INB related interactive dialogues
Topic 4. Articles 4 (Pandemic prevention and surveillance) and 5 (One Health approach for Pandemic Prevention, Preparedness and Response)

Discussion questions proposed by the Bureau for resource persons

1. What lessons can we draw from country experience in progressively strengthening pandemic prevention and surveillance / promoting a One Health approach to PPPR?

1.1. What lessons can we learn from country experience relating to developing, strengthening and implementing comprehensive multisectoral national pandemic prevention surveillance plans, programmes and/or other actions, including coordinated multisectoral surveillance and risk assessment? (as per yellow text in Article 4.2)

Based on the eight publicly available National One Health Strategic Plans and our own experience supporting governments in developing and implementing collaborative surveillance networks and communities of practice, national One Health, pandemic prevention, and surveillance plans must involve several critical criteria: 1. Coordination & Collaboration: coordinated efforts with clear communication channels and roles across multiple sectors, including health, agriculture, environment, and finance; 2. Data Sharing & Integration: Effective collaborative surveillance relies on integrating data from various sources and sectors. Countries with robust data-sharing protocols and platforms tend to have more effective surveillance systems; 3. Community Engagement & Transdisciplinary Approaches: Trusted engagement of communities in participatory surveillance efforts enhances the detection and reporting of potential outbreaks; 4. Capacity Bridging & Building: Investing in the training and developing surveillance personnel across the health, veterinary, and environmental sectors ensures a skilled workforce ready to respond to pandemics; 5. Policy & Legal Frameworks: Establishing firm policy and legal frameworks support the implementation and enforcement of surveillance measures; 6. Sustainability & Funding: Ensuring sustainable funding and resources for pandemic prevention and collaborative surveillance is essential for long-term success

1.2. What lessons can we learn from country experience in promoting a One Health approach for pandemic prevention, preparedness and response, and measures to identify and address the drivers of pandemics and the emergence and re-emergence of infectious disease at the human-animal-environment interface?

One Health, recognizing the interconnectedness of human, animal, and environmental health, offers valuable lessons for pandemic prevention, preparedness, and response: Countries that have successfully implemented One Health approaches develop collaborative surveillance systems across human, animal, and environmental health data. Because most emerging infectious diseases have a zoonotic and specifically wildlife origin, this approach helps in early detection, prevention, and response to potential outbreaks. Effective One Health strategies require collaboration across sectors, including public health, veterinary services, wildlife management (wild and farmed), and environmental agencies. Establishing multidisciplinary and cross-sectoral communities of practice across administrative silos with

trusted communication channels improves health outcomes. Most importantly, identifying and addressing the root causes of infectious disease emergence, such as habitat destruction, wildlife trade and markets, wildlife captive production, and agricultural practices, is critical. Countries that focus on these root-cause drivers reduce the risk of zoonotic spillovers and leverage co-benefits in climate change mitigation and biodiversity conservation.

2. How can the Pandemic Agreement support strengthening global cooperation for pandemic prevention and contribute to a One Health approach to PPPR?

2.1. What substantive content needs to be included on pandemic prevention and surveillance (article 4), including on partnerships and support for building country capacity (beyond existing yellow text)?

To ensure a successful collaborative and cross-sectoral prevention and surveillance approach, it is essential to identify and explicitly integrate critical sectors, such as human, animal (including wildlife), and environmental health, in the text. These sectors form the foundational pillars of an effective surveillance system. Additionally, fostering the development of supportive communities of practice is crucial. These communities facilitate collaboration, knowledge sharing, and innovation among professionals from diverse disciplines and fields. By building strong networks and partnerships, these communities will drive the implementation of integrated surveillance strategies, enhance data sharing, and improve the overall responsiveness to emerging health threats. This holistic approach strengthens surveillance efforts and promotes a more resilient and proactive health ecosystem. There is broad scientific consensus that a range of environmental, climatic, social, anthropogenic, and economic factors increase the risk of epidemics and pandemics; this primary prevention necessarily needs to be reinforced and highlighted in the existing text. Additionally, explicit capacity bridging and building needs should be added to the text. It is undisputed that animal health, environmental health capacity and an understanding of primary prevention need to be improved across many countries.

2.2. What substantive content needs to be included on One Health (article 5), including on partnerships and support for building country capacity (beyond existing yellow text)?

It is critical to explicitly name the sectors that need to be integrated as a bare minimum in a One Health approach: human health, animal health (wildlife and other animals), and environment. Our previous work has revealed varying levels of alignment of National One Health Strategic Plans with contemporary recognized One Health principles. Although most available plans acknowledge the importance of cross-sectoral collaboration and environmental health, they must consistently define specific actions. Additionally, disparities in addressing issues such as climate change and anthropogenic drivers are evident. It is essential to emphasize mainstreaming administrative and budgetary structures that facilitate a One Health approach and integrate One Health principles into the core operational frameworks of relevant sectors, ensuring that resources are allocated efficiently and effectively.

2.3. What existing guidance, commitments or frameworks can we draw on, including the IHR amendments (particularly expanded Core Capacities in Annex 1)?

The PA can draw on initiatives to enhance the global framework for Health Emergency Preparedness, Response, and Resilience (HEPR) and related efforts in defining Collaborative Surveillance and bolstering Public Health Intelligence. Furthermore, the PA can leverage the knowledge generated and shared by the Quadripartite Call for Action for One Health while building on and supporting the initiatives outlined in the One Health Joint Plan of Action (2022-2026). Additionally, the PA can draw on the draw on IHR amendments in Annex A 1, 2 & 3 while supporting efforts at specifically designated interfaces.

2.4. What additional commitments and guidance are needed to support pandemic prevention and One Health and how do these relate to the functional dimensions and details in Article 4.3Alt and modalities, terms and conditions and operational dimensions referred to in Article 4.3Alt and 5.4?

3. How could these elements (as per question two) be reflected in the Pandemic Agreement and/or an associated additional instrument?

3.1. Is it important these commitments are legally binding?

Yes, the legal text must include legally binding provisions on pandemic prevention, including primary prevention, prevention at source, and a commitment to associated actions, as well as the One Health approach for pandemic prevention, preparedness and response. Several multilateral environment agreements (CBD, CITES, CMS) have recently committed to reducing the risk of pathogen spillover from wildlife; however, those conventions have existed for decades (prior to the increasing prevalence of pandemics of zoonotic origin) and health is not their primary mandate. They are responding to the upsurge in zoonotic spillover and trying to do their part to prevent future pandemics. Nonetheless, there are many gaps in the existing global architecture. As the “directing and coordinating authority on international health work,” the WHO, and its Parties, have the mandate and a responsibility to ensure that this once-in-a-generation agreement includes provisions that will truly reduce the risk of pathogen spillovers, epidemics, pandemics, and the emergence and reemergence of diseases at the human-animal-environment interfaces from happening in the first place, thereby protecting human health and countless lives in the face of future pandemics of zoonotic origin. At a minimum, Parties to the pandemic agreement should be required to develop, strengthen and implement, comprehensive multisectoral national pandemic prevention and surveillance plans, programmes and/or other actions.

3.2. What are the implications of the different forms of a possible future instrument (e.g., annex to the Pandemic Agreement, protocol, or guideline) on countries’ / the world’s ability to prevent and prepare for the next pandemic?

The most important step Member States can take at this juncture is to adopt a pandemic agreement within the extension period (by WHA78) that provides a strong foundation for pandemic prevention using a One Health approach. An annex would add time to the negotiations and could further complicate the issues at hand. A protocol and/or guidelines could be good options, but those discussions would take place through the COP process after the agreement enters into force. Although COVID-19 is no longer considered a pandemic by the WHO, we continue to see multiple resurgence waves per year across at least 84 countries that continue to impact individuals and communities. That, combined with the declaration of mpox as a Public Health Emergency of International Concern for the second time and High Pathogenic Avian Influenza H5N1 continuing to expand its species range and finding a novel evolutionary pool in US dairy cattle herds to develop new traits and infection paths, clearly illustrate that the global community cannot afford to delay these negotiations further. Even if the pandemic agreement is adopted by May 2025, it will still take years for it to enter into force. We must act now to put the world on a course towards preventing, preparing for, and responding to future pandemics. However, arguably, prevention is key. While we must still be prepared for and ready to respond to future pandemics, if we actively work to prevent them then those actions become less important.

3.3. How would it link to other instruments and guidelines on prevention and One Health?

Links directly to efforts on strengthening the global architecture for health emergency preparedness, response and resilience [HEPR] and the linked efforts in Defining Collaborative Surveillance while supporting Public Health Intelligence. Additionally, the pandemic agreement can build on and support efforts outlined by the Quadripartite call for action for One health and the One health joint plan of action (2022-2026). Additionally, it is linked to multilateral environment agreements (CBD, CITES, CMS) that have recently committed to reducing the risk of pathogen spillover from wildlife by adopting resolutions, a global biodiversity framework, and soon a global action plan; however, those conventions have existed for decades (prior to the increasing prevalence of pandemics of zoonotic origin) and health is not their primary mandate.

3.4. How would the nature of the instrument affect a Parties' ability to access implementation support and financing under the Pandemic Agreement (e.g., Articles 19, 20)?

3.5. How would the instrument link to State Parties' prevention and surveillance commitments, and the monitoring and evaluation framework, under the amended IHR?

The document on the International Health Regulations (2005) presented at the Seventy-Seventh World Health Assembly emphasizes the importance of preventive surveillance in addressing public health risks and emergencies. The instrument would support article 5 on surveillance in the amended IHR, specifically the core capacity "to prevent" events. Additionally, systems-based One Health approach will be critical when implementing the decision instrument for the assessment and notification of events that may constitute a public health emergency of international concern, and specifically those of

unknown causes or sources [see Annex 2] The amended IHR also highlights the need to integrate other intergovernmental orgaizations when an event requires competencies beyond the traditional WHO remit.

3.6. How long would it take to negotiate and agree the instrument? Does this impact countries' implementation of prevention and One Health obligations and the world's ability to prevent and prepare for the next pandemic?

By the time WHA78 takes place, it would have been 3.5 years since the process to draft and negotiate a pandemic agreement launched. Further delay would not be advisable, but it should not impact countries' implementation of prevention and One Health obligations adopted in other fora or of national plans developed proactively. It would impact the world's ability to prevent and prepare for the next pandemic because we would be left with the status quo, which is the reason the world agreed to engage in this important exercise in the first place. There have been agreements negotiated in other fora in less time, and expeditious ratification and entry into force should be prioritised.

4. How important is it to engage communities in development and implementation of One Health policies, strategies and measures to prevent, detect and respond to outbreaks?

4.1. Is this different to community engagement outlined in Article 17?

Overall, community engagement is a cornerstone of effective One Health approaches, ensuring that policies and measures are scientifically sound and socially and culturally appropriate. Participatory community involvement improves surveillance systems by enabling early detection of unusual health events or outbreaks at human-livestock-wildlife interfaces. Local communities at spillover frontlines are often the first to notice wildlife deaths, changes in animal behavior, and environmental conditions that could signal emerging health threats. Engaging communities fosters trust and cooperation between health authorities and local populations. This trust is vital for successfully implementing health measures and encouraging community members to report health issues promptly. Article 17 touches on most of these aspects but could be strengthened by explicitly highlighting the human-livestock-wildlife interfaces and the practices and behaviours at these same interfaces. We also note that Article 17 / 2 is linked to the comments above concerning Article 5.