

Report of the meeting

1. The sixth meeting of the Standing Committee on Health Emergency Prevention, Preparedness and Response (“the Standing Committee”) was held in virtual format on 14 April 2025. The Vice-Chair of the Standing Committee, Ms Christine Harmston (Canada), presided over the meeting. In her opening remarks, she conveyed apologies from the Chair, Dr Bellefquih (Morocco), who was unable to join the meeting. She also referred to decision EB156(39) (2025), whereby the Executive Board had agreed to extend the mandate of the Standing Committee until the closure of the Seventy-ninth World Health Assembly in 2026; adopt the amended terms of reference of the Standing Committee; and request the Director-General to prepare a report, for consideration by the Executive Board at its 158th session, on the mandates and functions of the different governance and oversight mechanisms for health emergencies.
2. The Director-General welcomed all participants and noted the decision adopted by the Executive Board to extend the mandate of the Standing Committee until the end of the World Health Assembly in May 2026. He noted the recent massive shifts in the landscape of global health, causing disruptions to life-saving disease control programmes, essential health services and response to humanitarian emergencies around the world. He referred to the ongoing health emergencies that continued in different countries and WHO’s work supporting countries to strengthen their health systems; scanning the world for signals of outbreaks and other emergencies; and bringing countries together to meet shared threats with a shared response. He briefed on the preparations for the entry into force of the amendments to the International Health Regulations (2005) (IHR), and the ongoing work of the Intergovernmental Negotiating Body to draft a WHO pandemic agreement.
3. The Vice-Chair introduced the agenda, which was adopted.
4. The Secretariat delivered a presentation on the poliovirus public health emergency of international concern, providing an overview of recent poliovirus cases in the Eastern Mediterranean Region, as well as the immunization, integration and surveillance activities that supported poliovirus eradication. Although the available data indicated that global transmission of wild poliovirus type 1 (WPV1) was geographically limited to the two WPV1 endemic countries, Afghanistan and Pakistan, there had been geographical spread and intensifying transmission within the two endemic countries in 2024. The Director-General, on the advice of the Emergency Committee at its forty-first meeting in March 2025, determined that the international spread of poliovirus remained a public health emergency of international concern, and extended the temporary recommendations addressed to countries infected with poliovirus or those that remained vulnerable to reinfection. During the discussion, the following main points were raised.

(a) There was a need to continue to focus efforts on increasing vaccination coverage, especially in hard-to-reach areas, and on increasing vaccine uptake, working with local communities and community health workers; strengthening surveillance, including environmental surveillance; and enhancing cross-border work. Such work would benefit from the restructuring of risk analysis approaches.

(b) It was important to enhance efficiencies in working with other partners and organizations, including to explore models for financing of co-pay, co-financing, and repurposing of national loans and grants.

(c) Member States that had been declared polio-free were encouraged to continue to take all necessary actions to maintain that status.

(d) Continuity of services and financing posed challenges to the sustainability of the gains made to date, and an increased risk of spillover to other countries/regions. With these considerations, polio eradication efforts would need to be prioritized in the work of the Organization moving forward.

5. The Secretariat updated the Standing Committee on the upsurge of mpox that had been determined a public health emergency of international concern in August 2024. Since January 2022, and as at 28 February 2025, there had been 133 018 confirmed cases, with 293 deaths, in a total of 131 countries. Although most regions were reporting low levels of transmission, the African Region was at its highest reporting level, with around 3000 new confirmed cases a month. The Democratic Republic of the Congo, Burundi and Uganda continued to face large outbreaks, accounting for about 95% of all confirmed cases in 2025. Clade Ib mpox virus had been detected in 28 countries, with the majority of countries outside the African Region (16 countries) having reported single importations, which had not led to local community transmission. The most rapid virus expansion was seen in clade Ib mpox virus-affected areas. For the first time ever, cases due to clade Ia mpox virus had been exported outside the African Region. That was largely due to the increased and sustained transmission of the strain in urban areas of the Democratic Republic of the Congo. Through the Access and Allocation Mechanism, a total of 1 137 300 doses of the Modified Vaccinia Ankara–Bavarian Nordic (MVA–BN) had been allocated in two rounds to 12 countries, with 1 001 840 vaccine doses delivered to nine countries as at 7 April 2025. During the discussion, the following main points were raised.

(a) Community transmission continued to drive the outbreak in the African Region, and consequently the spillover within and outside the Region through travel-related cases. Response efforts required putting communities at the centre – communities should own the response and deliver it. That included building trust and addressing infodemics. That approach had been a top priority throughout the response for WHO, and would continue to move forward.

(b) The recent reduction of funding had immensely impacted laboratory testing, surveillance and response capacities in countries. That required rearrangement, leveraging on other existing activities to comprehensively tackle mpox as well as other diseases. That highlighted the importance of surveillance and laboratory systems that were supported in a comprehensive way for all diseases, otherwise a reduction on one side would have consequences on the response as a whole.

(c) As the African Region continued to witness the highest number of cases, WHO would continue to work with Member States and relevant organizations, including the Africa Centres for Disease Control and Prevention and civil society to optimize the use of limited resources available and privileging targeted interventions in specific geographical areas.

6. The Secretariat provided a report on the ongoing work to strengthen the global architecture for health emergency preparedness, response and resilience,¹ including the interconnectedness of networks and initiatives across the five associated subsystems (collaborative surveillance, community protection, safe and scalable care, access to medical countermeasures and emergency coordination). During the discussion, the following main points were raised.

(a) It was imperative for both Member States and the WHO Secretariat to avoid any duplication of health emergency preparedness and response frameworks and initiatives. That required efforts by all to align where possible and build on existing legal frameworks. Health emergency preparedness, response and resilience (HEPR) provided that framework for alignment and efficiency, for example to help support Member States in meeting their obligations under the IHR and the pandemic agreement, if adopted, and build on the comparative advantage of all involved.

(b) In the context of global financial challenges, it was critical for countries to optimize their national preparedness and response arrangements, including by improving the sharing of resources across sectors and leveraging on the partnerships with other international organizations.

(c) As part of national reviews undertaken post COVID-19 pandemic, countries were encouraged to leverage the spirit of doing more with less, which had been a necessity during the pandemic response.

(d) The anticipated medium- and long-term consequences of the current disinvestment in the WHO Health Emergencies Programme should be made patent by the ongoing prioritization exercise, emphasizing that HEPR subsystems, and especially the functions related to surveillance, safe and scalable care, and supply chains should be preserved. The prioritization exercise should take into account the needs and core capacities gaps in countries. Better strategic use of WHO collaborating centres and better articulation with the national systems could fill global gaps in other areas and was encouraged.

7. The Secretariat provided a report on the response to major ongoing health emergencies.² In 2024, WHO had responded to a total of 51 graded emergencies in 89 countries and territories, comprising 21 Grade 3 emergencies, requiring the highest level of Organization-wide support, and 30 Grade 1 and Grade 2 emergencies. Those health emergencies were taking place in the context of an increasing number of climate-related disasters and humanitarian crises, with nearly 300 million people across 72 countries currently in need of humanitarian assistance. The impact of reductions in humanitarian financing had had an immediate impact on healthcare, coverage and access. Currently 37 million of the most vulnerable were not able to access vitally needed medical care. To date, WHO had recorded over 3000 health facilities including 1000 hospitals in 154 states/provinces that would suspend and/or limit services. Furthermore, ongoing issues of violations to international humanitarian law had significantly impacted aid and health workers'

¹ Document EB/SCHEPPR/6/4.

² Document EB/SCHEPPR/6/3.

ability to reach to most in need. Attacks on healthcare were becoming a “new normal” with dramatic increases reported through the WHO Surveillance System for Attacks on Health Care: 16 countries or territories had reported 1622 incidents, 937 deaths, and 1774 injuries of patients or health workers throughout 2024. In particular, cholera, dengue and mpox outbreaks, as well as human infections with zoonotic influenza viruses, were occurring in multiple regions around the world.

8. The Standing Committee considered and adopted its meeting report. The meeting was closed.
