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GLOBAL PREPAREDNESS MONITORING BOARD

A world on the edge

Priorities for a pandemic-resilient future

2026 GPMB REPORT

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A world on the edge — Priorities for a pandemic-resilient world, 2026 GPMB report. Launch version.

Suggested citation. A world on the edge — Priorities for a pandemic-resilient world, 2026 GPMB report. Global Preparedness Monitoring Board, Geneva: World Health Organization; 2026. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at *http://apps.who.int/iris*.

Acknowledgements

We would like to thank Dr Tedros Adhanom Ghebreyesus, WHO Director-General, and Mr Ajay Banga, President of the World Bank, for convening the GPMB. We express our deep appreciation to the GPMB Secretariat for supporting the development of this report. We are also grateful to the World Health Organization for hosting the GPMB Secretariat and making the work of the GPMB possible. Finally, we are grateful for the financial support provided to the GPMB Secretariat by the Gates Foundation and the Institute of Philanthropy that has facilitated the development of this report.

Foreword

Our final report on global preparedness is both hopeful and sobering. Its message is stark.

Eight years ago, the GPMB was created to help ensure the world would never again experience a devastating crisis like the West African Ebola epidemic. Five new Public Health Emergencies of International Concern and numerous outbreaks have since tested countries and institutions alike, including a pandemic that reshaped societies, economies, and politics across the globe. Important reforms have followed: the WHO Health Emergencies Programme, Pandemic Fund, WHO Pandemic Agreement, United Nations High-Level Meetings, and billions invested in prevention, preparedness and response.

But the world we address today is very different from the one we confronted in 2018. It is a world of greater volatility, uncertainty, fragmentation and interconnected shocks with far-reaching consequences.

In this final report, we answer the fundamental question of whether our world is safer than it was a decade ago.

Our conclusion is grounded in an examination of the evidence. And that evidence is clear: health, economic, social and political impacts of health emergencies have not diminished, and in important areas are growing. In short, **reforms have not kept pace with rising pandemic risk — the world is not yet meaningfully safer**.

At the heart of this reality is a profound erosion of trust and unresolved inequities in access to basic services and medical countermeasures.

The world is now on the edge — a further fracturing of public trust, and rupturing of the collective action needed to address inequities, will leave all countries even more deeply exposed to the grave, inevitable health, social and economic impacts witnessed in the last pandemic.

However, we conclude our mandate convinced that political leaders, stakeholders and industry can rapidly change the trajectory of global preparedness by embracing the **three concrete priorities of this report—independent monitoring, equitable access to countermeasures and sustainable financing**. The GPMB emphasizes that advancing trust and equity ultimately requires multistakeholder accountability—across public, private and civil society actors—to translate commitments into measurable progress. Accordingly, our lead recommendation: independent monitoring must continue—**the world needs a holistic, uncompromising view from outside the system, that can speak uncomfortable truths, and anchor the ongoing innovation and investment needed to be truly prepared, globally**.

The GPMB is honored to have helped advance global preparedness over the past eight years and trusts that leaders will seize upcoming opportunities to act on our recommendations and ensure the world is better equipped to anticipate, withstand and respond to future health crises.

HE Kolinda Grabar-Kitarović
GPMB Co-Chair and former President of Croatia

Ms Joy Phumaphi
GPMB Co-Chair and former Minister of Health of Botswana

Key messages

1 GLOBAL PREPAREDNESS IS FAILING TO KEEP PACE WITH PANDEMIC RISK

- Within months of the **GPMB's first report warning that the world was not prepared for a fast-moving pandemic**, COVID-19 struck, the deadliest respiratory pandemic since 1918. Despite considerably more knowledge, tools and resources, the **trajectory of pandemic risk is moving in the wrong direction**.
- Climate change and armed conflict are exacerbating risk; geopolitical fragmentation, the erosion of civic space, and commercial self-interest are undercutting collective action. The enormous potential of advanced AI tools and digital technology to transform PPR is being compromised and —without safeguards and effective governance—could reduce health security and accelerate the access gaps that defined COVID-19.

2 THE EVIDENCE IS ALARMING—TRUST IS ERODED & INEQUITY EXPOSED

- **Public health emergencies of the past 10 years—from Ebola to mpox—demonstrate that the world is not substantially safer from their impact**, with rising economic and social costs, weakening access to medical countermeasures, declining financing, and societies emerging poorer, more unequal and more divided. Critical areas are neglected, from One Health and multisectoral approaches to calibrating public health and social measures and confronting misinformation.
- **Most critical, the bedrock of PPR—trust and equity—is collapsing**. Trust is eroding: between governments and citizens; between countries; in multilateral organizations; in industry. Deep-rooted inequity is exposed: in access to information, knowledge, financing, and countermeasures, from personal protective equipment to life-saving vaccines.

3 PRIORITIES FOR ACTION

- Broad-based, enduring trust and sustainable equity can be advanced, even while confronting misinformation, by establishing:
  - ***independent, multisectoral and comprehensive pandemic risk monitoring***, powered by cutting-edge, ethical AI and digital tools, directly accountable to the World Health Assembly (WHA), and reporting, through the WHA, to the UN General Assembly and relevant international and regional fora, especially on trade, financing, security, agriculture and animal health;
  - ***equitable access to countermeasures***, through finalization, ratification and full implementation of the WHO Pandemic Agreement, and robust regional manufacturing capacity, supported by technology transfer, workforce development and targeted investment;
  - ***sustainable financing***, with robust 'Day 0' financing mechanisms, standing commitments to the Pandemic Fund, and the obligation of domestic resources, enabled by a financial architecture that strengthens national investment capacity.

4 POLITICAL ATTENTION IS VITAL

- Pandemic and broader, multi-hazard PPR is no longer only constrained by capacities but by challenges to collective action that only political leaders can resolve.
- Sustained, unwavering political engagement is vital, beginning with two exceptional opportunities in 2026: to finalize the WHO Pandemic Agreement and to agree on new, meaningful commitments at the 2nd UN High-Level Meeting on PPPR to advance independent monitoring, equitable access and sustainable financing.

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Pandemic risk is moving in the wrong direction

The Global Preparedness Monitoring Board (GPMB) was established in 2018 following the devastating 2014–2016 West Africa Ebola epidemic, to assess global preparedness and drive reforms to make the world safer from health emergencies. Ten years after the end of the epidemic, the world has shifted profoundly, becoming more volatile, uncertain, complex, and ambiguous (VUCA). The decade has been marked by successive public health crises, most notably the COVID-19 pandemic, which triggered the deadliest pandemic since 1918, the sharpest global economic contraction since the Great Depression, and the most far-reaching disruption since World War II. **COVID-19 was not an isolated event, but the result of converging global trends that are driving increased pandemic risk, including climate change, ecological disruption, increased mobility, and armed conflict.**[1] At the same time, new technologies have advanced at unprecedented speed, including novel vaccine platforms, breakthroughs in diagnostics and genomics, and the rapid expansion of artificial intelligence and digital tools. Yet their enormous potential to transform PPR risks being undermined by misinformation, as well as legitimate concerns around data security, governance and privacy. In parallel, growing geopolitical fragmentation, nationalism and commercial self-interest are weakening the collective action on which PPR depends.

Together, these trends have contributed to profoundly weakening trust and exposing deep-rooted inequities, eroding the very foundations of effective PPR.

PPR has become more challenging, as the systems and conditions required for effective action are increasingly under strain. Preparedness financing remains highly dependent on political attention: declining between crises and constrained by rising debt burdens, fiscal pressures and shifting priorities. Health systems are weakening with reduced capacity to maintain essential services and respond to shocks. Inequities in access to medical countermeasures persist, and sustained political commitment remains uneven.

Over the past decade, new initiatives and mechanisms have emerged in response to these challenges, including the Pandemic Fund, the WHO Pandemic Agreement, the Africa CDC, the African Vaccine Manufacturing Accelerator (AVMA) and the 100 Days Mission. These efforts reflect a growing recognition of the need for faster, more coordinated and more equitable responses to health emergencies. Yet it is not clear that these investments are translating into a world that is measurably safer from the impacts of pandemics and other health emergencies, especially in this changing, VUCA world.

Building on the 2025 GPMB Report, ***The New Face of Pandemic Preparedness***, this report examines how this new environment has shaped the impacts of health emergencies over the past decade and what accelerating complexity, shifting geopolitical dynamics, and transformative technological change mean for strengthening preparedness and reducing risks in the years ahead. **This report uses the GPMB Monitoring Framework to assess how the impacts of the six new Public Health Emergencies of International Concern (PHEICs) of the past decade have evolved and identifies the areas where they are now most acute.**[2]

The year 2026 represents a capstone moment for GPMB as it concludes its mandate. It coincides with critical global processes that will help shape the future of PPR. Through this analysis, the Board seeks to bring authoritative evidence into global discussions at a time when aligning political commitments with real-world risk is more important than ever.

The Impact dimension of the GPMB Monitoring Framework evaluates how the immediate and long-term consequences of health emergencies evolve. This report assesses these impacts across the six public health emergencies of international concern (PHEICs) that were declared in the last 10 years.

The heatmap below summarizes the Board's assessment across the Impact indicators.

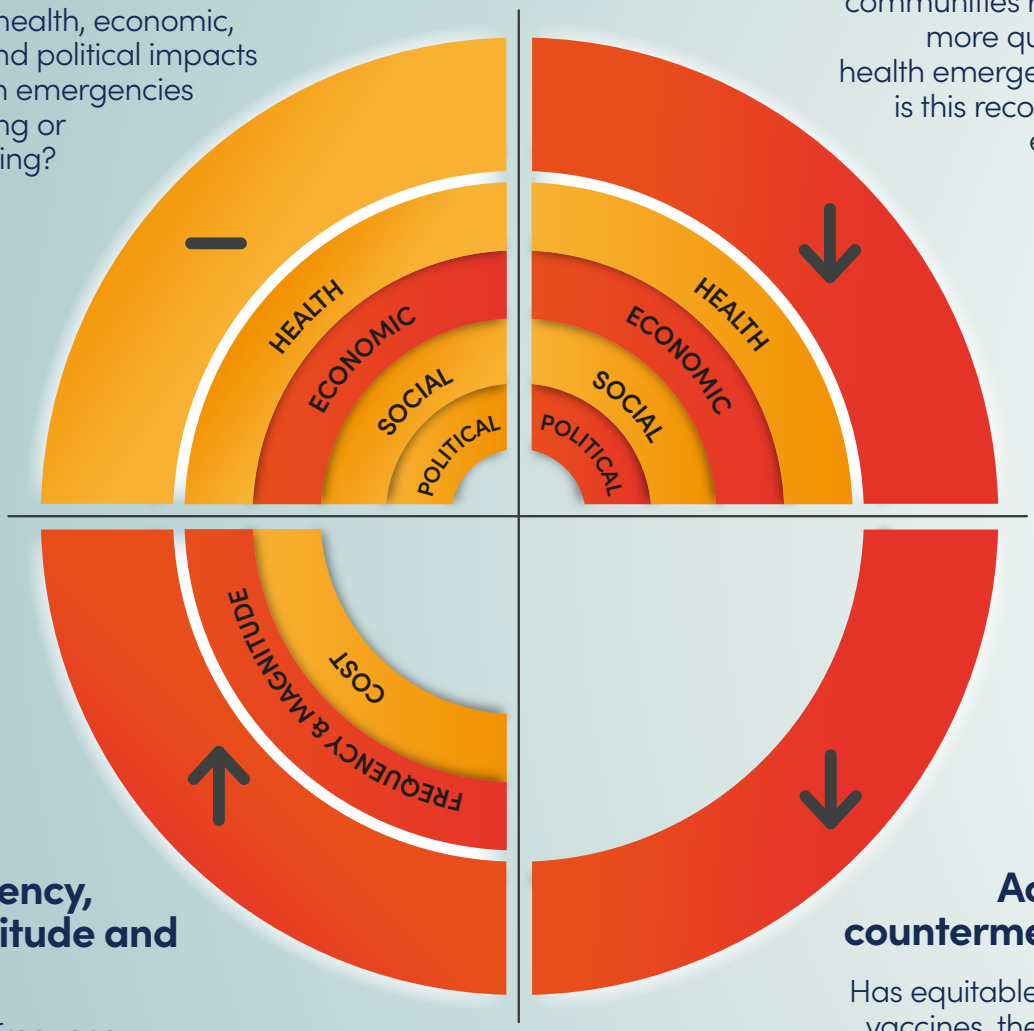
Figure 1. Impact of recent Public Health Emergencies of International Concern on global pandemic risk

Health, economic, social and political impacts

Are the health, economic, social and political impacts of health emergencies increasing or decreasing?

Speed and equity of recovery

Are countries and communities recovering more quickly from health emergencies and is this recovery more equitable?



Frequency, magnitude and costs

Are the frequency, magnitude and cost of health emergencies increasing or decreasing?

Access to countermeasures

Has equitable access to vaccines, therapeutics, diagnostics and other countermeasures improved or declined?

Worsening

No change

Improving

A decade on, the world is not safer from health emergencies

Multiple impacts signal mounting concerns

There are alarming signs that resilience could be weakening rather than strengthening, despite recent investments. Even impacts that appear stable over time continue to drive significant societal disruption.

This analysis finds that:

- **Infectious disease outbreaks are becoming more frequent and more consequential in terms of the number of cases and/or deaths**, reflecting the changing risk landscape, including shifts in global mobility patterns, agricultural practices and farming, climate change, and urbanization.[3]
- **The short- and long-term economic impacts of health emergencies[4] are increasing and driving important structural shifts in economies**, with the greatest impacts seen in outbreak responses that rely heavily on public health and social measures.
- **The timeliness and equity of access to medical countermeasures have declined.** A worrying "equity fatigue" is emerging, marked not only by reduced political and financial commitment, but by diminishing action to sustain equitable access as a global priority.
- Following the surge in COVID-19 response financing, overall development assistance for health has returned to levels last seen in 2009[5] and has decreased as a share of overall development assistance.[6]

Investments in preparedness have strengthened since the COVID-19 pandemic, but shifting geopolitical priorities now threaten to undermine this progress.

- **Many societies have emerged from major health emergencies poorer, more unequal, and more divided.** This is particularly concerning because previous Board analyses[7] identified these very factors as key drivers of pandemic risk, creating a vicious cycle in which post-crisis fragility fuels a spiraling pandemic threat.

PPR is not keeping pace with changing risks.

Taken together, these trends suggest that preparedness efforts are being outpaced by new and more complex stressors, including pandemic risks[8], geopolitical instability, and rapidly evolving information ecosystems. They point to a future in which pandemics and other public health emergencies may become more frequent, more disruptive, and harder to manage, in a world that is more vulnerable, more uncertain, and marked by declining trust and widening inequities. Without a step change in PPR capacities to explicitly address pandemic drivers, improve declining commitment to equity and collective action, and rebuild trust, the world risks entering a cycle of accelerating health crises, where each new shock further erodes resilience and widens existing fractures.

What a decade of PHEICs reveals about the impact of health emergencies

The GPMB developed the first-ever comprehensive monitoring framework to assess the state of pandemic risk, looking at drivers of pandemics and health emergencies, preparedness capacities to mitigate these drivers, and their impacts over time, including the world's capacity to recover. The Board has been testing this framework since its publication in May 2023, first assessing preparedness capacities in 2023[9], then reviewing pandemic drivers in 2024[10]. This assessment of impacts completes the framework's first full review cycle.

The Impact dimension of the GPMB Monitoring Framework evaluates how the immediate and long-term health, economic, social, and political consequences of health emergencies evolve over time. It assesses whether preparedness investments are effectively reducing risk and mitigating harm, using four composite indicators[11]:

GPMB Impact Indicators

1. whether the frequency, magnitude and cost of health emergencies are stable, increasing or decreasing;
2. whether the health, economic, social and political impacts of health emergencies are increasing or decreasing;
3. whether equitable access to vaccines, therapeutics, diagnostics and other countermeasures has improved or declined;
4. whether countries and communities are recovering more quickly from health emergencies and if this recovery is more equitable.

To review progress in mitigating these impacts over time, this report assesses these four areas across the six public health emergencies of international concern (PHEICs) that were declared in the last 10 years[12]: starting with the 2014–2016 West African Ebola epidemic, which led to the creation of GPMB; the 2016 Zika epidemic, largely concentrated in Latin America; to the 2018–2020 Ebola outbreaks in the Democratic Republic of Congo, the COVID-19 pandemic, and the recent multi-country mpox outbreaks and surge (2022-2025). While this analysis is limited by the small number of PHEICs, the different nature of those PHEICs, and the relatively short time since several major PPR reforms were put in place (e.g. Pandemic Fund, WHO Pandemic Agreement, Africa CDC, AVMA, and the 100 Days Mission), it identifies clear trends and areas for improvement.

Each of these events began with only a handful of cases that encountered the right conditions to spread rapidly and, in some instances, explosively. Although caused by four different pathogens, all had the potential to generate high mortality and/or morbidity and to trigger profound health, economic, social, and political disruption. The difference between a localized outbreak, a swiftly contained epidemic, and a global pandemic depends not only on pathogen characteristics but on the resilience of countries, institutions, and communities and on their PPR capacities. In all six cases, the trajectory of the initial outbreaks could potentially have been changed through more timely, coordinated action supported by an ecosystem of strong capacities, effective institutions, and trust.

Understanding the impacts of these crises enables us to assess whether years of commitments and investments in preparedness have delivered genuine protection, or whether substantive vulnerabilities remain.

Six Public Health Emergencies of International Concern (PHEICs) 2014–2025

WEST AFRICA EBOLA EPIDEMIC

8 August 2014 to 29 March 2016

This epidemic began in rural Guinea before spreading rapidly across borders into Liberia and Sierra Leone, ultimately becoming the largest Ebola outbreak ever recorded. **Weak health systems, dense mobility networks, and delayed international support allowed the virus to overwhelm national capacities, resulting in more than 28,000 cases and 11,000 deaths.**[13]

ZIKA VIRUS OUTBREAK

1 February to 18 November 2016

This PHEIC was declared in response to clusters of microcephaly and other neurological disorders in areas with Zika virus transmission. Infection during pregnancy was found to cause Congenital Zika Syndrome, including microcephaly, brain and eye abnormalities, seizures, and profound developmental delays. **Thousands of babies were born with lifelong disabilities, placing sustained medical, financial, and psychosocial burdens on families and health and social-care systems.**[14]

DRC EBOLA OUTBREAK

17 July 2019 to 26 June 2020

These outbreaks occurred primarily in North Kivu and Ituri in the east of the country, unfolding in an active conflict zone where insecurity, mistrust, and attacks on health workers severely hindered the response. Despite the rapid deployment of medical countermeasures that helped contain the outbreak, there were more than 3,400 cases and 2,300 deaths. **The crisis highlighted both the advances in Ebola preparedness since the West African epidemic and the persistent fragility of health systems and response operations in complex humanitarian settings.**[15]

COVID-19 PANDEMIC

30 January 2020 to 5 May 2023

Caused by the SARS-CoV-2 virus, COVID-19 emerged in December 2019 and rapidly spread worldwide, triggering an unprecedented global health, economic, and social crisis. **Despite remarkable advances in diagnostics, vaccines, and therapeutics developed at record speed, over 20 million deaths were estimated to have occurred, with the largest global economic contraction since World War II.**[16]

MPOX MULTI-COUNTRY OUTBREAKS

23 July 2022 to 11 May 2023

The rapid, global spread of clade IIb mpox, beginning in May 2022, affected more than 120 countries, the vast majority of which had no previous history of the disease. **This was the first sustained, multi-continent transmission of mpox, driven largely by close-contact networks and international travel.** The event exposed major gaps in surveillance, risk communication, and equitable access to vaccines, diagnostics, and treatment.[17]

2024 MPOX SURGE

14 August 2024 to 5 September 2025

From 2023, an upsurge of the more severe clade I/Ib mpox emerged, centered in the Democratic Republic of the Congo and extending into several neighbouring countries. This more virulent lineage had a markedly higher case fatality rate and substantial impact on children and underserved populations.[18] **Transmission spread through households, communities, and health-care settings, placing significant strain on already fragile health systems, highlighting persistent gaps in surveillance, cross-border coordination, and access to diagnostics, vaccines, and treatment.**[19]

Key evidence and insights from the GPMB analysis

Assessing the four impact dimensions of the GPMB Monitoring Framework across the six PHEICs reveals clear and concerning trends. The section below highlights the key findings, with the full analysis presented in the *Annex—Monitoring the impacts of PHEICs over the past decade: Evidence, analysis and insights*.

Is the frequency, magnitude and cost of health emergencies increasing or decreasing?

The frequency and magnitude of health emergencies are increasing, and the cost of response vs preparedness remains approximately the same.

Frequency and magnitude

In 2024, WHO detected almost twice as many health emergency events as in 2015. Although faster detection may have reduced the proportion of outbreaks that evolve into large epidemics, those that do break through have become high-impact events, as demonstrated by the scale of recent PHEICs. Overall, global deaths due to infectious diseases had fallen from 25% of all deaths in 2000 to 15% in 2015, but jumped back to 23% in 2021[20], due to the profound effect of COVID-19. Without the pandemic, infectious diseases would have accounted for only 11% of global mortality.[21] At the same time, **new drivers of risk are fueling a marked rise in emerging infectious diseases and zoonoses.**[22] In short, while the routine burden of infectious diseases is declining, **the frequency and severity of large-scale health emergencies are increasing**.

Response cost vs preparedness investments

Excluding COVID-19, **the cost of responding to health emergencies has remained stable** in the last decade. COVID-19 triggered the most expensive health emergency response on record but also catalyzed a step-up in preparedness funding that is still visible today. However, these gains are at risk due to shifting geopolitics, economic realities and fiscal priorities pushing spending downward. At the same time, WHO's financial and political footing has weakened, alongside a broader decline in international cooperation. As countries invest less in global health and systemic resilience, the potential impact of future outbreaks becomes significantly greater.

Are the health, economic, social and political impacts of health emergencies increasing or decreasing?

The health, social, and political impacts of health emergencies have remained largely unchanged, while the economic impacts are increasing.

Health

Health systems have accumulated response experience and internalized some lessons but **the systemic toll of pandemics and epidemics on health has seen limited improvement**. Across the PHEICs, an estimated one-third to one-half of survivors experienced mental health impacts. During both the West African Ebola epidemic and COVID-19 pandemic, the ratio of direct to excess mortality reached more than 30%[23], and access to antenatal care dropped by close to 40%[24]. Even low-fatality outbreaks such as Zika caused significant harm, with Congenital Zika Syndrome contributing to a measurable rise in infant mortality. These patterns reflect deep, persistent structural weaknesses in health systems that remain unaddressed, leaving them vulnerable to severe disruption—and, in some contexts, collapse—when crises occur.

Economic

As outbreaks expand and responses rely more heavily on public health and social measures (PHSM), economic impacts tend to rise in parallel. Responses that relied more on PHSM, such as the West African Ebola epidemic and the COVID-19 pandemic, saw worse economic outcomes. **Across both events, these effects followed a similar pattern, though they were far more pronounced during COVID-19 due to its global reach and prolonged disruptions.** During the West African Ebola epidemic and the COVID-19 pandemic, GDP declined by 5.1% and 2.9%,[25,26] public debt burdens rose by 13.7pp and 16pp,[27,28] and inflation increased by 5.1%,[29] respectively. In the first year of the COVID-19 pandemic, foreign direct investment fell dramatically (by 51% [30]), marking the steepest decline ever recorded. **Encouragingly, most economies have shown notable resilience, often rebounding faster than expected. However, these shocks came with longer-term structural shifts, including changes in trade patterns, fiscal deficits and widening inequalities. These effects were considerably more profound during the COVID-19 pandemic.**

Calibrating public health and social measures appropriately remains a persistent challenge. During both the West African Ebola epidemic and the COVID-19 pandemic, limited surveillance capacity, delayed case detection, and insufficient contact tracing led to the widespread use of highly disruptive, population-wide measures such as lockdowns and movement restrictions. These measures, while often necessary in the absence of timely and targeted interventions, carried high economic costs (as well as social and political consequences), and disproportionately affected vulnerable populations. They also exposed weaknesses in governance, including challenges in transparent decision-making, risk communication, and the provision of adequate social protection, factors which, in some contexts, contributed to declining public trust in the public health responses.

Social

Regardless of scale, **the social impacts of Ebola, Zika and COVID-19 have been remarkably similar**. In all three crises, the most vulnerable populations (women, children, informal workers, and marginalized groups) bore the greatest burdens. Where social protection systems were weak and trust in institutions was low, the consequences were far more severe: millions were pushed into poverty, educational progress was reversed (with ~50% of children out of school during Ebola in West Africa,[31] 20% in affected areas during Ebola in the DRC[32], and 80% globally during COVID-19[33]), millions of jobs were lost (83% of mothers with children affected by Zika left the labour market)[34], and child marriage increased (~ 2–3 million additional marriages during the COVID-19 pandemic).[35] Across contexts, weak information ecosystems and rising misinformation further magnified these harms by undermining trust and fragmenting social cohesion.

Political

From Ebola to COVID-19, the impact on governance and politics has grown significantly, with expanded state authority, rising polarization, and populist narratives increasingly eroding trust in institutions and weakening multilateral cooperation. During the West African Ebola epidemic, the Ebola outbreak in the DRC, and the COVID-19 pandemic, elections were postponed and governments relied heavily on border closures, movement restrictions, and emergency powers. The COVID-19 pandemic also brought a global reduction in media freedoms. These dynamics deepened societal divisions and undermined the consensus needed for effective crisis response.

Has equitable access to vaccines, therapeutics, diagnostics and other countermeasures improved or declined?

Equitable access to vaccines, therapeutics, diagnostics and other countermeasures has declined.

Despite the stark inequities in access to medical countermeasures during the COVID-19 pandemic, and subsequent efforts to address this problem, **momentum towards achieving equitable access may have begun to reverse**. During the recent mpox outbreaks, access was even slower: vaccines took 24–27 months to reach affected low-income countries, compared with 17 months for low-income countries during the COVID-19 pandemic.[36]

These setbacks reflect persistent structural failures: vaccines and treatments for priority pathogens do not yet exist or remain in early clinical development; global manufacturing is limited and concentrated; and early supplies are locked up through advance purchase agreements, stockpiling and export restrictions by high-income countries. LMICs also face delayed and unpredictable financing, regulatory and logistical hurdles, and weak delivery systems, all of which slow rollout even when tools finally become available.

There are increasing signs of a waning willingness to prioritize and finance equitable access ("equity fatigue"). This shift reflects a convergence of political fatigue, rising domestic pressures, and the perception that delivering equity is too complex, resource-intensive, or politically costly. As governments turn inward and the brief surge of solidarity seen during the COVID-19 pandemic recedes, momentum behind equity-focused reforms is weakening. This retreat risks cementing inequities as an accepted norm in global health, eroding hard-won progress, further marginalizing vulnerable populations, and undermining the foundations of future PPR.

Are countries and communities recovering more quickly from health emergencies and is this recovery more equitable?

Recovery is not faster or more equitable; the rate of health and social recovery is unchanged, and economic and political recovery has declined.

Health

Ebola, Zika, COVID-19, and mpox have all left lasting health impacts—many of which are still only partially understood, including long-term complications among survivors and a significant, enduring mental health burden. Although health systems have demonstrated resilience across these events, the long-term consequences of service disruptions, particularly during Ebola in West Africa and the COVID-19 pandemic, have persisted well beyond the acute phases. Interruptions to immunization, elective surgeries, and preventive care have increased disease burdens and widened existing health gaps, with recovery often taking years. The West African Ebola epidemic resulted in up to 16,000 additional measles deaths in the 18 months following the end of the PHEIC,[37] and COVID-19 is projected to cause 49,000 additional deaths due to missed immunizations between 2020 and 2030.[38] Health systems worldwide remain vulnerable, and their ability to recover from these broader health impacts does not appear to have fundamentally improved since 2016.

Economic

While economies recovered after recent PHEICs, the most fragile countries struggled to regain lost ground, falling further behind their pre-crisis trajectories and contributing to widening global inequalities. In West Africa, Ebola led to prolonged setbacks in growth, poverty reduction, and fiscal stability, whereas the DRC's outbreaks had more localized and shorter-lived economic impacts. The COVID-19 pandemic, far more than Ebola, reshaped the global economy in ways that will influence development for decades. Its effects on debt, labour markets, trade patterns, and supply chains are likely to redefine economic interdependence and resilience for a generation. Post-COVID, inflation remains half a percentage point higher (2025),[39] the world is projected to experience more than US$ 50 trillion in lost output between 2020 and 2030, and surveys show a 20% increase in companies regionalizing their supply chains.[40,41] The pandemic also weakened public finances over the long term (with a 12% increase in general gross government debt from 2019 to 2025), constraining governments' ability to invest in health and social systems and potentially reshaping the role of the state in economic and social policy.

Social

Ebola and COVID-19 both left deep and enduring social scars, from widespread orphanhood and mental-health challenges to widened educational and income disparities. More than 22,000 children were orphaned in West Africa during the Ebola epidemic,[42] and over 10.5 million children lost a caregiver during the COVID-19 pandemic,[43] leading to long-term trauma and vulnerabilities. The Zika outbreaks caused lasting educational exclusion for children with Congenital Zika Syndrome, limiting their long-term developmental and socioeconomic potential. Informal employment has continued to rise in the wake of both crises, growing by 3% in Liberia between 2010 and 2017 following the Ebola epidemic[44] and increasing globally after the COVID-19 pandemic by about 1% compared with 2019 levels.[45] Recovery has been uneven and inequitable, shaped by countries' differing capacities to close these gaps and stabilize social systems. These impacts have further entrenched long-standing structural inequalities.

Political

Health emergencies can erode democratic norms and strain governance for years, with prolonged states of emergency, restrictions on civil liberties, and heightened polarization often outlasting the crises themselves. In West Africa, many indicators of political recovery (such as those measured by V-Dem[46] and the Economist Democracy Index[47]) showed only partial improvement even five years after the Ebola epidemic. The COVID-19 pandemic has had an even more severe and enduring impact. By 2024, key indicators of democracy, civil liberties, polarization, and trust had still not returned to pre-pandemic levels. Trust in government, in particular, has been slow to rebound, undermined by sustained polarization, politicized public health responses and attacks on scientific institutions.

This democratic erosion has direct consequences for preparedness: weakened institutional trust, politicized governance, and diminished civil society space make it harder to sustain the cross-sectoral planning, public investment, and community engagement that effective preparedness requires. Countries entering the next health emergency with these pre-existing democratic deficits are less likely to have preparedness strategies that are politically sustained, subject to adequate oversight, or trusted by the populations they are meant to protect.

Looking ahead: PPR priorities for the next decade

More than 10 years after the Ebola epidemic in West Africa, the world is increasingly shaped by volatility, uncertainty, complexity and ambiguity.[48] Rapidly shifting risks, competing crises, fragmented geopolitics, and unpredictable global dynamics are making threats harder to anticipate, responses more difficult to coordinate, and vulnerabilities quicker to escalate. At the same time, resilience has been weakened by the cumulative effects of recent PHEICs: health systems have been severely strained; education losses persist; long-term health consequences continue to undermine population well-being; public debt has risen sharply; and mistrust and polarization remain deeply entrenched.

The greatest and most consequential casualty of these trends has been the profound erosion of trust and equity — the absolute bedrock of effective PPR.

Trust has been deeply compromised across all levels, between governments and citizens, among countries, and across multilateral institutions and industry, while profound inequities persist in access to information, knowledge, financing, health services and medical countermeasures. These dynamics are deeply intertwined: where equity is absent, trust cannot endure and where trust breaks down, the cooperation needed to correct inequities becomes much harder to sustain. The root causes lie within both the larger geopolitical and societal context where trust is increasingly compromised and localized[49], and within the health system itself, in part due to the residual effects of the COVID-19 response, including inequities in access to medical countermeasures, information, essential health services and social protection measures.

Together, these pressures make the world not only more likely to face epidemics and pandemics going forward, but also more vulnerable to their cascading impacts.

At the same time, scientific, technological, and operational capabilities have advanced dramatically, from rapid vaccine development and real-time genomic surveillance to AI-driven analytics and agile global communication systems. These advances, however, coexist with rising inequalities, geopolitical fragmentation, public distrust and security concerns, and mounting systemic strain, leaving the world paradoxically better equipped technologically while increasingly exposed socially, economically and politically.

This VUCA world is making PPR harder, but more important than ever.

Significant investments over the past decade have strengthened preparedness systems and capacities, yet GPMB's analysis shows that gains remain uneven and inadequate to reliably reduce the impacts of health emergencies or close persistent gaps. And because the world has shifted so dramatically, today's risk landscape requires new preparedness strategies capable of operating amid low trust, tight fiscal space, and growing unpredictability.

In this context, building broad-based, enduring trust and advancing sustainable equity are now the urgent priorities for multi-hazard PPR. This is possible, even in this increasingly VUCA world and in an environment that is increasingly shaped by misinformation. But it will require sustained political leadership and a commitment to evidence-based decision-making, directing resources to where they are most needed, and safeguarding accountability as political and fiscal pressures intensify.

To rebuild the trust needed to advance equity, this report points to four critical areas for action at the national and international levels.

RECOMMENDATION

1 ESTABLISH AN INDEPENDENT, COMPREHENSIVE AND MULTISECTORAL PANDEMIC RISK MONITORING MECHANISM REPORTING TO THE WORLD HEALTH ASSEMBLY

Current pandemic monitoring is fragmented, under-resourced, and structurally vulnerable to political and institutional interference. Closing this gap requires an independent monitoring mechanism that is empowered and directly accountable to the World Health Assembly and that can provide a trusted basis for action and help rebuild confidence in health systems and public institutions.

The World Health Assembly should establish an **independent, credible, transparent and comprehensive risk monitoring mechanism, powered** by cutting-edge, reliable AI and digital tools, and formally linked to the UN General Assembly and all relevant international policy fora for trade, finance, security, agriculture and animal health.

Monitoring architecture

- The pandemic risk monitoring mechanism should be established through a **WHA resolution with a defined mandate**, governance structure, and a sustainable funding stream that is not subject to annual political negotiation and ensures its independence.
- The scope of monitoring should be **multisectoral** (including **One Health**, R&D, finance, trade, tourism and travel, transportation, security, education, agriculture and food systems) **and comprehensive** (from assessing pandemic threats to vulnerability, risk and advancing action). It should **support implementation of the amended IHR and the WHO Pandemic Agreement**.
- The mechanism should operate through a **federated model**, accessing, coordinating and synthesizing information from all relevant existing national, regional, and international efforts, rather than duplicating existing infrastructure. These inputs should be integrated to provide a holistic analysis of pandemic risk, linking threat, vulnerability, preparedness, and response, and generating independent global insights and clearer signals for action.
- The mechanism should **formally report to the WHA, and through the WHA to the UN General Assembly** and governing bodies of agencies that are central to a multisectoral response, especially FAO, IMF, UNEP, UNICEF, WIPO, WOAH, the World Bank and WTO.

AI and digital tools

- The pandemic risk monitoring mechanism should be **powered by advanced and ethical AI** to enable risk modelling and early warning.
- Appropriate and ethical **AI governance must be embedded** in the mechanism from the outset, to ensure transparency, equity, and accountability in how data are used, algorithms are applied, and risk signals are translated into policy action. AI-supported analyses must be clearly evidenced and documented, auditable, and with human-in-the-loop oversight and a transparent methodology.
- All countries must have meaningful access to the mechanism's analytical outputs, not just its warnings.

RECOMMENDATION

2 ENSURE EQUITABLE ACCESS TO MEDICAL COUNTERMEASURES IN THE WHO PANDEMIC AGREEMENT WITH REGIONALLY DISTRIBUTED MANUFACTURING

Vaccine inequity during the COVID-19 pandemic was not a market failure: it was a governance failure, enabled by the absence of binding obligations on both states and the private sector. The WHO Pandemic Agreement offers a structural opportunity to correct this, but that opportunity will be lost if governments ratify the Agreement without meaningfully implementing its equity provisions.

To withstand supply chain disruptions, export restrictions, and geopolitical fragmentation, equitable access also requires building more resilient access to countermeasures globally, through distributed manufacturing and regional production capacities, with pre-agreed technology and knowledge transfer and licensing mechanisms to enable it.

Governments must establish binding obligations, predictable financing, and globally distributed capacities to enable timely access to countermeasures by all countries, particularly low- and middle-income countries, rather than relying on voluntary arrangements or market mechanisms alone.

WHO Pandemic Agreement and Benefit-Sharing

- WHO Member States should **finalize, ratify and fully implement the WHO Pandemic Agreement, including the Pathogen Access and Benefit-Sharing system,** as a vital element of the global strategy to ensure equity in access to countermeasures and effective pandemic containment.
- Global mechanisms should be established to implement the WHO Pandemic Agreement and ensure equitable allocation, reliable supply chains, and coordinated procurement.

Regionalized manufacturing capacity, technology transfer & the private sector

- Countries and international partners should strengthen **sustainable regional and distributed manufacturing capacities for personal protective equipment, diagnostics, vaccines and therapeutics, supported by technology transfer,** workforce development, regulatory harmonization, and digital and AI-enabled forecasting and production optimization tools.
- **Pharmaceutical companies** receiving public R&D funding, regulatory fast-tracking, or liability protections **should be required** — as a condition of those benefits — **to participate in equitable allocation mechanisms**. Governments should require that **publicly funded R&D agreements include provisions for technology transfer** to regional manufacturing hubs, ensuring that public investment results in more equitably distributed global manufacturing capacity.
- Access to medical countermeasures should not depend on ad hoc voluntary licensing negotiations during crises. **Pre-agreed mechanisms for licensing, technology transfer, and the use of TRIPS flexibilities** should be established through the WTO, WIPO, and WHO.
- Equitable access to countermeasures should be included as a core metric of preparedness performance in the future pandemic risk monitoring mechanism to assess whether availability, affordability, and timely delivery are achieved during crises.

RECOMMENDATION

3 ESTABLISH FINANCING FOR PPR THAT IS SUSTAINED BETWEEN CRISES AND CAN ENABLE IMMEDIATE 'DAY 0' ACTION

Preparedness financing that depends on sustained political attention is inherently fragile: it is prioritized immediately after crises and neglected between them. With political attention shifting and fiscal pressures increasing, preparedness financing is declining, and recent gains are at risk of being reversed. Predictable financing for core PPR and essential health measures is fundamental to rebuilding trust and equity, both of which require a sustained approach over the long term. Financing mechanisms must be designed so that preparedness is sustained, even when political attention declines. As importantly, immediate financing must be available for early action and emergency response, with mechanisms that reduce the economic and political costs for countries that report outbreaks early or implement rapid containment measures.

Governments, donors, and international and regional financial institutions should **establish sustainable financing for PPR, with a coordinated financing architecture** that can mobilize rapid response resources while sustaining long-term preparedness investments.

Day 0 financing

- Countries and regional and international partners should **establish reliable "Day 0" surge financing mechanisms** with pre-authorized disbursement procedures and triggers, enabling the immediate deployment of resources upon detecting a pandemic-prone pathogen. These mechanisms should finance vital early action, including crucial public health measures (i.e. case finding and isolation, contact tracing and quarantine) and deployment of medical countermeasures. They should not depend on political approval during crises.
- **The WHO Contingency Fund for Emergencies should be maintained at a minimum capitalization level of US$100 million** through predictable and secured financing commitments. Emergency response financing should not depend on voluntary fundraising during crises.

Domestic financing

- National governments must **ensure predictable domestic investment in PPR that strengthens the broader health system, integrates One Health and multisectoral risk management, and maximizes the efficiency and impact of existing resources.** They should establish dedicated, ring-fenced domestic financing streams, protected from budget reallocation during non-emergency periods.
- The future pandemic risk monitoring mechanism should track domestic PPR investment as a standard preparedness metric, with public disclosure of allocation and expenditure.

International financing

- Donors, including governments, philanthropies and the private sector, should **make standing financial commitments to the Pandemic Fund,** not pledges renewed on a discretionary cycle.
- Regional institutions should establish financing mechanisms for cross-border preparedness functions, including surveillance, laboratory networks, and distributed manufacturing, as these are regional public goods that cannot be sustainably financed through national budgets.
- The G20 should **prioritize reforms to the global financial architecture** that enable low-income countries to invest in preparedness without sacrificing debt sustainability. This requires addressing structural barriers that limit fiscal space for preparedness and resilience by increasing access to concessional financing, reforming lending conditionalities, and expanding the use of international financial instruments to support sustained investment in PPR.

CROSS-CUTTING RECOMMENDATION

SUSTAIN POLITICAL ATTENTION ON PANDEMIC PREPAREDNESS AND RESPONSE

The main barriers to PPR are no longer only capacity gaps — they are also the barriers to collective action and political economy challenges that only political leaders can resolve. The recommendations above require difficult, binding decisions that have been repeatedly deferred. Rebuilding trust between countries and advancing equity in PPR requires resolving these issues.

The GPMB calls on heads of government to **use the 2026 UN High-Level Meeting on PPPR and the finalization of the WHO Pandemic Agreement to resolve these outstanding political issues and deliver the commitments required to strengthen global preparedness** through independent pandemic risk monitoring, equitable access to all vital countermeasures, and sustainable financing for both preparedness and 'Day 0' response. Political forums such as the G20 and coalitions of committed countries and partners should maintain momentum and support implementation.

Finally, at a time when pandemic risks are increasing, the GPMB is alarmed that geopolitical developments are fragmenting global health cooperation and stresses that effective pandemic PPR depends on the continued participation and commitment of all countries. The GPMB urges all countries to maintain, strengthen, and, where necessary, renew their commitment to multilateral health cooperation, recognizing that global health security ultimately depends on collective action and shared responsibility.

CONCLUSION

Many important reforms have been introduced since the COVID-19 pandemic[50], and their full impact will only become evident in the coming years. For example, finalization and implementation of the WHO Pandemic Agreement, including its pathogen access and benefit-sharing (PABS) annex, will help to address some of the issues identified in this report. However, as investments in PPR slow and important reforms stall, this report's findings offer a clear warning that sustained momentum is essential to prevent preparedness from slipping backward.

This year, 2026, offers a pivotal moment for the multilateral system, UN and WHO Member States to confront the systemic weaknesses highlighted in this report with ambition and unity. If successful, the 2nd UN HLM on PPPR, the PABS negotiations, and wider discussions on the global health architecture can lay the foundations for a more resilient, equitable, and coordinated global approach to PPR.

The decade ahead is likely to see the emergence and amplification of infectious hazards intensify; the world is not going back to the pre-pandemic era. Climate change, demographic shifts, geopolitical volatility, and other converging pressures will continue to drive the challenges facing global health security. At the same time, rapid technological advances offer powerful tools to help, but only if they are harnessed effectively and equitably. To navigate this new era, countries will need to enhance their multilateral collaboration as they invest more strategically and efficiently, directing their resources—both nationally and internationally—towards the capacities and systems that genuinely strengthen global security and reduce the escalating human, economic, and political toll of future health emergencies.

The GPMB's expectation is that the years ahead will be defined by renewed trust and meaningful progress towards equity, as the foundations of a more resilient and effective global system.

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GPMB purpose and membership

The GPMB is an independent monitoring and accountability body to ensure preparedness for global health crises, co-convened by the World Health Organization and the World Bank Group. The Board provides an independent and comprehensive appraisal for leaders, key policy-makers and the world on system-wide progress towards increased preparedness and response capacity for disease outbreaks and other emergencies with health consequences. The Board monitors and reports on the state of global preparedness across all sectors and stakeholders, including the UN system, government, non-governmental organizations, and the private sector.

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