion of the Pathogen Access and Benefit-Sharing (PABS) Annex is indispensable for the Agreement to become operational through ratification. In this regard, the IOAC expresses its deep concern that, at the conclusion of the resumed sixth meeting of the IGWG on 1 May 2026, Member States were unable to reach consensus on the PABS Annex. This delay risks undermining the momentum, credibility, and practical impact of the Pandemic Agreement at a time when global health security requires decisive and coordinated action. As the Health Assembly considers extending the IGWG's mandate pursuant to resolution WHA78.1 (2025), with a view to submitting outcomes to the next Assembly in May 2027, or earlier through a special session in 2026, the IOAC underscores the urgent need for Member States to demonstrate flexibility and political commitment to reach a mutually agreed PABS Annex without further delay. The Committee calls for a decisive breakthrough at the seventh meeting from 6 to 17 July 2026.

Part 3. Recommendations

46. The Committee acknowledges that the current global context, marked by geopolitical uncertainties and persistent financial constraints, is affecting the Organization as a whole. Member States must reaffirm their support for WHO's leadership in health emergencies. Recognizing the shared responsibility of Member States and the WHO Secretariat, the IOAC recommends that:

WHO leadership in health emergencies

- (a) WHO leadership should ensure that essential emergency capacities continue to be preserved during institutional transitions and that the organizational structure continues to be aligned across the three levels of the Organization. The WHE Programme should take stock of current structures at the end of each biennium to ensure that the "single programme" model continues to function effectively in the various operational environments. [paragraph 15]
- (b) The Director-General and Regional Directors must continue to speak out against attacks on healthcare and violations of the relevant international regulations. [paragraph 17]
- (c) The Director-General should update the delegations of authority to regional directors and the EXD/WHE to remove ambiguities and ensure alignment and complementarity between these roles in emergencies. [paragraph 18]

⁸ [NAPHS | Strategic Partnership for Health Security and Emergency Preparedness \(SPH\) Portal](#) (accessed 21 April 2026).

- (d) The next EXD/WHE should be recruited through an open, international competitive process to support continuity during organizational transitions. [paragraph 19]
- (e) If Member States and the WHO Secretariat should decide to assess whether the Organization's practice should be realigned with the initial WHE Programme design as reflected in document A69/30 or be renewed based on lessons learned, the Committee reiterates that the EXD/WHE must be equipped with the authority to act across the global health emergency ecosystem, empowered to engage at the appropriate levels, with the mandate, clarity, respect and accountability required for an effective response. [paragraphs 18 and 19]
- (f) In the near to medium term, when feasible, the Director-General should appoint a deputy EXD/WHE. [paragraph 20]
- (g) The EXD/WHE, together with the respective Regional Director, should be involved in the mandatory review of performance management and development for regional emergency directors. [paragraph 22]

Financing, budgeting, and resource mobilization for emergencies

- (h) Member States should honour the commitment they made when they adopted the recommendations of the Working Group on Sustainable Financing⁹ and approve a third increase in assessed contributions at the Eightieth World Health Assembly in 2027 for the 2028–2029 biennium, such contributions to represent 50% of WHO's core budget by the 2030–2031 cycle to ensure sustainable, predictable financing. [paragraph 24]
- (i) Member States and donors should contribute to the Contingency Fund for Emergencies in line with its replenishment model, to ensure that WHO can continue to respond in a timely manner to emergencies. [paragraph 27]
- (j) WHO should continue to explore innovative financing mechanisms and partnership platforms, including by engaging with multilateral development banks and international financial institutions, making selective use of trust funds, and leveraging platforms such as the WHO Foundation to broaden and sustain donor support. [paragraph 28]

Human resources and workforce management

- (k) The Department of Human Resources and Talent Management should revisit and roll out its efforts on risk appetite regarding contracts and contract modalities, to provide staff with stability and to support staff retention and development. [paragraph 30]
- (l) A technical mechanism should be established to link applicant profiles in the talent pool with documented performance ratings, ensuring that high-performing staff are prioritized for re-engagement should additional funding become available and that future rehiring decisions are based on performance. [paragraph 31]
- (m) The Director-General, Regional Directors and the EXD/WHE, together with the Department of Human Resources and Talent Management, should ensure that

⁹ [Recommendations of the Working Group on Sustainable Financing to the Seventy-fifth World Health Assembly](#) (accessed 21 April 2026).

emergency-affected countries have WHO Representatives appointed with emergency experience. WHO leadership should also prioritize country-level succession planning and invest in candidates to successfully complete the assessment centre process and expand the qualified pool of WHO Representatives. [paragraph 32]

(n) The IOAC also reiterates its previous recommendation on the importance of duty of care for both national and international staff working in emergencies, including careful management of assignment duration to avoid excessively long deployments in hardship duty stations. [paragraph 33]

WHE operations support and enabling functions

(o) The Department of Human Resources and Talent Management, the Department of Gender, Rights, Equity and Sexual Misconduct Prevention, and the Office of Internal Oversight Services should closely monitor the trend in reporting of sexual misconduct and determine the cause of the reduction in case reports. [paragraph 35]

(p) The WHE Programme, together with the Comptroller, should design and implement a dedicated cost recovery mechanism that ensures secure sustainable financing for the prevention of and response to sexual misconduct in emergency operations, enables clear and transparent reporting to Member States, and ensures donor accountability for the direct costs of sexual misconduct prevention and response when programme support cost rates are reduced. [paragraph 36]

(q) WHO leadership should prioritize, safeguard and adequately invest in core security functions, particularly in emergency-affected countries, recognizing that robust security systems are essential to protect personnel, sustain operations and ensure an effective emergency response. [paragraph 37]

Partnerships

(r) WHO should more effectively leverage the full extent of its partners' capacities and resources, while establishing clearer expectations and stronger accountability mechanisms to ensure delivery on commitments. [paragraph 40]

(s) WHO leadership should leverage partnerships with WHO Collaborating Centres through structured and mutually beneficial arrangements to carry out normative and operational work, while ensuring clearer roles, predictable engagement modalities and strong accountability frameworks to maximize their added value to WHO's mandate. [paragraph 41]

(t) As part of discussions on the reform of the global health architecture and the UN80 Initiative, WHO, together with UN agencies, Member States and relevant partners, should streamline country-level coordination and identify areas to rationalize resources within the cluster coordination mechanism. [paragraph 42]

Member State leadership and national ownership for health security

(u) Member States should, as a matter of highest priority, urgently conclude negotiations on the PABS Annex and submit a finalized outcome to a special session of the Health Assembly in 2026; any further delay beyond this timeline should be avoided given the centrality of the Annex to the entry into force and effectiveness of the WHO Pandemic Agreement. [paragraph 45]

- (v) WHO governing bodies must avoid duplicating health emergency governance mechanisms and advisory groups and determine how best to synergize existing groups.

Conclusion

47. The 2014–2016 Ebola virus disease outbreak in West Africa starkly revealed WHO's shortfalls in health emergency management and highlighted the critical importance of clarifying WHO's role, responsibilities and accountability in emergencies. Under the leadership of the former Director-General, Dr Margaret Chan, the Organization underwent a reform to its work in emergencies which led to the creation of the WHE Programme as presented in document A69/30. Over the past 10 years, tremendous progress has been made and the WHE Programme has evolved into a cornerstone of global health emergency management, providing essential support to countries and communities facing urgent threats. It has strengthened WHO's position as a global health leader, demonstrated the Organization's capacity to manage multiple concurrent emergencies, and enabled WHO to deliver a high level of operational performance as a reliable partner to Member States and stakeholders. However, this ten-year milestone is reached at a time of significant geopolitical and financial volatility. In this context, strengthening global health security will require a renewed commitment to solidarity, cooperation and multilateral governance.

48. WHO is operating in a rapidly changing and increasingly constrained geopolitical environment, where rising tensions and limited resources challenge collective action. The IOAC commends the Director-General, the Regional Directors and the WHO leadership for their stewardship during the 2025 prioritization and realignment process. The IOAC emphasizes that sustained attention continues to be required to preserve essential emergency prevention, preparedness, response and resilience capacities across all levels of the Organization. Now, more than ever, the world needs a strong, agile and fully equipped WHO to respond to current and emerging public health threats.

49. The IOAC is currently conducting a comprehensive ten-year review of WHO's work in emergencies to assist the Organization in establishing a sustainable vision for the future. A preliminary analysis indicates that implementation of the reforms has evolved over time from the original design outlined in document A69/30. While some deviations were necessary adaptations to an evolving context, others represent an intentional shift from the initial intent. The inconsistent application of delegations of authority, standard operating procedures for emergencies and the Emergency Response Framework has remained a persistent issue since the inception of the WHE Programme. Critically, there is no consensus on WHO's mandate in emergencies, including the scope of its operational role in humanitarian settings.

50. Throughout the second half of 2026, the IOAC will finalize its analysis to provide an evidence base and recommendations for Member States to consider as they define and sanction WHO's future role in emergencies. This will require a unified understanding of that role, together with a renewed commitment to align Member States' expectations with institutional authority and sustainable financial resources.

**Walid Ammar (Chair), Christopher Baggoley, Felicity Harvey, Yasmin Ali Haque,
Youngmee Jee, Jeremy Konyndyk, Samba Sow, Elhadj As Sy, Theresa Tam**