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Improving international cooperation and multilateral efforts to address global health challenges and promote equity in health for the achievement of the 2030 Agenda for Sustainable Development

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the report on improving international cooperation and multilateral efforts to address global health challenges and promote equity in health for the achievement of the 2030 Agenda for Sustainable Development, prepared by the World Health Organization, pursuant to Assembly resolution 78/280.

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I. Stocktaking of key global health and foreign policy commitments

1. Global health and foreign policy are inextricably linked. This was highlighted by the Foreign Policy and Global Health Initiative launched in 2006, referenced in the Oslo Ministerial Declaration of 2007 and emphasized by the General Assembly in its resolution 63/33. Over the past decade, the importance of State preparedness, diplomacy and cooperation among nations and commitment to health as a common good for all people has underpinned ongoing attention to this crucial area. In the current inter-pandemic phase, in the wake of the global coronavirus disease (COVID-19) pandemic and in the light of the growing climate crisis and emergent foreign policy challenges, the interplay between global health and foreign policy is pivotal for people, prosperity, planet and peace.

2. The COVID-19 pandemic caused severe economic upheaval, erasing trillions of dollars from gross domestic product, disrupting travel and trade, shuttering businesses and plunging millions of people into poverty. It caused severe social upheaval, with borders closed, movements restricted, schools shut and millions of people experiencing loneliness, isolation, anxiety and depression. It also laid bare inequities, with the poorest and most vulnerable communities the hardest hit and the last to receive access to vaccines and other tools. The pandemic also highlighted the importance of multilateralism in the face of global crises, as the international community came together to respond to this unprecedented event. It is critical for the international community to stay vigilant and strengthen capacities to prevent, prepare for and respond to future pandemics and other health emergencies. This is also critical for achieving the Sustainable Development Goals and achieving universal health coverage.

II. Addressing global health challenges in the foreign policy space

3. Strong global health leadership is critical now more than ever. Urgent new challenges, such as antimicrobial resistance, noncommunicable diseases, climate change and weather crises, and the threat of pandemics and other health emergencies pose pressing threats and call for a collective response. In addition, the international community must ensure that it is on track to achieve the Sustainable Development Goals. Tackling the health risks posed by conflicts and natural and environmental hazards in emergency settings is key to success in that regard.

A. Sustainable Development Goals

4. International coordination and cooperation on a massive scale produced a clear plan for transforming global health as part of the Sustainable Development Goals. The Goals were a call to action to end poverty, protect the planet and improve the lives and prospects of everyone, everywhere.[1] Goal 3 is recognized as a precondition, outcome and indicator for all other Goals. Health is not created in the health sector, but through how people live, eat, work and learn. At the same time, good health is an enabler, including for access to work and children's participation in education. The social, economic, environmental, commercial and other determinants of health only too clearly underscore the significance and necessity of integrated and whole-of-society approaches to policymaking to create and sustain health and well-being.

[1] See www.un.org/sustainabledevelopment/development-agenda.

5. Evidence has shown that many of the enormous improvements in health experienced over the past two centuries owe as much to enhancements in broad economic and social conditions as to medical advances. Similarly, many increasingly problematic challenges and megatrends, including those related to climate change, biodiversity loss, air pollution, urbanization and demographic change, such as ageing societies, raise new questions and issues to be tackled if progress on Goal 3 is to be made. Rising conflict, displacement and humanitarian emergencies, as well as natural disasters, increase the divide between the well-off and those suffering the direst health consequences. In many countries, social and political tensions have complicated the governance of healthcare systems, and political factions increasingly use divisive rhetoric, often in relation to sexual and reproductive health and rights, for immediate gains.

6. The COVID-19 pandemic brought health to the front and centre of the global policy discussions, stimulated greater investments in health and highlighted the crucial importance of resilient health systems and international collaboration. At the same time, the pandemic resulted in setbacks to hard-won health gains, put considerable strain on health systems, health and care workers and exacerbated many underlying inequalities while intensifying mental health impacts and the burden of unpaid care work, mostly undertaken by women. The COVID-19 pandemic also highlighted the fact that the health of people is closely connected to the health of animals and our shared environment. This holds especially true in a world where many factors have changed interactions between people, animals, plants and our environment, including changes in land use and climate, disruptions to habitats and the movement of people, animals and plants due to international travel and trade. The spread of zoonotic diseases – diseases that spread between animals and people – has highlighted the need for cooperation between human, animal and environmental health partners, as have issues such as antimicrobial-resistant pathogens, diseases in food animals and vector-borne diseases.

7. Progress in achieving the Sustainable Development Goals was lagging even before the global pandemic unfolded. While some health-related indicators have moved in the right direction globally, current trends indicate that, if progress continues at the present rate, the targets set for 2030 will not be met. For example, the COVID-19 pandemic had a major impact on health. Prior to the pandemic, global life expectancy rose consistently, from 66.8 years in 2000 to 73.1 years in 2019, reflecting years of improvements in health and related areas. COVID-19 swiftly reversed that positive trend, with global life expectancy plummeting to 71.4 years by 2021, back to the level of 2012. Life expectancy at birth has begun to improve again since the end of the COVID-19 pandemic, reaching 73.3 years in 2024.[2]

8. There were also significant setbacks in vaccination rates during and following the COVID-19 pandemic. Between 2000 and 2019, the proportion of children receiving three doses of the diphtheria-tetanus-pertussis vaccine rose from 72 to 86 per cent, then dipped to 81 per cent in 2021 before rebounding to 84 per cent in 2022.[3] In 2023, 14.5 million infants did not receive an initial dose of the diphtheria-tetanus-pertussis vaccine, pointing to a lack of access to immunization and other essential health services, and an additional 6.5 million infants were only partially vaccinated.[4] There were 2.7 million additional unvaccinated or under-vaccinated children in 2023 compared with 2019. The inequitable distribution of the COVID-19 vaccine exposed large gaps in the capacity of developing countries to access or produce vaccines and therapeutics in the event of a pandemic. The harmful use of intellectual property rights to limit access to affordable quality-assured medicines, combined with limited

[2] *World Population Prospects: Summary of Results* (United Nations publication, 2024).
[3] *The Sustainable Development Goals Report 2024* (United Nations publication, 2024).
[4] World Health Organization (WHO), “Immunization coverage”, 15 July 2024. Available at www.who.int/news-room/fact-sheets/detail/immunization-coverage.

technology and knowledge transfer, continues to be a major impediment in the fight against future large-scale health crises.[5]

9. Despite a lack of progress in some areas, there have been positive trends in others. Globally, the number of deaths of children under 5 years of age reached a historic low of 4.9 million in 2022, down from 9.9 million in 2000 and 6.0 million in 2015.[6] The under-5 mortality rate was 37 deaths per 1,000 live births in 2022, which represents a decline of 51 per cent since 2000 and 14 per cent since 2015. As at 2022, 134 countries had already met the target for under-5 mortality. Seven more are expected to reach the target by 2030, but 59 countries, nearly three quarters of which are in sub-Saharan Africa, will need faster progress to meet the target. Since 2000, on average, pregnancy and childbirth have become safer. Globally, the number of maternal deaths per 100,000 live births (the maternal mortality ratio) fell by 34 per cent between 2000 and 2020, largely due to better access to skilled and emergency obstetric care.[7] Declines in maternal mortality have stalled, however, with wide disparities by region and income, with sub-Saharan Africa and Southern Asia accounting for 87 per cent of maternal deaths between 2015 and 2020.[8] Although there was a slight increase in the proportion of women of reproductive age who had their need for family planning satisfied with modern methods between 2000 and 2023,[9] in many countries, laws, policies, social norms and practices still deny sexual and reproductive health and rights to many people, including adolescents and the most marginalized populations. This situation is particularly dire in humanitarian crises, with half of all maternal deaths recorded in fragile settings.[10]

10. Efforts to combat communicable diseases have prevented millions of deaths since the adoption of the Goals in 2015, but progress towards achieving the target is threatened by inequalities and uneven progress. For example, significant strides have been made in combating HIV. In 2023, there were an estimated 1.3 million new infections, representing a decline of 28 per cent since 2015 and 39 per cent since 2010. The number of new infections in 2023 in sub-Saharan Africa, the region most affected by HIV, had more than halved since 2010.[11] However, not everyone is benefiting equally from these advancements: in 2023, 43 per cent of the 1.4 million children living with HIV were not receiving treatment.[12] The progress is even more uneven for other communicable diseases. While significant reductions in the global incidence of malaria and tuberculosis have been achieved over the last few decades,[13] and 54 countries have eliminated at least one neglected tropical disease,[14] progress on other communicable diseases has stalled since 2015. Community-based action and multisectoral cooperation for social protection need to be expanded and considered in covering the last mile.

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[5] See https://publichealth.jhu.edu/2024/is-a-pandemic-treaty-still-possible.

[6] Inter-Agency Group for Child Mortality Estimation, *Levels and Trends in Child Mortality: Report 2023, Estimates Developed by the United Nations Inter-Agency Group for Child Mortality Estimation* (2024).

[7] WHO, *Trends in Maternal Mortality 2000 to 2020: Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division* (Geneva, 2023).

[8] *The Sustainable Development Goals Report 2024.*

[9] Ibid.

[10] Howard S. Friedman, Alexandra Trant and Gretchen Luchsinger, “Navigating megatrends: the ICPD Programme of Action for a Sustainable Future ICPD30 Think Piece – the future of sexual and reproductive health and rights”, United Nations Population Fund, July 2024.

[11] *The Sustainable Development Goals Report 2024*.

[12] Joint United Nations Programme on HIV/AIDS, *The Urgency of Now: AIDS at a Crossroads – 2024 Global AIDS Update* (Geneva, 2024).

[13] WHO, *Global Tuberculosis Report 2024* (Geneva, 2024); WHO, *World Malaria Report 2024: Addressing Inequality in the Global Malaria Response* (Geneva, 2024); and WHO, *Global Tuberculosis Report 2024*.

[14] WHO, *Global Report on Neglected Tropical Diseases 2024* (Geneva, 2024).

B. Universal health coverage

11. Overall, universal health coverage has hit a roadblock, with 4.5 billion people still without essential health services and 2 billion facing financial hardship from out-of-pocket health costs. Improvements to health service coverage have stagnated since 2015, and the proportion of the population that faced catastrophic levels of out-of-pocket health spending increased between 2000 and 2019.[15] Moreover, most countries (108 out of 194) experienced worsening or no significant change in service coverage since the launch of the Goals in 2015. Despite the overall pattern of stagnation on universal health coverage, 30 per cent of countries (42 out of 138) have both improved service coverage and reduced catastrophic out-of-pocket health spending since 2000, demonstrating that progress towards universal health coverage is attainable.

12. Urgent political action is needed to address the alarming stagnation of progress towards universal health coverage. Significantly improving the service coverage dimension of universal health coverage by 2030 will require accelerating the expansion of all essential health services, especially those for which minimal progress is being seen, such as coverage for noncommunicable diseases and maternal health. Progress in universal health coverage will also ensure that member States are in a better position to prevent, prepare for and respond to future pandemics and other health emergencies.

13. Expanding health service coverage hinges on the effective availability, accessibility, acceptability and quality of the health and care workforce. The World Health Organization (WHO) estimates that there are now over 70 million health workers globally.[16] However, the rate of progress in addressing health worker shortages has slowed, with varying trends across and within regions. Consequently, the projected workforce shortages by 2030 have been adjusted upward to 11.1 million workers, from the previous estimate in 2022 of 10.2 million workers. The slower progress is due largely to chronic underinvestment in health worker education and training in certain countries and a mismatch between education and employment opportunities relative to health systems and population needs. In addition, difficulties in deploying health workers to rural, remote and underserved areas compound challenges. The increasing international migration of health workers may exacerbate gaps, particularly in low- and lower-middle-income countries. Limited capacity in terms of human resources for health information systems in some countries makes it challenging to accurately analyse health labour markets in order to inform evidence-informed investments and actions. Budgetary constraints also limit the public sector's capacity to absorb the available health worker supply, leading to a paradox wherein health worker unemployment coexists with major unmet health needs. Consequently, in some countries, people struggle with gaining access to health workers, resulting in significant health service gaps.

C. Noncommunicable diseases

14. Noncommunicable diseases – including cardiovascular disease, cancer, diabetes and chronic respiratory disease – remain the world's leading causes of death.[17] Mental health conditions are increasing and often untreated, affecting nearly one billion people worldwide in 2019, with the rates of anxiety and depression increasing by 25 per cent

[15] WHO and World Bank, *Tracking Universal Health Coverage: 2023 Global Monitoring Report* (Geneva, 2023).

[16] See www.who.int/teams/health-workforce/3.

[17] WHO, *World Health Statistics 2024: Monitoring Health for the SDGs, Sustainable Development Goals* (Geneva, 2024).

during the COVID-19 pandemic.[18] Therefore, prioritizing noncommunicable diseases in large-scale acute and protracted crisis response and ensuring the continuity of services at the primary and secondary levels are essential to cover existing gaps. The Global High-level Technical meeting on noncommunicable diseases in emergencies and displacements, which was co-organized by UNHCR and WHO in February 2024, brought together member States, non-governmental organizations and relevant technical networks to address key actions to make further progress in this regard.

15. For substance abuse prevention and treatment, globally, only about 1 in 11 people with substance use disorders received related treatment in 2022, with coverage decreasing from 11 per cent to under 9 per cent between 2015 and 2022.[19] In 2019, global per capita alcohol consumption was 5.5 litres, only a slight decline from 5.7 litres in 2010.[20]

16. Road traffic deaths and injuries remain a major global health and development challenge. As of 2021, road traffic injuries are the leading cause of death, globally, among children and young people aged 5 to 29 years, and a significant share of the burden of road traffic deaths is among people of working age (18–59 years), causing huge health, social and economic harm throughout society.[21] While more than half of all member States reduced road traffic deaths slightly between 2010 and 2021, at the same time the global motor vehicle fleet more than doubled and the road networks were significantly expanded, resulting in a need for a true transformation of transport systems both for safety and overall sustainability.

D. Antimicrobial resistance

17. Drug-resistant bacteria kill an estimated 1.3 million people globally every year and are at alarming levels in many countries. The global problem of antimicrobial resistance can occur anywhere and does not respect borders. Without urgent action, antimicrobial resistance could unravel the gains of modern medicine. With such high stakes, WHO has drawn on its mandate as the leading directing and coordinating authority in health to drive action, raise global awareness and set guidelines and priorities. At its seventy-ninth session, the General Assembly adopted the political declaration of the high-level meeting on antimicrobial resistance, in which it outlined concrete commitments to accelerate the global response to antimicrobial resistance. Those commitments were welcomed by member States at the fourth Global High-level Ministerial Conference on Antimicrobial Resistance, hosted by Saudi Arabia, which resulted in the Jeddah Commitments, aimed at reinforcing the commitments set out by the General Assembly. Addressing financial and governance gaps while enhancing intersectoral coordination remains crucial in ensuring a sustainable and effective global response to antimicrobial resistance. Member States have made notable progress in implementing multisectoral national action plans on antimicrobial resistance and integrating a health systems approach, including infection prevention and control and water, sanitation and hygiene interventions. Specifically, 73 (43 per cent) of the 186 countries that have developed national action plans on antimicrobial resistance have linked their antimicrobial resistance action plans to their national water, sanitation and hygiene strategies, underscoring a growing recognition of the interconnection between antimicrobial resistance and these critical preventive interventions.

[18] WHO, *World Mental Health Report: Transforming Mental Health for All* (Geneva, 2022); and see www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide.

[19] *The Sustainable Development Goals Report 2024*.

[20] WHO, *World Health Statistics 2024*.

[21] WHO, *Global Status Report on Road Safety 2023* (Geneva, 2023).

E. Health and humanitarian emergencies

18. While the COVID-19 pandemic has passed the acute stage, health emergencies continue to be prevalent. The World Bank estimates that nearly 1 billion people live in fragile and conflict-affected States, with an estimated 60 per cent of the world's extreme poor projected to live in fragile, conflict-affected and vulnerable settings by 2030. Combined with weak health systems, these settings make it difficult to access essential health services where they are most needed. Consequently, fragile, conflict-affected and vulnerable settings have a high burden of disease and death: more than 70 per cent of cases of epidemic-prone diseases, such as cholera, measles and meningitis; 60 per cent of preventable maternal deaths; 53 per cent of deaths in children under age 5; and 45 per cent of infant deaths; 55 per cent of unvaccinated children and 85 per cent of children affected by polio.

19. In 2024, there were 45 graded health emergencies globally, occurring in the context of an increasing number of climate-related disasters and humanitarian crises, with nearly 4 per cent of the world's population currently in need of humanitarian assistance.[22] While the COVID-19 pandemic is no longer classed as a public health emergency of international concern, there are currently two active public health emergencies of international concern, one pertaining to poliovirus, which was declared in 2014 due to a rise in cases of wild poliovirus and circulating vaccine-derived poliovirus, and the other pertaining to mpox, which was declared in 2024 due to outbreaks in parts of Africa of a new variant of the disease. Women, children, persons with disabilities, older persons, internally displaced persons, refugees, migrants and other minorities are disproportionately affected by humanitarian crises. In 2023, more than one in every six children in the world – approximately 473 million – were living in or fleeing conflict zones.[23]

20. The year 2024 was the deadliest on record for humanitarian workers, with over 370 killed.[24] Humanitarian and medical personnel were attacked, killed, threatened, abducted and harassed. The highest number of casualties and incidents was recorded among local and national staff. Humanitarian personnel stayed and delivered in the most challenging circumstances.

21. Healthcare remained under severe threat in humanitarian situations. In 2024, WHO documented over 1,617 attacks on healthcare facilities, personnel and resources across 16 complex emergencies, resulting in over 900 deaths and 1,700 injuries, with the highest figures recorded in the Occupied Palestinian Territory, Ukraine, Lebanon and the Sudan.[25] Hospitals, clinics and ambulances were frequently bombed, looted or significantly obstructed from the delivery of essential medical services. The criminalization of medical care, including through the detention, prosecution and harassment of health workers providing impartial medical assistance, continued in some contexts. Attacks on healthcare contributed to the increased risk of disease outbreaks, exacerbated severe malnutrition and caused excess deaths. The active protection of healthcare – including the protection of workers, patients, supplies, transport and facilities – must be respected, particularly in humanitarian situations when health systems are already under strain. Consideration needs to be given to social protection approaches and mechanisms for health workers in these circumstances.

[22] WHO, document EB156/5.
[23] UNICEF, "2024: devastating year for children in conflict zones", 27 December 2024.
[24] Briefing by the Assistant Secretary-General for Humanitarian Affairs and Deputy Emergency Relief Coordinator to the Security Council, 2 April 2025 (see S/PV.9889).
[25] WHO, Surveillance System for Attacks on Health Care database, available at https://extranet.who.int/ssa/LeftMenu/Index.aspx.

22. Health labour market analyses, supported by WHO, were conducted in nearly 50 countries to inform national policies and investment plans, leading to increased financing for and the additional recruitment and improved retention of health and care workers. Areas of emphasis include: (a) advancing gender equality and empowering women, who form 67 per cent of paid workers in the health and care sector, through policies that address the widespread undervaluation of health and care work performed by women, tackling the gender pay gap and promoting equal opportunities for leadership and decision-making; (b) improving the working conditions of health and care workers through the adoption and implementation of a global health and care worker compact, which is aimed at protecting health and care workers and safeguarding their rights, promoting and ensuring decent work, free from discrimination, and providing a safe and enabling practice environment, including mental health support; and (c) strengthening the national workforce capacity for essential public health functions, including the skills and systems needed for emergency preparedness and response.

23. WHO coordinates a global programme of work to advance equitable access to health and care workers, a prerequisite for universal health coverage and for pandemic preparedness and response capacities. Ongoing work includes the strategic analysis of health workforce challenges and trends and the monitoring of progress in the implementation of the Global Strategy on Human Resources for Health: Workforce 2030, the WHO Global Code of Practice on the International Recruitment of Health Personnel and the Working for Health 2022–2030 Action Plan. Based on data reported by member States through the national health workforce accounts, WHO estimates indicate that the health workforce shortage decreased from 15.4 million workers in 2020 to 14.7 million workers in 2023 and is projected to further decrease to 11.1 million by 2030.

24. In an increasingly complex emergency landscape, partnerships with local communities are more essential than ever, as communities lie at the heart of public health emergencies. It is at the community level where the impact of emergencies is most directly felt and local communities not only face the physical and mental toll of crises, but also act as the foundation for resilience and response.

25. Efforts to build resilience require the continued addressing of the broader social and economic disruptions caused by health emergencies, which disproportionately affect the most vulnerable populations, including women, children, older persons, persons with disabilities and displaced individuals, through social and community protection mechanisms and efforts. Social protection measures that preserve livelihoods and address occupational risks, ensure food security and maintain educational continuity are vital components of such efforts.

F. Climate crisis

26. The escalating climate crisis has had a profound impact on global health. It threatens the essential ingredients of good health – clean air, safe drinking water, nutritious food supply and safe shelter – and has the potential to undermine decades of progress in global health. Between 2030 and 2050, climate change is expected to cause approximately 250,000 additional deaths per year from malnutrition, malaria, diarrhoea and heat stress alone. The direct damage costs to health are estimated to be between $2 billion and $4 billion per year by 2030. Areas with weak health infrastructure – mostly in developing countries – will be the least able to cope without assistance to prepare and respond. The most vulnerable groups will be hit the hardest. Social and community protection mechanisms need to be able to address these groups in particular. Greenhouse gas emissions that result from the extraction and burning of fossil fuels are major contributors to both climate change and air pollution. Many

policies and measures taken by individuals, such as transport, food and energy use choices, have the potential to reduce greenhouse gas emissions and produce major health co-benefits, particularly by abating air pollution. The phase-out of polluting energy systems, for example, or the promotion of public transportation and active movement could both lower carbon emissions and cut the burden of household and ambient air pollution, which cause 7 million premature deaths per year.

27. People living in humanitarian settings are particularly vulnerable to climate change. The devastation caused by the El Niño phenomenon has contributed to widespread malnutrition, disease outbreaks and displacement. Across the globe, severe droughts have led to emergencies and millions have been displaced by flooding. In the African region, 56 per cent of all public health emergencies between 2001 and 2021 were climate-related. In parts of Southern Africa affected by El Niño, 1.1 million children are suffering from severe acute malnutrition.[26] In 2024, extreme weather events such as flooding, droughts and cyclones have contributed to widespread malnutrition, disease outbreaks and displacement.[27]

28. At its 156th session, the WHO Executive Board adopted a decision to adopt the Global Action Plan on Climate Change and Health (2025–2028) and requested the Director-General to report on its implementation at the World Health Assembly in 2027 and 2029.[28]

III. Global governance

29. The proposal for a WHO pandemic agreement has been an ongoing priority since the World Health Assembly decided, in December 2021, to establish the Intergovernmental Negotiating Body to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response.[29] These discussions culminated in the adoption of a legally binding international instrument, the WHO Pandemic Agreement, by the World Health Assembly in May 2025.[30] The Pandemic Agreement strengthens global cooperation and provides a legal framework for future pandemic prevention, preparedness and response.

30. Despite progress made, the Intergovernmental Negotiating Body was unable to complete its work by May 2024. During the seventy-seventh World Health Assembly, member States decided to extend the mandate of the Intergovernmental Negotiating Body to finish its work as soon as possible and submit its outcome for consideration by the seventy-eighth World Health Assembly in May 2025.[31] Since its inception, the Intergovernmental Negotiating Body has held 13 formal meetings, with nine resumed sessions, as well as much intersessional work through informal meetings and discussions to move towards consensus on the text.[32] The WHO Pandemic Agreement is an intergenerational commitment that would serve as a tool of international health law with agreed principles, rules and approaches for strengthened pandemic prevention, preparedness and response.

31. The seventy-seventh World Health Assembly also adopted a package of amendments to strengthen the International Health Regulations (2005), which are an integral piece of the global health emergency architecture and are being strengthened

[26] WHO, document EB156/18.
[27] WHO, document A78/13.
[28] WHO, document EB156(40).
[29] World Health Assembly decision WHA SSA2(5).
[30] WHO, document WHA78.1.
[31] World Health Assembly decision WHA77(20).
[32] See https://apps.who.int/gb/inb/.

in line with other global efforts to protect the world.[33] The amendments to the International Health Regulations and the work of the Intergovernmental Negotiating Body to finalize the WHO Pandemic Agreement are built on a commitment to equity and solidarity, and an understanding that health threats do not recognize national borders and that therefore prevention, preparedness and response are collective endeavours. These critical actions were taken to ensure that comprehensive, robust systems are in place in all countries to protect the health and safety of all people everywhere from the risk of future outbreaks and pandemics and represent two important steps taken by member States to build on lessons learned from several global health emergencies, including the COVID-19 pandemic.

32. Since its establishment in 2018, the Global Preparedness Monitoring Board continues to contribute to health emergency governance, acting as an independent monitoring and accountability body that assesses and advocates pandemic and global health crisis preparedness. The Board, through its membership of political leaders, agency principals and experts, provides comprehensive evaluations and policy recommendations to strengthen response capacities for pandemics and other health emergencies. Through its monitoring and advocacy work and its convening power, the Board continues to drive global collaboration and accountability for a more resilient health future.

33. Under the presidency of South Africa of the Group of Twenty (G20) in 2025, the G20 Joint Finance and Health Task Force will address the ongoing need to improve coordination between health and finance in order to analyse policy priorities for mitigating pandemic risks to the global economy and plan for improved readiness for a more effective, efficient and equitable response. The Task Force has previously identified three priorities: improving finance and health coordination for key health financing issues, especially pandemic prevention, preparedness and response; better understanding and mitigating economic risks and vulnerabilities from pandemics; and improving readiness for large-scale pandemic response interventions with a focus on day zero and surge financing.

IV. Addressing inequities

34. Health inequalities between and within countries remain a major concern. In 2021, 11 per cent of the world's population lived in countries that spent less than $50 per person per year on health, while the average per capita spending was $4000 in high-income countries.[34] Those living in more rural settings and the poorest households experienced less coverage of essential health services, with catastrophic health spending concentrated among people living in multigenerational and older households.[35] Around 1.3 billion people (16 per cent of the population) in 2021 had a disability and faced health inequities due to avoidable, unfair and unjust factors.[36] Substance abuse treatment coverage for women consistently lags behind that for men across all regions, with over 13 per cent of men receiving treatment compared with less than 6 per cent of women in 2022.[37] Persistent inequalities also exist with household air pollution and associated health risks that are particularly high among women and children, who tend to spend more time in and around cooking stoves.

35. There are huge inequalities in health spending across and within countries. Of the 2 billion people facing financial hardship, 1.3 billion people were pushed or

[33] World Health Assembly resolution WHA77.17.
[34] WHO, *Global Spending on Health: Emerging from the Pandemic* (Geneva, 2023).
[35] WHO and World Bank, *Tracking Universal Health Coverage*.
[36] WHO, *World Health Statistics 2024*.
[37] *The Sustainable Development Goals Report 2024*.

further pushed into poverty due to out-of-pocket health costs. In 2021, 11 per cent of the world's population lived in countries that spent less than $50 per person per year on health, while the average per capita spending was $4000 in high-income countries. Increased levels of government debt constrain health spending – 3.3 billion people live in countries where debt-interest payments are greater than health or education expenditure. The health and care workforce situation with the projected shortfall of 11.1 million health and care workers by 2030, particularly in low-income and lower-middle-income countries, must be addressed through urgent investments and action to deliver on universal health coverage commitments.[38]

A. Research and development

36. The COVID-19 pandemic has reinforced the need for countries to be proactive and stay ahead of the curve, and also to react quickly in the face of a public health emergency. Efforts are being made to ensure that member States are prepared for pandemics and other health emergencies, as well as to attain the health-related Sustainable Development Goals. WHO has made significant progress in strengthening global research preparedness for epidemic and pandemic threats. The introduction of Collaborative Open Research Consortiums, organized by viral families and bacteria, has enhanced global research coordination and collaboration. This mechanism improves standardization in clinical research and accelerates critical studies needed for the rapid development of vaccines, treatments and diagnostics. Pre-approved standardized clinical research protocols and study designs, endorsed by national ethics committees and regulatory authorities, have enabled the swift initiation of clinical trials during outbreaks. In addition, pre-approved agreements with manufacturers have streamlined vaccine availability, ensuring distribution within 7–15 days of an outbreak declaration. These efforts have been further reinforced by targeted training initiatives in 17 at-risk African countries, strengthening trial capabilities and regulatory preparedness.

B. Interim Medical Countermeasures Network

37. In the lead-up to the adoption of the Pandemic Agreement, WHO established the interim Medical Countermeasures Network, which is aimed at facilitating timely and equitable access to quality, safe, effective and affordable medical countermeasures in response to public health emergencies by building on existing networks and fostering global collaboration. The recent global surge in mpox cases and the declaration of a public health emergency of international concern, along with emerging data indicating limited availability of medical countermeasures in the short to medium term, necessitated the urgent need for a collaborative and transparent process to ensure timely and sufficient sourcing and distribution of medical countermeasures to control the outbreaks. In addition to complementary measures, such as case investigation, surveillance and contact tracing, one of the immediate priorities was to vaccinate those at the highest risk of infection, thereby helping to control the outbreak. Building on the foundation of the interim Medical Countermeasures Network, an access and allocation mechanism for the mpox response was established with key partners to estimate demand and needs in countries, source and secure available supplies and allocate them strategically, in order to ensure that medical countermeasures have the desired public health impact.

[38] See the WHO Executive Board reports on the health and care workforce for the 156th session, available at https://apps.who.int/gb/e/e_eb156.html.

C. Scalable manufacturing and local production

38. During the COVID-19 pandemic, there was an increasing emphasis on the importance of local production and related technology transfer in the context of promoting equitable access to medicines and other health technologies. Progress has been made in promoting local production and improving access; however, existing challenges remain, and new challenges have emerged. The World Local Production Forum is a WHO initiative that provides member States, United Nations agencies, representatives of the pharmaceutical industry, financial institutions and civil society with a regular platform to shape strategies, galvanize collective action and foster partnerships on sustainable local production to improve timely and equitable access to quality-assured health products. It serves as a platform to generate actionable recommendation outcomes that support local production, with a focus on improving access to quality, safe and effective health products and strengthening global, regional and national health security. The Forum has met three times since its establishment in 2021 and is the only global platform to draw high-level attention and discuss key issues surrounding technology transfer and local production to improve access and protect health security.

D. Technology transfer

39. The mRNA vaccine technology transfer hub has developed an effective COVID-19 mRNA construct that is being transferred to 15 partners across the six WHO regions. This initiative, while initially focused on COVID-19, is also building long-term capacity for the development of other mRNA-based vaccines and therapeutics. Collaborative mRNA-based research consortiums have been established to develop further products, fostering regional self-sufficiency in pandemic response technologies. The Health Technology Access Programme is aimed at bridging the technology access gap for recipients in low- and middle-income countries by targeting platform technologies that are relevant to both pandemic response and other public health needs. Rapid diagnostic test technology, which would strengthen outbreak detection and response capabilities, was secured for sublicensing under the auspices of the Programme, and a shortlist of potential recipients is under assessment.

40. The WHO Biomanufacturing Workforce Training Initiative, established in 2024, synchronizes training in quality biomanufacturing primarily for low- and middle-income countries. Over 7,000 participants globally have been trained by WHO and the Global Training Hub for Biomanufacturing. Regional training centres are being established to tailor training to regional contexts and needs. The initiative enhances the ability of low- and middle-income countries to produce biologics, including vaccines and therapeutics, ensuring that manufacturing expertise is in place before the next pandemic.

E. Financing

41. Financing is central to effective prevention, preparedness and response to health emergencies and challenges, requiring coordination across multiple sectors, including health, environment, finance, and trade. Financing effective local, national, regional and global health emergency preparedness alone will require approximately $30 billion annually,[39] and there is currently a gap of $10 billion per year. Effective financing not only depends on making more funds available, but also requires the

[39] WHO, “Strengthening health emergency prevention, preparedness, response and resilience”, 2023.

mechanisms to ensure that funds are allocated rapidly, scaled appropriately and targeted to fill critical gaps. Progress had been made, with the launch of the Pandemic Fund in November 2022, as well as the first WHO investment round in 2024. However, severe funding cuts to global public health in 2025 put that progress at risk. Addressing this requires a blend of sustainable and scalable solutions, paired with robust needs and gaps analyses to prioritize investments effectively.

42. The Pandemic Fund was established to mobilize financing to help low- and middle-income countries to strengthen their critical front-line capacities, including those in relation to infectious disease surveillance and early detection, laboratories for rapid testing and a health emergency workforce, which are essential to stop outbreaks from spreading. The Fund arose from the realization that investments in preparedness and more resilient health systems yield a high return and contribute to saving lives and trillions of dollars in pandemic-related costs at a later date. Under its first two funding rounds, the Fund awarded grants totalling $885 million, which benefited 75 countries through 47 projects across six geographical regions. Demonstrating its agility and speed to respond to unfolding crises, in September 2024, the Fund allocated $129 million to 10 countries affected by mpox. On average over the first two funding rounds, 43 per cent of Fund resources have been allocated to countries in sub-Saharan Africa.[40] Although the Fund has created a vital platform to drive much-needed global solidarity and collaboration, challenges remain, as the funding requests to date have far exceeded available resources, requiring increased and more sustainable financing.

43. The WHO Contingency Fund for Emergencies provides immediate financing for emergency operations around the world. This flexible resource enables WHO to rapidly investigate, verify and respond to health emergencies. As at 5 November 2024, donor contributions amounted to $20 million, and $47 million had been released by WHO to deliver life-saving assistance as part of the health response to 23 emergencies in 28 countries and territories. In its Health Emergency Appeal 2024,[41] WHO called for $1.5 billion to protect the health of the most vulnerable populations facing emergencies. It represents the estimated total amount needed to provide support for 41 ongoing health crises around the world. As at 22 October 2024, WHO had access to $1.02 billion in funding to respond to urgent and complex health emergencies, of which $415 million had been received in 2024. The remaining funding gap of $478 million limits the ability of the secretariat and of member States to meet the health needs of communities affected by health crises.

44. WHO has supported countries across all regions to strengthen protection from financial hardship due to out-of-pocket health costs since the adoption of the 2023 political declaration of the high-level meeting on universal health coverage. Reforms to external funding approaches, as promoted in the Lusaka Agenda, which was launched in December 2023, particularly in the context of reduced foreign aid for global health, can help to facilitate the support and alignment of partners with domestic systems and priorities through a “one plan, one budget, one monitoring and evaluation process” approach. WHO is working with member States and partners to analyse the impact of foreign aid cuts on the health sector and is supporting over 100 countries in the design and implementation of strategies to mitigate risks to universal health coverage.

[40] Pandemic Fund, *Building a Pandemic-Resilient World: The Pandemic Fund Inaugural Progress Report 2023–2034* (2024).

[41] WHO, *WHO Health Emergency Appeal 2024* (Geneva, 2024).