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)

The origin of most disease outbreaks is often localized in animal or human populations, if it is not detected, it risks evolving into an epidemic or pandemic. Identifying high-risk practices and hotspots, working with and supporting communities at the human-animal-environment interface in protecting themselves, setting up early detection and control and developing multisectoral surveillance, coordination and strategies will achieve equity before communities at the interface suffer and before outbreak becomes an epidemic. Examples of such measures exist. Ghana's collaboration with farmers, poultry companies and associations was critical in reducing HPAI risk. Peru's involvement of veterinary associations and livestock producers brought diverse perspectives and lead to comprehensive health measures. Thailand's national plan for EIDs involved wildlife markets, slaughterhouses and livestock businesses leading to improved compliance to health rules and reduced disease transmission.

Lessons learned show the importance of collaboration across relevant sectors, government institutions, disciplines and with communities. On surveillance, monitoring drivers of disease emergence, not only outbreaks, is key, so they are integrated into strategies. Guidance on risk assessments, surveillance methods, how to interpret assessments, identify hotspots and actions to be taken is needed.

(Responses by FOUR PAWS with input by Born Free Foundation, WVA, Asia for Animals, Dr. Meganne Natali)

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 interventions no longer start after pathogen spillover from animals to humans but rather begin at an earlier stage, identifying activities that drive health risks in animal and the environment so that measures prevent disease emergence and spillover, before animals and humans suffer. Measures within One Health plans now also tackle drivers and high-risk activities at the human-animal-environment interface in a collaborative top-down and bottom-up approach. In the past, One

Health strategies overlooked the role wildlife plays in disease emergence. Involving and training practitioners and ministries specialized in animal welfare, agriculture, wildlife and environment on collaborative surveillance and EID risk assessments is key. Vietnam strengthened their One Health system including wildlife, identifying risks and interventions and incorporating their health into health security strategies. Bolivia and China showed the necessity for cohesive One Health legislation, intersectoral collaboration, a unified approach to wildlife disease management and monitoring. Their experience shows the importance of interagency coordination and data sharing. Kenya has integrated surveillance across sectors to address zoonotic diseases showing value for unified One Health strategies. Liberia set up surveillance for baseline pathogen data, empowered local communities and addressed drivers via a One Health approach. One Health focal points, clear mandates and collaboration are key.

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)?

Prevention at source is the most effective stage member states can support each other with to achieve equity before an outbreak and before communities suffer. Article 4 can be strengthened on: support and means of implementation, support by specialized agencies (e.g. QPT) upon request and the role of other international instruments, so that prevention is not contingent on "taking into account national capacities"(Art4.1.), or "subject to the availability of resources" (Art4.2.), or a measure where member states "shall endeavour to consider" factors that drive outbreaks (Art4.2.bis). Paragraph 4.2 indicates that national prevention and surveillance plans shall "cover inter alia" a set of essential measures. Instead the national plans "should aim at strengthening" those measures.

A further elaboration on collaboration, capacity building and support for prevention and One Health is generally missing. An Annex with a list of ways member states can support each other or request support in designing and implementing their national plans is needed. To ensure support is available for the most essential outcomes, clarity - on what factors and activities increase spillover and spillback risk, what is meant by multisectoral surveillance, types of actions and outcomes that can be implemented progressively - can offer a broad frame to 1.member states on what to include in their plans and 2. funding and implementing bodies on what steps they must be prepared to support.

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)?

The One Health approach is about the "how"; a way of working together that is rooted in collaboration, equity and the interconnectedness between human, animal, environment health. It is an approach that we must not only "promote" on "voluntary basis", but "follow" or "implement" (Art5.1.). Equity, before the most vulnerable suffer, can be best achieved via a One Health approach. Identifying

the highest risks and activities to focus on in national strategies will require a multisectoral approach and the involvement of communities. Involving communities who come into daily contact with animals, enabling them to protect themselves by becoming aware of high risk activities that must be avoided and ways to prevent spillover is key. Learning from them on solutions that work best in their circumstances and including the measures into national One Health strategies so that support is made available will be essential for effective One Health national plans.

Implementing a One Health approach will require national multisectoral coordination (Art17.2.), a national One Health focal point, and implementation support. Clarity is missing on how to identify activities and practices that must be prioritized in national plans, what key One Health outcomes linked to PPR should be in plans, guidelines, forms of coordination that enable One Health implementation, synergies with other instruments, and a compilation of means of implementation and types of support needed and to be made available.

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

Many papers and guidance materials available on risk assessments, surveillance methodologies, and the operationalisation of One Health. It would be useful for the WHO, WOAH, FAO and UNEP to create a portal containing these materials which should be made freely and easily available to Parties, so that high-level guidance documents can be developed. (from Born Free)

Specific guidance includes:

- The Global Action Plan for Biodiversity and Health, due to be submitted for adoption at the CBD COP16 in October.

- The One Health Joint Plan of Action (https://iris.who.int/bitstream/handle/10665/363518/9789240059139-eng.pdf?sequence=1), and the associated Implementation Guide (https://iris.who.int/bitstream/handle/10665/374825/9789240082069-eng.pdf?sequence=1).

- WOAH guidelines on monitoring, disease detection, surveillance and diagnosis (https://www.woah.org/en/what-we-do/standards/observatory/implementation-of-standards-the-observatory-annual-report/monitoring-disease-detection-surveillance-and-diagnosis/).

- The UK JNCC information on the zoonotic potential of international trade in CITES-listed species (https://hub.jncc.gov.uk/assets/964ae259-410e-4205-8ec7-e2c54f5c6e3d).

- The One Health High Level Expert Panel's white paper on Prevention of Zoonotic Spillover (https://www.who.int/publications/m/item/prevention-of-zoonotic-spillover).

- Global Health Centre: The Deep Prevention of Future Pandemics through a One Health Approach: What Role for a Pandemic Instrument?

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?

Capacity building and support for prevention and a One Health approach to PPR, in line with and complementary to the IHR (2005) Annex A to enable Member States to address the areas including those listed below in a manner that remains general enough to be adapted to and implemented according to and inline with national contexts.

1. What prevention and One Health entail (factors that increase the risk of spillover/emergence/pandemics depending on national contexts; key prevention and surveillance outcomes in national plans and what they aim to achieve at the community, national and international levels; key One Health Approach outcomes specifically in relation to Pandemic PPR- at the community, national and international level; key provisions to be implemented progressively for the realization of such outcomes)

2. Forms of coordination that support effective prevention and One Health implementation and what they entail (prevention, multisectoral coordination, coordinated multisectoral surveillance

3. Synergies with other instruments (IHR and MEAs)

4. A compilation of needed means of implementation (financing for the implementation of national plans and for One Health coordination; support and technical assistance for capacity building; trainings and trainings of trainers; partnerships between Member States and/or academic institutions (e.g. joint courses), support with strategy development (e.g. multisectoral workshops), support with review of relevant policies…)

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?

Pandemics are a collective challenge that requires a collective and serious commitment by all member states. With 75% of emerging infectious diseases in humans having animal origin, legally binding provisions tied to preventive measures at the human-animal-environment interface would be key to protecting human health before vulnerable communities suffer and before an outbreak develops into a pandemic.

Legally binding provisions on prevention of emergence of pathogens, their spillover and spillback, addressing the drivers of outbreaks via a One Health approach, etc. go hand in hand with legally binding provisions on means of implementation, supporting member states where needed in achieving the objective of pandemic prevention.

If this is a challenge we cannot afford to fail on, then this balance, of ensuring measures that enable compliance are sufficiently built in, will be an essential ingredient for success. Legally binding provisions will enable more effective monitoring on progress, challenges that need to be addressed to enable compliance, etc.

When the provisions on prevention via a One Health approach are legally binding, this commitment by all member states will offer clarity and certainty on the types of measures that funding bodies and implementing agencies, that are eligible to support member states, must cater to.

Regular reporting on efforts and gaps can inform ways to support compliance.

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?

It is our strongly held view that the key requirements relating to preventing disease emergence and pathogen spillover at source as well as the implementation and operationalisation of One Health, should be incorporated into the legally binding body text of the Pandemic Agreement.

If provisions relating to pandemic prevention and One Health are to be articulated in an additional instrument, they should be included in an Annex to the Pandemic Agreement, to be agreed and ratified alongside the Pandemic Agreement. An Annex would be legally binding and would apply to all member states that sign and ratify the Pandemic Agreement. It would not delay action on prevention and One Health to a later date, pending a future round of negotiations.

While a protocol would also have a legally binding nature, it will delay clarity on the necessary efforts for effective prevention and One Health as well as support for the implementation of such measures to an uncertain moment in the future. A protocol would follow a separate ratification process and may not be ratified by the same or all member states as the Pandemic Agreement.

A guideline would be non-binding and would include information aimed at supporting member states in the implementation of provisions outlined in the Pandemic Agreement and its Annex. Guidelines would for instance cover, trainings of trainers, guidance for partnerships between member states and academic institutions (e.g. joint courses), etc.

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

The Pandemic Agreement and corresponding instrument have the aim of protecting human health. Pandemic prevention via One Health is the most effective path to these ends and is contingent on other sectors and instruments doing their part. The challenge here is that multilateral environmental agreements have other aims (climate change, biodiversity, conservation etc.) and will not yet have built in provisions where the drivers of outbreaks are tackled with the clear purpose of protecting human health.

There is therefore a need to identify which measures those instruments cover that are necessary for pandemic prevention as well as the gaps.

A coordination mechanism or scientific and technical body could be created to

1. map efforts outlined in all relevant instruments and institutions versus necessary science and knowledge informed measures for pandemic prevention

2. identify gaps and provisions that must be undertaken but have not yet been outlined.

3. Refer gaps and recommendations back to member states and the mechanism or body so that decisions are made on how those gaps are to be addressed.

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)?

An Annex, as per Article 4.3.alt, and future guidelines, as per Article 4.3., would offer clarity on the types of measures, outcomes and activities, for which international cooperation, support for implementation and financing must be made available. It would also inform member states when designing their national plans and would give them certainty that the outcomes and activities they need to implement are eligible for support.

When member states agree on detailed provisions in an Annex to the Pandemic Agreement and when the agreement is signed and ratified by an overwhelming majority of member states, that global commitment will send a clear signal to entities that wish to be considered eligible to provide technical and financial support. This signal would inform their priority setting, strategy and the support they will offer.

Regular reporting of the measures that received or did not receive implementation or financial support would be necessary to continuously inform signatories to the Pandemic Agreement on where additional support would be needed in the years that follow, to enable compliance.

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

Upstream prevention and One Health are not part of the scope of the IHR. The scope of the IHR does not include surveillance of the drivers of outbreaks, emergence, (re)emergence, spillover and spillback, early warning of outbreaks of concern in animals, etc. These earlier stages of prevention and surveillance would need to be supported by the Pandemic Agreement, making it complementary to the amended IHR instead of "inline" with the IHR. The amended IHR's provisions on prevention, surveillance and the monitoring and evaluation framework should be clearly referenced within the Pandemic Agreement and corresponding instrument. Measures must be taken to avoid duplication of resources for implementation of the amended IHR and Pandemic Agreement can be avoided.

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?

The question is not how long it would take but rather how long can vulnerable communities afford for this negotiation to take. An instrument on prevention via a One Health approach will help avoid spillover and emergence of pathogens that evolve into a public health emergency of international concern at the earliest possible stages.

The length of the negotiation could be influenced by the nature of the instrument member states decide to proceed with. A detailed guideline or protocol would be negotiated after the Pandemic Agreement is finalized, thereby subject to a deadline beyond the WHA78. A protocol may not be ratified by all member states leading to fragmentation on a global health challenge where success is contingent upon a concerted effort by all member states. An Annex to the agreement can be finalized together with the Pandemic Agreement.

Comprehensive knowledge-based guidance on pandemic prevention and One Health is already available for the consideration of member states and their inclusion in the instrument, meaning the negotiation could be concluded fairly quickly. The contents of the instrument should not be political but rather technical and informed by science and knowledge from practitioners, experts and communities from all regions.

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?

Community engagement under Article 5 will achieve equity before the most vulnerable communities suffer, preventing outbreaks at the earliest stage possible, while protecting their livelihoods. Reference to community engagement in Article 17 is general and does not specify the way they are involved or which stages of PPR they would be involved in. Particular focus must be given to communities, who come into daily contact with animals and who are at the frontlines of disease emergence and pathogen spillover.

When governments develop One Health strategies in consultation with those communities, they ensure the outlined measures are owned by the communities and enable the most vulnerable to protect themselves before an outbreak. This is equity.

Specific language on community engagement in the design and implementation of One Health strategies will mean they are involved in identifying the drivers of outbreaks and supported in tackling them via measures they can actually implement. In some cases, communities may rely on high-risk activities to secure their livelihoods. A sole focus on legislative measures including bans of high-risk activities without consulting and working with communities to identify alternative sources of livelihood would be detrimental to their survival. In addition to identifying the drivers of outbreaks, communities will also play an important role in surveillance and developing preventive interventions that are workable in their specific circumstances.