

Report of the Review Committee regarding standing recommendations for COVID-19

4 August 2023

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PREFACE

The COVID-19 pandemic has caused tens of millions of cases of severe disease, sequelae and long-lasting disease, and deaths, as well as disrupted health care delivery. The COVID-19 pandemic and the measures to control it have hurt economies and the health and well-being of populations. Inequitable access to vaccines and treatment worsened the outcomes particularly in the less well-resourced parts of the world.

As almost everyone on earth now has some immunity against SARS-CoV-2 from vaccination, natural infection, or both, the virus is a much less threat to individuals, health care services and societies. The virus, however, will not disappear. In the years to come, many people will suffer from severe COVID-19. Others will experience long-lasting symptoms after infection. The evolution of the virus, waning of immunity, or both, may lead to waves of infection.

Although it may no longer be feasible, nor desirable, to suppress the spread of the virus, much can still be done to reduce disease burden from COVID-19. Many COVID-19 hospitalizations and deaths may be preventable. The main approach is to immunize those at highest risk of severe outcomes, and to treat people once infected. In the coming years, repeated infections among those who are at very low risk of severe outcomes will also contribute to maintained immunity in the population.

Countries around the world will now have to navigate the transition from the emergency response to the pandemic emergency, to the management of an epidemic-prone disease. Countries need to normalise the health care services and society while remaining vigilant for changes in the risk from COVID-19, as well as preparing for and responding to outbreaks caused by SARS-CoV-2 or other infectious agents with epidemic and pandemic potential.

Reviews of the response during the emergency phase and research into the virus and its interactions with the human body and the human society will inform this transition.

During the public health emergency of international concern associated with the COVID-19 pandemic, from January 2020 to May 2023, countries' response efforts were guided by temporary recommendations issued under the International Health Regulations (2005) (IHR). In the current transitional phase, countries' preparedness and response actions can be guided by standing recommendations, issued under the IHR.

In this report, the Review Committee advises the Director-General on the contents of such recommendations.

Members of this Review Committee came from all regions of the world, and were appointed to the Committee for their expertise, their independence, and their commitment to global health. I thank them for their work on this report, which will form a basis for the Director-General of the World Health Organization (WHO) to issue standing recommendations for COVID-19 to all States Parties to the IHR.

Preben Aavitsland

Chair, Review Committee regarding standing
recommendations for COVID-19

4 August 2023

Kristiansand, Norway

ACRONYMS AND ABBREVIATIONS

COVID-19	Coronavirus disease 2019
GISRS	Global Influenza Surveillance and Response System
HICs	High-income countries
ICU	Intensive Care Unit
IHR	International Health Regulations (2005)
LICs	Low-income countries
LMICs	Low- and middle-income countries
PCC	Post COVID-19 conditions
PHEIC	Public health emergency of international concern
RT-PCR	Reverse transcription polymerase chain reaction
SAGE	WHO Strategic Advisory Group of Experts on Immunization
TAG-CO-VAC	Technical Advisory Group on COVID-19 Vaccine Composition
TAG-VE	Technical Advisory Group on SARS-CoV-2 Virus Evolution
VOC	Variants of Concern
WHO	World Health Organization

All hyperlinks embedded in the text were accessed on 4 August 2023

1. INTRODUCTION AND BACKGROUND

1.1 SHORT HISTORY OF THE EVENT

COVID-19 or Coronavirus disease 2019 is a new disease caused by a novel coronavirus, the severe acute respiratory syndrome coronavirus 2 or SARS-CoV-2, which was first reported as a cluster of pneumonia of unknown aetiology in Wuhan, People's Republic of China on 31 December 2019. Since then, an estimated 768 million cases and 6.95 million deaths of Coronavirus disease 2019 (COVID-19) have been reported to the World Health Organization (WHO), numbers that are understood to be underestimates of the true infections and deaths that have occurred globally to date^{1, 2}.

The outbreak of pneumonia due to the novel coronavirus was determined by the Director-General of WHO as a public health emergency of international concern (PHEIC) under the [International Health Regulations \(2005\)](#) (IHR) on [30 January 2020](#), and the subsequent worldwide spread of SARS-CoV-2 was characterised by the WHO Director-General as a pandemic on [11 March 2020](#). Since then, the Emergency Committee, initially convened by the Director-General under the IHR to advise on whether the event constituted a PHEIC, and which became known as [the Emergency Committee regarding the COVID-19 pandemic](#), continued to advise the Director-General on whether the COVID-19 pandemic continued to constitute a PHEIC, as well as on temporary recommendations to guide States Parties in responding to the event.

On 5 May 2023, the Director-General [stated](#) *“with great hope that I declare COVID-19 over as a global health emergency. However, that does not mean COVID-19 is over as a global health threat.”*

The SARS-CoV-2 virus continues to evolve and circulate in every country and while there has been a significant decline in the impact of COVID-19 due to increasing population level immunity, access to diagnostics and therapeutics, thousands of people die from COVID-19 each week and there are a significant number of people globally currently suffering from acute and post COVID-19 conditions (PCC).

WHO regularly assess the risk of COVID-19 at global and regional levels. A summary provided by the WHO Secretariat of the current COVID-19 global situation and long-term risk assessment is presented in section 2.1.

1.2 MANDATE OF THIS REVIEW COMMITTEE

The [Review Committee regarding standing recommendations for COVID-19](#) was convened by the Director-General of WHO pursuant to Part IX – Chapter III – The Review Committee of the IHR (Articles 50-53) of the IHR. The IHR are a binding instrument of international law that entered into force in 2007. Their 196 States Parties include all 194 Member States of WHO, plus Liechtenstein and the Holy See.

Pursuant to Articles 50.1(b) and 53 of the IHR, this Review Committee is providing its views and technical advice to the Director-General with respect to standing recommendations for COVID-19, as

¹ <https://covid19.who.int/> [accessed on 4 August 2023]

² <https://www.who.int/data/sets/global-excess-deaths-associated-with-covid-19-modelled-estimates> [accessed on 4 August 2023]

proposed by the Director-General. The Review Committee functions in accordance with the [WHO Regulations for Expert Advisory Panels and Committees](#).

This is the first time that these specific provisions of the IHR are being applied; as such, it is understood that further details in support of the [Terms of Reference](#) of the Committee may be provided as experience is gained.

1.3 METHODS OF WORK

The Review Committee was convened by the Director-General of WHO on 27 July 2023. It was expected to meet virtually and to deliver their final report to the Director-General before 4 August 2023, when the current temporary recommendations, issued by the Director-General after the termination of the PHEIC related to the COVID-19 pandemic, will have come to an end.

The Review Committee includes 20 Members, selected from the IHR Roster of Experts or other WHO Expert Advisory Panels and Committees, representing a wide range of expertise, from all six WHO regions, in accordance with Articles 47 and 50 of the IHR. Ahead of their convening, the Committee was provided with a draft agenda, its Terms of Reference and mandate under the IHR, as well as with the draft standing recommendations and global long-term risk assessment for COVID-19, prepared by the WHO Secretariat.

The Review Committees met virtually in both, open and closed sessions as follows:

- 27 July 2023 – First closed session, opened by the Director-General via a pre-recorded video. The opening remarks are available [here](#). The Review Committee were reminded of their obligations under the WHO Rules of Procedures for Advisory Panels and Committees, and no conflict of interests were reported. In accordance with the Rules of Procedures, the Committee selected its officers: as Chair Professor Preben Aavitsland, from Norway; as Vice-Chair Mister Andrew Forsyth, from New Zealand; and as Rapporteur, Dr Carmen Aramburu, from Spain.

The Review Committee proceeded then to consider the proposed standing recommendations for COVID-19, presented by the WHO Secretariat, who also provided an update of the epidemiological situation, and the long-term risk assessment.

- 27 July 2023 – Open joint session of the Review Committees regarding standing recommendations for COVID-19 and Review Committees regarding standing recommendations for mpox. In accordance with Article 51.2 of the IHR, the two Review Committees met with States Parties, the United Nations, other UN specialized agencies, relevant intergovernmental organizations and non-State actors in official relations with WHO.
- 2 August 2023 – Second closed session. After electronic communications to elaborate their report, the Review Committee reconvened virtually to finalize and adopt it.

This report of the Review Committee contains its views and technical advice to the Director-General regarding the the proposed standing recommendations, and was transmitted on 4 August 2023 to the Director-General for consideration and decision. Any standing recommendation that the Director-General may be issuing, would enter into effect upon issuance. To that effect, pursuant to Article 53 (f) of the IHR, the Director-General shall communicate to States Parties any standing recommendation, together with the views and technical advice of the Review Committee.

Furthermore, in accordance with Article 53 (e) and Article 53 (g), the Director-General shall communicate the Review Committee's views and technical advice, as well as standing recommendations, to the Seventy-seventh World Health Assembly (2024) for its consideration.

1.4 EMERGENCY COMMITTEE, PUBLIC HEALTH EMERGENCY OF INTERNATIONAL CONCERN, AND TEMPORARY RECOMMENDATIONS

The Director-General of WHO first convened an Emergency Committee under the IHR on [22 January 2020](#), to advise him on whether the outbreak of pneumonia of unknown aetiology, reported by the People's Republic of China, constituted or not a PHEIC. At that time, the Emergency Committee could not reach consensus and requested further information. The Director-General reconvened the Committee on 30 January 2020, when their advice was unanimous. Taking their advice into account, as well as other elements as per Article 12.4 of the IHR, the Director-General then determined that the event [constituted a PHEIC](#) and issued temporary recommendations, in accordance with Articles 1, 15, 17 and 18 of the IHR. The temporary recommendations were reviewed every three months.

At their [15th meeting](#), held on 4 May 2023, the Emergency Committee advised the Director-General that in their views the event no longer constituted a PHEIC and suggested that standing recommendations under the IHR may provide a better tool to manage the long-term public health risks posed by SARS-CoV-2.

On 5 May 2023, on the advice of the Emergency Committee, the Director-General determined that *"COVID-19 is now an established and ongoing health issue which no longer constitutes a public health emergency of international concern"* and stated that he would *"convene an IHR Review Committee to advise on Standing Recommendations for the long-term management of the SARS-CoV-2 pandemic, taking into account the 2023-2025 COVID-19 Strategic Preparedness and Response Plan."* In accordance with Article 15 of the IHR, the Director-General continued to issue temporary recommendations after the termination of the PHEIC, at the advice of the Emergency Committee, and these recommendations expire on 4 August 2023.

1.5 LEGAL BASIS IN THE INTERNATIONAL HEALTH REGULATIONS (2005)

The IHR include the following specific provisions related to standing recommendations:

The standing recommendations are defined in **Article 1 - Definitions** as *"non-binding advice issued by WHO for specific ongoing public health risks pursuant to Article 16 regarding appropriate health measures for routine or periodic application needed to prevent or reduce the international spread of disease and minimize interference with international traffic."*

Article 16 authorises the Director-General with the discretion to issue standing recommendations.

Article 16 - Standing recommendations

WHO may make standing recommendations of appropriate health measures in accordance with Article 53 for routine or periodic application. Such measures may be applied by States Parties regarding persons, baggage, cargo, containers, conveyances, goods and/or postal parcels for specific, ongoing public health risks in order to prevent or reduce the international

spread of disease and avoid unnecessary interference with international traffic. WHO may, in accordance with Article 53, modify or terminate such recommendations, as appropriate.

Article 17 includes the criteria that Director-General shall consider when issuing, modifying or terminating any standing recommendations

Article 17 - Criteria for recommendations

When issuing, modifying or terminating temporary or standing recommendations, the Director-General shall consider:

(a) the views of the States Parties directly concerned;

(b) the advice of the Emergency Committee or the Review Committee, as the case may be;

(c) scientific principles as well as available scientific evidence and information;

(d) health measures that, on the basis of a risk assessment appropriate to the circumstances, are not more restrictive of international traffic and trade and are not more intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection;

(e) relevant international standards and instruments;

(f) activities undertaken by other relevant intergovernmental organizations and international bodies; and

(g) other appropriate and specific information relevant to the event. [...].

Article 18 provides a list of public health measures that may be included in standing recommendations.

Article 18 - Recommendations with respect to persons, baggage, cargo, containers, conveyances, goods and postal parcels

1. Recommendations issued by WHO to States Parties with respect to persons may include the following advice:

– no specific health measures are advised; – review travel history in affected areas; – review proof of medical examination and any laboratory analysis; – require medical examinations; – review proof of vaccination or other prophylaxis; – require vaccination or other prophylaxis; – place suspect persons under public health observation; – implement quarantine or other health measures for suspect persons; – implement isolation and treatment where necessary of affected persons; – implement tracing of contacts of suspect or affected persons; – refuse entry of suspect and affected persons; – refuse entry of unaffected persons to affected areas; and – implement exit screening and/or restrictions on persons from affected areas.

2. Recommendations issued by WHO to States Parties with respect to baggage, cargo, containers, conveyances, goods and postal parcels may include the following advice: [...]

Article 53 includes provisions related to the procedure for issuing standing recommendations. These are issued by the Director-General, taking into account the advice of a Review Committee convened with this sole purpose.

Article 53 - Procedures for standing recommendations

When the Director-General considers that a standing recommendation is necessary and appropriate for a specific public health risk, the Director-General shall seek the views of the Review Committee. In addition to the relevant paragraphs of Articles 50 to 52, the following provisions shall apply:

- (a) proposals for standing recommendations, their modification or termination may be submitted to the Review Committee by the Director-General or by States Parties through the Director-General;*
- (b) any State Party may submit relevant information for consideration by the Review Committee;*
- (c) the Director-General may request any State Party, intergovernmental organization or nongovernmental organization in official relations with WHO to place at the disposal of the Review Committee information in its possession concerning the subject of the proposed standing recommendation as specified by the Review Committee;*
- (d) the Director-General may, at the request of the Review Committee or on the Director-General's own initiative, appoint one or more technical experts to advise the Review Committee. They shall not have the right to vote;*
- (e) any report containing the views and advice of the Review Committee regarding standing recommendations shall be forwarded to the Director-General for consideration and decision. The Director-General shall communicate the Review Committee's views and advice to the Health Assembly;*
- (f) the Director-General shall communicate to States Parties any standing recommendation, as well as the modifications or termination of such recommendations, together with the views of the Review Committee;*
- (g) standing recommendations shall be submitted by the Director-General to the subsequent Health Assembly for its consideration.*

Articles 50 to 52 include provisions related to the mandate and conduct of business of a Review Committee, which is meant to advise the Director-General on the issuance, modification or termination of standing recommendations. The conduct of business of the Review Committee is subject to the WHO Advisory Panel Regulations.

2. THE COVID-19 PANDEMIC

2.1 CURRENT WHO RISK ASSESSMENT OF THE COVID-19 SITUATION

This section is based on the Long-Term Risk Assessment for COVID-19 provided by the WHO Secretariat to the Review Committee in advance of the first session of its meeting.

According to the assessment by the WHO Secretariat, the global public health risk associated with COVID-19 remains high.

The WHO Secretariat indicated that, while the risk of disease transmission is regarded as high, there is evidence that the impact to the health and well-being of the aggregate human population is no longer considered to be as dire. The latter is driven by multiple factors, including: high population-level immunity from infection, vaccination, or both; lower virulence of the currently circulating Omicron sublineages, compared to previous variants of concern (VOCs), and which has remained unchanged since the emergence of SARS-CoV-2 Omicron sublineages; implementation of public health and social measures; improvement in early diagnosis; and, in some regions, improved clinical case management. According to WHO, these factors have contributed to a progressive global decline in the weekly number of COVID-19-related deaths, hospitalizations, and admissions to intensive care units (ICU), although the available information is provided from a limited number of countries, most of which are high-income countries (HICs). The decline in COVID-19-related hospitalizations and ICU admissions are expected to increase the capacity of health systems to cope with potential COVID-19 resurgences and the burden of cases of PCC. With the persistent risk of emergence of new SARS-CoV-2 variants, the risk of more virulent variants emerging continues to exist.

According to the risk assessment provided by the WHO Secretariat, the number of reported cases has consistently declined, reaching levels comparable to those seen in March 2020. Contrary to the nearly 16 million cases per week recorded from 3 January to 27 March 2022, three million cases per week were reported between 26 September 2022 and 22 January 2023. Subsequently, from 23 January to 2 April 2023, the average number of weekly cases decreased to approximately one million. A further decline has been observed in recent months, with about 463 000 cases per week reported between 3 April and 2 July 2023. Crucially, however, it is important to state that the observed decreasing trend coincided with a decline in global testing rates, meaning that these figures are an underestimate of the true global circulation of the virus, as evidenced by other indicators such as test positivity rates and wastewater sampling, suggesting higher actual high rates of SARS-CoV-2 in circulation in all WHO regions. As of 3 August 2023, more than 768 million confirmed cases have been reported globally to WHO, while seroprevalence estimates suggest that there have been billions of infections and reinfections.

According to the WHO's risk assessment, the number of COVID-19 related deaths has been steadily declining, with the weekly reported number of deaths now consistently below 3 000. These levels are comparable to those seen in March 2020, prior to the introduction of COVID-19 vaccination and therapeutics. This figure is significantly lower compared to previous periods, such as the 8 000 deaths per week recorded between 23 January and 2 April 2023, over 16 000 from 26 September 2022 to 22 January 2023, and more than 57 000 from 3 January to 27 March 2022. The cumulative number of deaths reported globally since the start of the pandemic has now surpassed 6.9 million, with estimated deaths at least three times higher. It is worth highlighting that most countries still do not differentiate COVID-19 deaths and hospitalizations between those directly caused by SARS-CoV-2 and those

incidentally testing positive for the virus. The population aged 65 years and over, as well as those who have not been vaccinated, continues to be most at risk of severe disease and death.

WHO notes that progress has been made in vaccinating the world's population against COVID-19, with 66% having received a primary series and 31% having received booster doses as of 22 June 2023. Importantly, progress has also been made in vaccinating high-priority groups. The coverage for the primary series is 82% (with a range of 39% to 92% across countries based on income strata) among those aged 60 years and over, and 89% (with a range of 52% to 92% across countries based on income strata) among healthcare workers. Significant variations in vaccination rates persist between and within countries, highlighting the continued inequities in vaccine accessibility and demand. Furthermore, booster doses for optimizing the effectiveness of vaccines against severe diseases remain inadequate despite vaccine availability, and the global booster coverage rate of only 58% for those over 60 years is of concern. The inequity in booster coverage by regions and country income levels is even more pronounced compared to primary series doses, with lower than 8% coverage in low-income countries (LICs) reporting data. Health workers have booster coverage rates below those of at-risk elderly populations; only 31% of health workers globally have received a booster dose. Especially in low-income settings, only approximately 8% of health workers have received a first booster dose.

WHO Secretariat noted that since February 2022, Omicron has accounted for 98% of all publicly shared sequences globally. As the virus continues to evolve, descendent lineages and recombinants of Omicron descendent lineages – some with the ability to spread and replace previous Omicron sublineages – have exhibited similar phenotypic characteristics. Crucially, these lineages have exhibited similar or lower levels of severity, on average, compared to previously circulating VOCs. However, it is important to note that this does not eliminate the possibility of a more severe variant emerging in the future.

The confidence of the WHO Secretariat in the available information used to currently conduct a global public health risk assessment is mixed, but overall remains moderate due to various factors. Numerous countries continue to face challenges with surveillance, such as the deprioritization, defunding, and scaling down of SARS-CoV-2 surveillance activities, alongside persistent declines in RT-PCR-based testing rates – despite consistent temporary recommendations by the WHO Director-General to all States Parties to sustain national capacity gains for COVID-19. This makes it increasingly difficult to accurately assess the scale of community transmission and track and rapidly assess circulating variants and detect new ones. These difficulties are exacerbated by the ongoing reduction in the number of sequences submitted to publicly accessible databases. This hampers WHO and the WHO Technical Advisory Group for Virus Evolution (TAG-VE)'s ability to effectively detect, assess, and monitor the circulation and characteristics of current and future variants, as well as outbreaks linked to them. Moreover, surveillance in animals, including in wildlife and domestic animals known to be susceptible to SARS-CoV-2 infection, as well as environmental surveillance, remain extremely limited globally. The high circulation of SARS-CoV-2 in humans could allow for the undetected spread of SARS-CoV-2 in animal populations, for the continued circulation of past VOCs, and for future variants to emerge. Uncertainties remain regarding the phenotypic impact and the degree of protection offered by the different vaccines against future variants. This must be constantly assessed by WHO with advisory groups including TAG-VE, the Technical Advisory Group on COVID-19 Vaccine Composition (TAG-COVAC) and the Strategic Advisory Group of Experts on Immunization (SAGE).

Furthermore, in addition to the acute effects of SARS-CoV-2 infections that require clinical interventions such as hospitalizations and intensive care, WHO notes that there are still substantial knowledge gaps regarding PCC. While available data indicate a reduced risk of developing PCC after a

new infection if a person has prior immunity from a previous infection and/or vaccination, it is important to recognize that there may still be a substantial burden of PCC in the years and possibly decades to come. While our knowledge of PCC is growing, our current level of understanding remains inadequate, hindering our ability to optimally manage PCC cases. Uncertainties also remain about the short- and long-term health risks associated with repeated infections given the widespread current and continued circulation of SARS-CoV-2 globally.

Lastly, the origins of SARS-CoV-2 remain unknown. The limited knowledge regarding the origin of this pandemic affects our capacity to understand the potential risk of further zoonotic spillover of SARS-CoV-2 and to prevent future pandemics.

2.2 ASSESSMENT OF THE CURRENT AND FUTURE COVID-19 SITUATION BY THE REVIEW COMMITTEE

The potential disease burden caused by the COVID-19 pandemic continues to be determined by a number of elements, including the evolution of SARS-CoV-2, the extent of transmission and the impact on infected persons in terms of mild disease, severe disease, and long-term sequelae, including PCC.

Transmission: The main factors influencing transmission are virus evolution and characteristics, population immunity and the nature and frequency of contact between infectious people and others:

- SARS-CoV-2 continues to evolve, favouring variants with a higher transmissibility caused by intrinsic viral factors and/or increased evasion of immunity.
- Current evidence suggests that immunity (acquired by vaccination, infection, or both) against infection wanes considerably in a matter of months but may be increased after booster doses of vaccination or (re)infection.
- With the reduction of use or elimination of public health and social measures in most countries, infection and re-infections are continuously occurring in all countries. These measures, however, may have adverse effects on well-being of the population and the economy of the society.
- To date, in temperate regions in the Northern and Southern Hemispheres, seasonality of SARS-CoV-2 infections has not been observed. In all regions of the globe, transmission is likely to be enhanced when people spend more time indoors, with poor ventilation.

Impact on health: The main factors influencing impact are virus characteristics, immunity among the infected persons, access to and quality of medical care, access and use of appropriate medication, and misinformation and disinformation.

- As the virus continues evolving towards increased transmissibility, one of the foreseeable scenarios is change in virulence, i.e., the ability of cause more severe disease. Evolution may also lead to variants that can evade current diagnostic tests or therapeutics and thus potential delayed care with lower quality.
- Current evidence demonstrates that immunity (acquired by vaccination, infection, or both) against severe disease wanes more slowly than against infection but the immune response increases after booster doses or (re)infection. The risk of developing severe disease after infection is influenced by immunity, older age, and underlying medical conditions.

- Early diagnosis and entry into clinical care pathways with appropriate use of therapeutics increases the chances of a better outcome of disease.
- The extent and future impact of PCC is not fully understood both clinically and at a population level.

The future of the COVID-19 pandemic is thus highly dependent on SARS-CoV-2 evolution, immunity in the population in all countries, as well as access, affordability and use of life-saving tools. Currently, almost everyone has some immunity after infection, vaccination, or both. This, together with early diagnosis and better clinical care, has fundamentally reduced the impact of this pandemic on the global population in the last year.

SARS-CoV-2 will continue to circulate and evolve in the coming days, months and years, and to pose people of older age, those with comorbidities, or both, at risk of severe disease. These individuals will benefit from periodic boosting according to SAGE recommendations, which will be adapted as new data becomes available on updated vaccines. Boosting of the highest risk groups will become more important if a highly transmissible variant evolves which also evades immunity against severe disease.

For these reasons, standing recommendations, applying to all States Parties, are necessary, at least for the coming years, to stimulate efforts in all countries to reduce disease burden and maintain preparedness against an uncertain future.

2.3 WHO COVID-19 STRATEGIC PREPAREDNESS AND RESPONSE PLAN: APRIL 2023-APRIL 2025

Throughout the COVID-19 pandemic, WHO has supported States Parties with temporary recommendations, Global Strategic Preparedness, Readiness and Response Plans (first published on 4 February 2020), technical guidance, guidelines, policy briefs and advice (published since January 2020), and other types of information products developed to address the COVID-19 pandemic.

In April 2023, WHO updated its COVID-19 Strategic Preparedness and Response Plan to outline the strategy until April 2025³. The plan aims to support countries in transitioning towards integrating COVID-19 pandemic response actions into broader infectious disease prevention and control programmes, so that those actions can be sustained in the context of other concurrent challenges to the health of populations.

The plan presents its goals and objectives as follows:

“The underlying goal of the April 2023-April 2025 SPRP is to end the emergency phase of the COVID-19 pandemic in all countries and shift from emergency response to sustainable comprehensive management of COVID-19 within broader disease prevention and control programmes.

This will be achieved by:

³ [“From Emergency Response to Long-term COVID-19 Disease Management: Sustaining Gains Made during the COVID-19 Pandemic.”](#) [accessed on 4 August 2023]

- 1) *Reducing and controlling the incidence of SARS-CoV-2 variants with increased growth rates and immune escape, with a particular focus on reducing infections in high-risk and vulnerable populations;*
- 2) *Preventing, diagnosing and treating COVID-19 to reduce mortality, morbidity, and long-term sequelae; and*
- 3) *Supporting Member States' transition from crisis response to sustainable, integrated, longer-term and strengthened COVID-19 disease management."*

The plan then goes on to present the main tools:

- *"vaccination in at risk populations to prevent severe disease and death;*
- *early diagnosis, treatment and clinical care, especially in at-risk populations;*
- *integration of COVID-19 vaccination and COVID-19 disease management into existing primary health services;*
- *protecting health workers and other priority groups; and*
- *strong surveillance and monitoring of SARS-CoV-2 variants, including strategic and geographically representative sequencing to track known and future variants, respiratory pathogens, and other pandemic threats."*

The plan is centred around the five components outlined in the WHO document ["Strengthening the global architecture for health emergency prevention, preparedness, response and resilience"](#).

- Collaborative surveillance: The plan calls for sustained, robust surveillance, including genomic surveillance, to support the objectives of the plan.
- Community protection: The plan calls for a clear strategy to engage, empower and enable people and communities to use all available tools to protect themselves, their families and their communities, including the use vaccination to protect those at highest risk from developing severe disease.
- Safe and scalable care: The plan calls for efforts to integrate COVID-19 clinical care pathways into primary health care systems and to update COVID-19 policies in infection prevention and control.
- Access to countermeasures: The plan calls for investments in research that addresses critical unknowns about SARS-CoV-2, including acute and PCC, and for preparation for adequate supplies of key commodities.
- Emergency response: The plan calls for continued inter-ministerial, multi-disciplinary and multisectoral coordination during the transition period with a focus on key priorities, including strengthening integrated surveillance to track known and detect new SARS-CoV-2 variants and achieve vaccination targets for at risk-groups, continuing to develop strategies to increase access to and use of affordable diagnostics and therapeutics to prevent severe disease and death among people with vulnerabilities and strengthening pandemic preparedness more broadly.

3. THE REVIEW COMMITTEE'S TECHNICAL ADVICE ON PROPOSED STANDING RECOMMENDATIONS

3.1 NECESSITY, APPROPRIATENESS, AND SCOPE OF STANDING RECOMMENDATIONS

Necessity and appropriateness of standing recommendations

The Director-General of WHO has not previously issued standing recommendations provided for in the current IHR. There are several reasons why the Review Committee considers standing recommendations should be issued for COVID-19 to all States Parties:

- While the PHEIC associated with the COVID-19 pandemic was terminated, COVID-19 remains a risk to human health globally and a driver of demand for health services. Despite high population immunity, COVID-19 continues to cause a substantial number of hospitalisations and deaths, particularly in vulnerable populations.
- There is a risk that, should a new variant emerge that causes more severe disease, this will alter the risk assessment considerably.
- There are still several unknowns regarding COVID-19, including the magnitude of risk of long-lasting symptoms after infection, the health consequences of repeated infections and the duration of immunity following infection, vaccination, or both.
- When the Emergency Committee, after its meeting on 4 May 2023, advised the Director-General to terminate the PHEIC associated with the COVID-19, it also suggested that he “consider convening an IHR Review Committee to advise on standing recommendations for long-term risks posed by SARS-CoV-2”. The Director-General followed this advice with the intention of issuing standing recommendations.
- The use of standing recommendations will help with the transition from the emergency phase of the response, which included the use of temporary recommendations, to the new normal, as we increasingly bring COVID-19 into the mainstream of infectious disease management.

With this background, the majority of the Review Committee considered that standing recommendations are both necessary and appropriate according to IHR Articles 16 and 17. Standing recommendations should stimulate States Parties to keep up their interest and vigilance around COVID-19 so that the disease burden can be reduced and the evolution of the virus and changes in the epidemiology can be rapidly identified and globally shared.

Two other considerations were discussed by the Review Committee. Firstly, the concern that standing recommendations with respect to COVID-19 might reduce focus on other national disease priorities at a time when the health impact of COVID-19 is diminishing. Secondly, that WHO's guidance on next steps and integration of COVID-19 response into existing health services, might be better done through technical advice to WHO Member States, rather than through standing recommendations.

After deliberating on these diverging views regarding the necessity and appropriateness of issuing standing recommendations, the Review Committee reached a consensus about the fact that, in the

current context, standing recommendations may prove useful for managing the current risk posed by COVID-19.

Scope of the standing recommendations

The Review Committee discussed the scope of the proposed standing recommendations. Both of the following interpretations were represented among the Members of the Review Committee.

A narrow interpretation of the scope of relevant articles of the IHR, especially 16, 17 and 18, is that recommendations should be concerned with only measures that *directly* “reduce the international spread of disease and avoid unnecessary interference with international traffic” (Article 16). Article 18 lists examples of such measures. Furthermore, standing recommendations should be specific and relevant to the particular disease and risks associated with it and not generic recommendations, e.g. regarding strengthening of health systems or surveillance systems in general.

A broad interpretation of the scope of the same articles is that the prevention and control of disease, including inside individual States Parties, could *indirectly* serve to reduce international spread as well. The Committee noted that temporary recommendations of similar scope, which are not explicitly listed in Article 18, have been issued by the Director-General in relation to the PHEIC associated with the COVID-19 pandemic.

The Review Committee recalled that the severe impact of the COVID-19 pandemic was due to inequity in access to medical countermeasures and advised that the standing recommendations should be guided by the public health risk posed by SARS-CoV-2. Lessons should be learned from initiatives such as [Access to COVID-19 Tools Accelerator](#), and, in particular, from its [COVAX](#) pillar. Further, the Review Committee advised that the standing recommendations should be in line with Articles 3, 42 and 44 of the IHR.

3.2 TECHNICAL ADVICE ON PROPOSED STANDING RECOMMENDATIONS

Based on the proposed standing recommendations presented to the Review Committee in advance of its first session, the formulation of the standing recommendations enumerated below reflect the technical advice of the Review Committee.

A. States Parties are recommended to revise and implement, as appropriate, national COVID-19 plans and policies that take into account the WHO COVID-19 Strategic Preparedness and Response Plan April 2023- April 2025. This document outlines critical actions that support States Parties in transitioning from emergency response to COVID-19 into strengthened and integrated infectious disease prevention and control programmes with the goal of reducing disease burden from COVID-19 and preparing for a possible worsening situation caused by new variants of the virus. Actions are recommended to:

1. Incorporate lessons learnt from national and sub-national evaluations of the COVID-19 response into COVID-19 related plans and policies.

2. Sustain national and sub-national capacities, as appropriate, for preparedness, prevention, and response for COVID-19. The capacity gains achieved during the public health emergency of international concern (PHEIC) associated with the COVID-19 pandemic should be leveraged to prepare for current and future events of both COVID-19 and other infectious pathogens with epidemic and pandemic potential. These capacities may include multi-source surveillance, risk assessment, testing and sequencing capacities, infection prevention and control, clinical management, planning and delivery of mass gathering events, risk communication and community engagement, infodemic management, public health and social measures, and access to and use of medical countermeasures.
3. Based on the current COVID-19 epidemiological situation, refrain from any unilateral travel-related restrictions or health measures, including requirements for testing or vaccination, and lift any such remaining measures to avoid unnecessary interference with international traffic and trade.
4. Continue to restore health programmes adversely affected by the COVID-19 pandemic.

B. States Parties are recommended to sustain collaborative surveillance⁴ for COVID-19, in order to provide a basis for situational awareness and risk assessment and the detection of significant changes in virus characteristics, virus spread, disease severity and population immunity. Actions are recommended to:

5. Incorporate information from different COVID-19 monitoring systems to ensure detection of early warning signals and prepare to scale up and adapt systems, as needed. Include, as applicable, surveillance in sentinel populations, genomic sequencing, event-based surveillance, wastewater or environmental surveillance, serosurveillance, clinical severity assessment, and surveillance in animal populations. Support the enhancement of surveillance using a One Health Approach⁵ to better understand SARS-CoV-2 circulation and evolution in animals.
6. Integrate COVID-19 surveillance with surveillance for other respiratory infections, e.g. influenza, where applicable, to provide baselines relative to other circulating viruses.

C. States Parties are recommended to continue reporting COVID-19 data, particularly mortality data, morbidity data, SARS-CoV-2 genetic sequences with meta-data, and vaccine effectiveness data to WHO or in open sources so that WHO can understand and describe the epidemiological situation and variant landscape, perform global risk assessments and work with expert networks and relevant WHO Advisory Groups. Actions are recommended to:

7. Report COVID-19 burden and impact data including hospitalization, ICU and mortality data to WHO or publish the data.

⁴ The definition of collaborative surveillance by WHO is available at: <https://www.who.int/publications/i/item/9789240074064> [Accessed on 4 August 2023]

⁵ The WHO One Health page is available at: https://www.who.int/health-topics/one-health#tab=tab_1 [Accessed on 4 August 2023]

8. Maintain public reporting of sequences with meta-data and support the establishment of the WHO Global Coronavirus Laboratory Network (CoViNet) in order to, inter alia, support future selection of strains for updated vaccines.
9. Report epidemiological and laboratory information in a timely manner to established WHO regional or global platforms, through RespiMart and the expanded activities of the Global Influenza Surveillance and Response System (GISRS).
10. Improve reporting on COVID-19 vaccine implementation and programme data to WHO, in particular vaccine uptake in high risks groups, via established systems.
11. Notify WHO through IHR channels about significant COVID-19 related events.

D. States Parties are recommended to continue to offer COVID-19 vaccination based on both, the recommendations of the WHO Strategic Advisory Group of Experts on Immunization (SAGE) and on national prioritization informed by cost benefit reviews. Vaccine delivery should be appropriately integrated into health services. Actions are recommended to:

12. Improve efforts to increase COVID-19 vaccination coverage for all people in the high-priority groups using COVID-19 vaccines recommended by WHO or vaccines approved by national regulatory authorities, taking into account SAGE recommendations, and continue surveillance of vaccination uptake and adverse events.
13. Address actively vaccine misinformation, disinformation, acceptance, and demand issues with communities and health care providers.

E. States Parties are recommended to continue to initiate, support, and collaborate on research to generate evidence for COVID-19 prevention and control, with a view to reduce the disease burden of COVID-19. Actions are recommended to:

14. Contribute to the global research agenda to generate and promptly disseminate evidence for key scientific, social, clinical, and public health aspects of COVID-19 prevention, control, and disease burden reduction.
15. Improve collaboration between countries and with national and international organizations to design and perform such research. Particular attention should be paid to funding aimed at strengthening research institutions in low- and middle-income countries (LMIC) and to support LMIC researchers to lead and or participate in research for national, regional or global research agendas.
16. Continue primary research and systematic reviews of research, including but not limited to the following topics:
 - Understand SARS-CoV-2 transmission patterns and the impact of climate, seasonality and behavior.
 - Understanding SARS-CoV-2 evolution and its impact on medical countermeasures.
 - Understanding the optimal use and impact of single and combined public health and social measures and travel related health measures on reducing SARS-CoV-2 transmission as well as the impact of misinformation and disinformation on adherence to such measures.

- Vaccination efficacy, effectiveness, duration, and safety in groups defined by age, medical conditions and previous infection and vaccination with various products.
- Development of vaccines that reduce transmission and have broad applicability.
- Improved treatment of severe COVID-19 cases.
- Development of therapeutics for COVID-19.
- Understanding the full spectrum, incidence, impact, and treatment possibilities for PCC.
- Understand the origins of SARS-CoV-2.
- Understanding the breadth and duration of immunity after infection, vaccination, or both, and cross-reactivity with other coronaviruses.

The Review Committee acknowledged that limited or lack of access to countermeasures in lower resource settings, including diagnostics, vaccines and therapeutics, contributed to the severe disease burden caused by SARS-CoV-2. Nevertheless, members of the Review Committee expressed different views regarding the following two proposed standing recommendations, which address clinical care and access to countermeasures respectively. Some members considered that these issues fall outside the scope of IHR as per Article 2. Other members, acknowledging that their interpretations of Article 2 are broader than the previous view, considered the issue of equity in access to countermeasures as very critical to the response to COVID-19 pandemic. Similarly, it was argued that the provision of clinical care has a direct impact on the clinical outcomes of COVID-19 and PCC cases, consequently on the morbidity and mortality, and an indirect effect on the reduction of international transmission. Therefore, the two recommendations below are included for the discretion of the Director-General.

F. States Parties are encouraged to continue deliver optimal clinical care for COVID-19, appropriately integrated into all levels of health services, including access to proven treatments and measures to protect health workers and caregivers as appropriate. States Parties are encouraged to take actions to:

17. Ensure provision, and related scaling-up mechanisms, of appropriate clinical care, with infection prevention and control measures in place, for suspected and confirmed COVID-19 cases in clinical settings. Ensure training of health care providers accordingly and provide access to diagnostics and to personal protective equipment.
18. Integrate COVID-19 clinical care within health services as appropriate.
19. Ensure access to provision of evidence-based care and health products for patients with acute COVID-19 and PCC.

G. States Parties are encouraged to continue to work towards ensuring equitable access to safe, effective and quality-assured medical countermeasures for COVID-19. State Parties are encouraged to take action to:

20. Support and enhance equitable access to safe, effective, and quality-assured diagnostics, therapeutics and vaccines for all communities for COVID-19, including through, for example resource mobilization mechanisms and technology transfer, as appropriate.

21. Intensify ongoing efforts, including through global and regional networks, to expand the manufacturing capacity of diagnostics, therapeutics and vaccines for COVID-19.
22. Strengthen regulatory authorities to support efficient and effective authorization of diagnostics, therapeutics and vaccines within national regulatory frameworks.

3.3 REPORTING, DURATION OF STANDING RECOMMENDATIONS, AND MISCELLANEOUS ITEMS

The Review Committee welcomes the presentation by the Director-General of this report and of the standing recommendations that he may issue to the Seventy-seventh World Health Assembly in May 2024, for its consideration, in accordance with Article 53 of the IHR.

The Committee advises that the standing recommendations that the Director-General may issue should have a defined duration, for example that they are effective from 5 August 2023 to 30 April 2025, subject to possible modification or termination, in accordance with the procedure in Article 53 of IHR. Furthermore, depending on any views that may be expressed by States Parties at the Assembly in May 2024 or otherwise, the Director-General may wish to consider reviewing the standing recommendations in June or July 2024.

The Committee notes that there is a monitoring and evaluation framework related to the WHO COVID-19 Strategic Preparedness and Response Plan April 2023-April 2025 and that this is likely to be related to the standing recommendations that the Director-General may issue.

APPENDICES

APPENDIX 1. NAMES AND AFFILIATIONS OF REVIEW COMMITTEE MEMBERS

Professor Preben Aavitsland (Chair), Director of Surveillance, Area of Infection Control, Management and Staff, Norwegian Institute of Public Health, Norway

Mr Andrew Forsyth (Vice-Chair), Manager, Public Health Strategy, Ministry of Health, New Zealand

Dr Carmen Aramburu Celigueta (Rapporteur), Director of Health and Social Policy, Delegation of the Spanish Government in Catalonia, Spain

Dr Mohammad Abdelfattah Abdelmawla Abdelaziz, Undersecretary for Preventive Affairs, Ministry of Health and Population, Egypt

Dr Mohannad Al-Nsour, Executive Director, Eastern Mediterranean Public Health Network (EMPHNET), Amman, Jordan

Dr Jacqueline Bisasor-McKenzie, Chief Medical Officer, Ministry of Health and Wellness, Jamaica

Dr Inger K. Damon, Adjunct Professor of Clinical Medicine Emory University, Atlanta, USA, retired Director, Division of High Consequence Pathogens and Pathology, National Center for Emerging and Zoonotic Infectious Diseases, Centers for Disease Control and Prevention, USA

Dr Eduardo Hage Carmo, Associate Researcher, Fundação Oswaldo Cruz (Fiocruz) - Brasilia, Distrito Federal, Brazil

Dr Akram Ali Eltoum, COVID-19 Regional Program Development Consultant/Project Director for Project HOPE in North Africa; Former Federal Minister of Health of Sudan

Dr Yang Liu, Assistant Professor, Law School, and Director of the Center for Global Law and Strategy, Law and Technology Institute, Renmin University of China, Beijing, China

Dr Mohamed Moussif, Chief Medical Officer at Casablanca International Airport, Morocco; National Coordinator of the Points of Entry Program of Morocco

Dr Mahmudur Rahman, Country Director, Eastern Mediterranean Public Health Network (EMPHNET), Bangladesh Office, Dhaka, Bangladesh

Professor Helen Rees, Executive Director, Wits Reproductive Health and HIV Institute, University of the Witwatersrand, Johannesburg, South Africa

Dr Aalisha Sahukhan, Head of Health Protection, Ministry of Health and Medical Services, Fiji

Dr Tomoya Saito, Director, Center for Emergency Preparedness and Response, National Institute of Infectious Diseases, Japan

Dr Sandhya Dilhani Samarasekera, Consultant Community Physician, Quarantine Unit, Ministry of Health, Sri Lanka

Dr Vyacheslav Smolensky, Deputy Head, Federal Service for Surveillance on Consumer Rights Protection and Human Wellbeing (Rosпотребнадзор), Russian Federation

Ms Sunita Sreedharan, Lawyer and Registered Patent Agent, New Delhi, India

Dr Oyewale Tomori, Professor of Virology, Redeemer's University, Ede, Osun State, Nigeria

Professor Maria Zambon, Head of Influenza, Respiratory Virology & Polio Reference Services, United Kingdom Health Security Agency; Co-Director, Health Protection Research Unit in Respiratory Infections, NIHR, Imperial College London, United Kingdom

APPENDIX 2. SELECTED RELEVANT WHO DOCUMENTS

All hyperlinks enumerated below we accessed on 4 August 2023

- [WHO COVID-19 Strategic Preparedness and Response Plan. From emergency response to long-term covid-19 disease management: sustaining gains made during the covid-19 pandemic](#)
- [Preparedness and resilience for Emerging Threats](#)
- [Strengthening pandemic preparedness planning for respiratory pathogens: policy brief](#)
- [WHO COVID-19 policy briefs](#)
- [Emergency Response Reviews](#)
- [Infection prevention and control in the context of coronavirus disease \(COVID-19\): A living guidelinePublic health surveillance for COVID-19](#)
- [End-to-end integration of SARS-CoV-2 and influenza sentinel surveillance](#)
- [Global COVID-19 Vaccination Strategy in a Changing World \(July 2022 update\)](#)
- [SAGE Roadmap \(Updated March 2023\)](#)
- [Good practice statement on the use of variant-containing COVID-19 vaccines](#)
- [Behavioural and social drivers of vaccination: tools and practical guidance for achieving high uptake](#)
- [Considerations for integrating COVID-19 vaccination into immunization programmes and primary health care for 2022 and beyond](#)
- [WHO COVID-19 policy briefsTherapeutics and COVID-19: living guideline](#)
- [COVID-19 Clinical Care Pathway](#)
- [Emergency Use Listing procedures](#)
- [Prequalification procedures for vaccines](#)
- [Prequalification procedures for in vitro diagnostics](#)
- [Interim position paper: considerations regarding proof of COVID-19 vaccination for international travellers](#)
- [Policy considerations for implementing a risk-based approach to international travel in the context of COVID-19](#)