28 April 2022

European Union contribution to the identification of the substantive elements for a convention, agreement or other international instrument on pandemic prevention, preparedness and response

1. Multilateral cooperation and governance are essential to prevent, prepare for, and respond to pandemics that by definition know no borders and require collective action. The international community needs to be better prepared to avert and rapidly, coherently and effectively tackle future pandemics. In this context, international law can play an important role in improving prevention of, preparedness for, and response (PPR) to future pandemics and combatting serious cross-border threats to health at national, regional and international level.

2. The COVID-19 pandemic has laid bare several governance weaknesses and inequities in the global health architecture, as well as in national, regional and international responses. These need to be overcome. The International Health Regulations (2005) (hereafter IHR) have provided a foundation for joint action throughout the pandemic, and will continue to function as an important cornerstone of the international pandemic PPR system.

3. Setting stronger objectives for cooperation, common rules and obligations for States, as well as regional and international institutions is essential, but it is not a comprehensive solution if done in isolation. If undertaken alongside efforts to strengthen health systems (including infection prevention and control measures, primary and community health services and progress in universal health coverage) and crisis management at domestic level, and if pursued with the aim of strengthening and complementing the IHR, a pandemic agreement (hereinafter PA)[1] will lead to a more robust and

[1] At this stage of the reflection, the designation PA refers to an "international agreement" within the meaning of Article 2.1(a) of the Vienna Convention on the Law of Treaties (VCLT) and Article 19 of the WHO Constitution. This is without prejudice to the name that the agreement's signatories may ultimately chose.

effective PPR framework. While voluntary cooperation and strong political engagement are essential, setting legally-binding obligations and compliance incentives and mechanisms is a crucial component of an effective multilateral cooperative response, with a central leadership role for the World Health Organization (WHO).

4. The Intergovernmental Negotiating Body under the able stewardship of its Bureau is capable of moving discussions forward in an effective manner. In line with doc. A/INB/1/5, we intend to contribute to the identification of substantive elements for a convention, agreement or other international instrument on pandemic prevention, preparedness and response. *This paper should not be regarded as the EU negotiation position.* Additional contributions may also be sent at a later stage. All contributions are without prejudice to more specific proposals to be presented during the negotiations.

5. The PA is intended to be a binding agreement under international law. However, the agreement's negotiating Parties should also be able to deploy the cooperation tools that are best suited to achieve the desired results in any particular area. Typically, binding international agreements also include hortatory provisions and other commitments. Similarly, the PA should include compulsory provisions. However, it should also - where negotiating Parties find it preferable - set out voluntary standards accompanied by compliance incentives, "best efforts" commitments backed by a general good faith obligation, as well as "political" commitments subject to reputational considerations. The PA design should therefore be dynamic and encompass both compulsory and voluntary provisions (such as guidelines, standards, statements of best practice and declarations), with the specific choice to be made by the negotiating Parties in order to devise the most effective solution for each individual issue under negotiation.

6. In addition, in keeping with the PA's aspiration to be a universal instrument, a flexible, open and inclusive participation model should be adopted to allow for the largest number of Parties to sign on and start implementing the agreement's provisions in a timely and effective manner, without creating barriers for countries' acceptance of the PA at a later stage. All States and regional (economic) organisations[2] should thus be able to become Parties to the PA and/or any of the possible future specialised Protocols that may be negotiated under its umbrella.

[2] More specifically regional economic integration organisations to which their respective Member States have transferred competences over matters related to the provisions of the agreement.

7. All States should be allowed to participate as observers even if they are not Parties of the PA or any of its Protocols. Openness to experts' and non-governmental stakeholders' participation and contribution, both during the negotiation and implementation of the agreement, should also be a hallmark of the PA initiative. Transitional periods for implementation and related implementation support should also be considered, with particular attention to the needs of low and lower middle income countries.

8. The PA **object and purpose** should be to set out **substantive obligations** for the Parties and other related provisions aimed at three main, interrelated **objectives**:

1. Preventing and controlling,
2. Detecting and reporting, and
3. Preparing for, and responding to, public health threats with pandemic potential (adopting a whole-of-a-society approach).[3]

9. The definition of "public health threats with pandemic potential" will be important to establish the **scope of the agreement**.[4] Similarly, it will be important to set out **definitions** of other key terms, while relying on definitions established or supported by the international organisations, such as the new definition of "One Health" developed by the One Health High Level Expert Panel (OHHLEP).

10. The substantive obligations should be framed by a series of **general goals** and **overarching principles**, in particular:

- the human right to health, including universal health care access and the links between health (both physical and mental health) and human rights (comprising sexual and reproductive health and rights (as per the European Consensus on Development), as well as a gender-responsive approach to health, among other elements)[5],

[3] Under each of these objectives many different obligations, commitments and other cooperative initiatives can be pursued. Many of these are outlined below in a non-exhaustive fashion.

[4] In particular, there should be clarity on the relationship of the PA with existing instruments, in particular the IHR in line with the relevant provisions of the VCLT.

[5] The EU remains committed to the promotion, protection and fulfilment of all human rights and to the full and effective implementation of the Beijing Platform for Action and the Programme of Action of the International Conference on Population and Development (ICPD) and the outcomes of their review conferences and remains committed to sexual and reproductive health and rights (SRHR), in this context.

- international solidarity and equity, with respect inter alia to equitable access to medical and non-medical countermeasures, financing and capacity strengthening,
- the centrality of WHO, as the lead and coordinating authority in international health cooperation, and more generally the role of multilateral cooperation in the global health governance,
- the "One Health" approach, including the need to address the close links between human, animal and environmental health,
- the crosscutting effects of pandemics beyond health, including socio-economic impacts (affecting for instance employment, trade, transport, gender inequality, education and culture) requiring an intersectoral "whole-of-society" approach to pandemic PPR.

11. These principles could be set out in the **preamble** and/or the introductory part of the PA, and most importantly should permeate the substantive provisions of the agreement.

12. In particular, the principle of "**equity**" will entail setting out, inter alia, provisions aimed at ensuring the timely availability and affordability of countermeasures, the support for regionally-based manufacturing facilities, the enhancement and diffusion of scientific knowledge and research relating to the causes and impacts of epidemics, the sharing of burdens and benefits of the cooperation efforts set out in the agreement, as well as the provision of requisite implementation support and capacity building, especially for the low and lower middle income countries. It will also require adopting disability-sensitive and gender-responsive approaches and addressing the needs of vulnerable groups.

13. The PA will also need to include **horizontal provisions**[6] setting out:

4. The institutional framework,
5. Rules on possible future rule-making and other procedural provisions,
6. Monitoring, compliance and accountability provisions, and
7. Implementation support, technical assistance and capacity building.

For further elaboration see New European Consensus on Development, 2017, paragraph 34, available at: European Consensus on Development | International Partnerships (europa.eu)).

[6] The PA will also need to include several other procedural provisions related to amendments, signature, ratification, entry into force, among others.

1. Preventing and controlling public health threats with pandemic potential

This objective requires new or enhanced provisions, inter alia, aimed at:

a) Enhancing the global early warning capacity, through:

14. An early warning and alert system for modelling and forecasting, based on the collection and harnessing of information from multi-sectoral sources. These should include those focused on environmental, climate, human and animal health data, aimed at assessing and predicting the occurrence of public health threats with pandemic potential, and allowing the early activation of emergency measures.

15. Establishing harmonised modalities for the sharing of relevant data and information collected at national and regional level, as well as for cooperation in the improvement of the quality of data and analytical capacities.

b) Preventing and controlling zoonotic spill-overs through:

16. Enhancing and harmonising surveillance and notification systems at the wildlife-livestock-human interface (in line with the One Health approach) and enabling the timely flow of information through interoperable surveillance and risk assessment systems between human health, animal health and environmental authorities at local, regional and international levels (including by supporting the WHO Hub for Pandemic and Epidemic Intelligence). The PA provisions should be complementary to existing IHR and World Organisation of Animal Health (OIE) provisions.

17. Regulation of wild and live domestic animal markets and stricter surveillance and control of illicit wildlife traffic and wet markets, both domestically and internationally.

18. Pathogen surveillance and identification of emerging and re-emerging pathogens with a high zoonotic infection potential (including through the early warning and alert system described in section a) above and the improvement and interconnection of databases) in livestock, companion animals and high-risk wildlife populations and vectors. This should build on the work of the Scientific Advisory Group for the Origins of Novel Pathogens (SAGO), while

mindful of remaining consistent and avoiding duplications with the OIE mandate.

19. Systematic exchange of information and data on pathogens, variants and genetic sequencing at the animal-human interface with standardized and harmonized data.

20. Universally accessible sample collection capacities (repositories) and equitable pathogen sample sharing, also by connecting and standardizing existing sharing platforms, while respecting biosecurity and biosafety requirements.

21. Developing protocols and recommendations for voluntary sharing of scientific findings, surveillance and diagnostic data, research results and samples, including through the contributions of the WHO Hub for Pandemic and Epidemic Intelligence.

22. Increasing knowledge and capacity to prevent and address risks from zoonoses and other public health threats at the human-animal-ecosystem interface, notably due to the loss of natural habitats and decreasing biodiversity or other factors, in line with the "One Health" approach and taking into account the work of the OHHLEP.

23. Promoting environmental protection actions aimed at significantly reducing the risk of zoonotic spill-overs.

24. Enhancing joint trainings between, and continuing education of, human and animal health professionals and the inclusion of the One Health approach in health studies.

c) Preventing inadvertent laboratory release of pathogens through:

25. Elaborating and implementing biosafety regulations to control access to highly dangerous pathogens (including by considering promoting the global database registration of highly dangerous microorganisms used in research laboratories) and prevent their inadvertent laboratory release and providing inspection and training.

26. Enhancing the independent oversight of laboratory conditions and safety protocols to ensure biosecurity and biosafety.

d) Preventing epidemics due to pathogens resistant to antimicrobial agents through a One Health approach including:

27. Enhancing the provisions on surveillance and reporting of antimicrobial use (AMU) and antimicrobial resistance (AMR) in human, plant/crops and livestock populations, mindful of the need to strengthen data-sharing platforms, streamline processes and avoid duplication.

28. Strengthening the knowledge and evidence base through surveillance and research in both human and animal populations and plants.

29. Together with One Health/Quadripartite (WHO, Food and Agriculture Organization (FAO), OIE and United Nations Environment Programme (UNEP)), setting global AMR targets, *inter alia* on reductions in current levels of resistance, on the use of antimicrobials in human, animal and plant health, on infection prevention and control measures, as well as related indicators on the release of antimicrobials in the environment.

30. Requiring the establishment and effective implementation of One-Health National Action Plans, in line with the WHO Global AMR Action Plan, and the recommendations of the Interagency Coordination Group on Antimicrobial Resistance, as well as the future independent panel on evidence for action against AMR.

31. Committing to reduce the unnecessary use of antimicrobials globally by applying antibiotic stewardship practices (e.g. no antibiotic without prescription, increased use of diagnostic tests prior to antibiotic prescription when relevant, phasing out of the use of antimicrobials for growth promotion in animals, restriction in the prophylactic use in animal husbandry).

32. Promoting the development and availability of preventative, diagnostic and therapeutic medical countermeasures relevant to combat AMR, notably old and new antimicrobials and rapid diagnostic tests for human and animal use.

33. Committing to provide a specific support to low and middle income countries, where the burden of AMR is disproportionately higher.

e) Capacity building

34. Review the capacities and needs for preparedness and response at local, national and regional levels.

35. Establish a framework for the provision of PPR capacity building to relevant personnel of PA Parties in need under the guidance of the WHO (including the WHO Academy in Lyon and other capacity networks with wide geographical reach).

36. Consider the establishment of coordinated plans and multidisciplinary training tools for health professionals (including shared protocols on common skills, use of distance-learning, periodic coordinated exercises and the development of equivalent job profiles).

2. Detecting and reporting public health threats with pandemic potential

This objective requires new or enhanced provisions, inter alia, aimed at:

37. Complementing the IHR by strengthening the obligations of PA Parties to identify and report health threats with pandemic potential and share data and information on such threats, as well as sequences and pathogen materials. This should be done with a view to facilitating the rapid development, availability of and access to medical and non-medical countermeasures.

38. Providing, in addition to obligations, strong positive incentives to report health threats and share data, to avoid the risk of countries withholding information due to concerns that doing so might produce negative responses from other countries (such as travel and trade restrictions).

39. Enhancing human, animal and environmental health threats detection capacities and cooperation among PA Parties also by resorting to the interconnection of digital tools.

40. Taking the One Health approach as well as the IHR into account, consider enlarging the mandate of WHO, FAO, OIE and other relevant organisations to investigate rapidly, in a coordinated manner and in close cooperation with national authorities concerned, events and outbreaks which may pose public

health threats with pandemic potential (including the authority to verify State reports, disseminate outbreak data, conduct in-country assessment and share available scientific data) and commit to swift information sharing.

3. Preparing for, and responding to, public health threats with pandemic potential

41. This objective requires new or enhanced provisions, inter alia, aimed at:

a) enhancing medical and non-medical tools needed to respond to outbreaks that risk developing into pandemics, while ensuring equitable access to such tools;
b) coordinating emergency responses;
c) strengthening capacity and resilience of national health systems for a) and b), as well as to mitigate disruption and ensure continuity of healthcare, especially for the most vulnerable;
d) addressing misinformation and disinformation.

a) Enhancing preparedness and response tools

42. Provide WHO, FAO, UNEP and OIE with the necessary resources (including by supporting regional and national centres of expertise within a network of Pandemic Readiness) to field health emergency teams (and related resources). These could be deployed rapidly at national and regional level to identify and respond to health emergencies and support States Parties as soon as information of high-risk events becomes known to the WHO or the OIE.

43. Encourage the coordination of and support for research, development and innovation, including at regional level, related to diagnostic, therapeutic and preventative medical and non-medical countermeasures with the objective of accelerating their development and production.

44. Support the development and strengthening of genomic sequencing capacities at national and regional level, with particular attention to low and lower middle income countries.

45. Develop protocols and recommendations for non-pharmaceutical, non-medical interventions.

46. Consider setting up a dedicated multi-stakeholder platform to facilitate research as well as demand-driven, emergency procurement and delivery of vaccines, diagnostics, therapeutics and other essential supplies , building upon the experience and lessons learned of the "Access to COVID-19 Tools Accelerator" (ACT-A) and other relevant WHO initiatives.

47. Develop mutual recognition and/or equivalence protocols for emergency use and transport of vaccines, diagnostics, therapeutics and other essential medical products, while taking into account the requirements for quality, safety and efficacy of such products.

48. Enhance the availability, accessibility and affordability of medical and non-medical countermeasures, including through:

- Considering international stockpiling of relevant healthcare materials for emergency and humanitarian use.

- Providing incentives to increase national and regional manufacturing capacity for vaccines, therapeutics and diagnostics and other essential medical products, as well as personal protective equipment[7] on the basis of the identification of geographical gaps in the ability to deliver the above (e.g. manufacturing, distribution capacity).

- Facilitating technology diffusion and encouraging voluntary participation in technology sharing platforms building on the experience of the WHO COVID-19 Technology Access Pool (C-TAP) and other relevant initiatives.

49. Strengthen the ongoing coordination and cooperation between WHO and other relevant organizations, such as the World Trade Organization (WTO), World Customs Organization (WCO) and World Intellectual Property Organization (WIPO), with each organisation contributing to prevent, prepare for and respond to pandemics by promoting - within their respective mandates and while avoiding duplication of initiatives - the reduction of trade barriers and restrictions, and the facilitation of trade in critical products during pandemics.

[7] An important problem to also consider is the pollution that may result from emissions and waste deriving from the increased production of protective equipment.

50. Establish a harmonised and secure system for the issuance, verification and acceptance of digital certificates for vaccination, test and recovery, as well as for contact tracing activities (e.g. the electronic passenger locator form), to facilitate travel of persons during a pandemic, while guaranteeing strong protection for personal data (the EU Digital Covid Certificates may provide some inspiration for such a system, given its widespread use). This objective should be pursued consistently with the possible inclusion of digital tools within the IHR.

b) Coordinating emergency response measures

51. Mindful of the legal framework set out in the IHR related, inter alia, to travel and transport restrictions, quarantine, border controls, consider enhancing coherence and coordination of containment measures at international and regional level, while taking into account that control measures need to be appropriate to the country-specific pandemic situation. Such enhanced coordination, including specific provisions for essential workers, especially health professionals and transport workers,[8] should also aim at maintaining the integrity of supply chains and ensuring supplies of essential goods, such as food and medical products.

52. Increase inter-sectoral coordination and engagement to ensure that all health components, particularly mental health and socio-economic well-being, are considered when adopting response measures.

53. Reinforce WHO's mandate for coordination of emergency response and better equip WHO to discharge this role within the territories of the PA Parties, including through enhanced cooperation with other relevant UN agencies, such as the UN Office for the Coordination of Humanitarian Affairs (OCHA), the United Nations Development Programme (UNDP), the International Labour Organization (ILO), the International Maritime Organization (IMO) and the International Civil Aviation Organization (ICAO), regional organisations and their specialised bodies, and other international health organisations, such as the Global Fund, GAVI, the Joint United Nations Programme on HIV and AIDS (UNAIDS) and Unitaid.

[8] Including seafarers.

54. Pay special consideration to humanitarian and fragile contexts, including conflict zones, and improve coordination at regional level.

c) Strengthening of national health systems in order to mitigate disruption, ensure continuity of healthcare, especially for the most vulnerable, and advance Universal Health Coverage

55. Commit to supporting strong, resilient and inclusive health systems that are foundational for effective and efficient PPR systems, through strengthening primary and community health care systems, health care worker capacities and universal health coverage measures, and with the objective of enhancing the protection of the most vulnerable populations especially in low and lower middle income countries.

56. Commit to promoting innovative approaches for continued prevention, care, and management of acute and chronic health issues, including non-communicable diseases and mental health conditions, during health emergencies and with particular attention to vulnerable and/or marginalised groups in society, especially in low and lower middle income countries.

d) Addressing misinformation and disinformation

57. Commit to exchanging information and promoting good practices to increase the accuracy and reliability of crisis communication, based on robust and independent evaluation of public health risks. This should be done with a view to providing the public, public health decision makers and health care professionals with accurate, transparent and evidence-based information.

58. Encourage meaningful and inclusive dialogue with civil society, frontline workers, vulnerable groups and other relevant stakeholders, to promote community involvement and engagement. This should incentivise and sustain positive behaviours and health practices aimed at reducing the impact of health emergencies and the spread of pathogens, leveraging community structures as appropriate.

59. Commit to increasing health education and health literacy for pandemic preparedness and response, with a view to increasing the population

understanding and correct use of the information provided and the effectiveness of risk communication in public health.

60. Develop effective tools to promptly identify and counteract misinformation and disinformation.

4. Institutional aspects

61. Consideration should be given to establish a Conference of the Parties (COP) as the PA's governing body. In this perspective all States and relevant international and regional organisations should be allowed to participate in the COP as observers, even if not Parties to the PA, with a view to promoting their eventual accession to the PA. The COP should also serve as the Meeting of the Parties (MOP) to any of the Protocols which may be agreed under its umbrella. Similarly, all States should be allowed to participate as observers in the MOP of any specific Protocol. The COP and the MOPs should oversee and take decisions to promote the effective implementation of the respective instruments. The participation and input of non-state actors (e.g. NGOs, academia, private sector entities) should be allowed and encouraged, especially with a view to informing, promoting and facilitating the implementation of the PA.

62. The WHO should provide Secretariat support to the PA and its possible Protocols (different arrangements involving joint secretariat functions bringing together different international organisations could be envisaged in specific policy areas, especially when linked to One Health). Secretariat arrangements should be decided by the time of the adoption of the PA by the WHA to facilitate an early start of the implementation phase. Appropriate assessed financial means should be made available to cover Secretariat costs.

63. The actions related to preventing and dealing with pandemic threats go beyond the WHO's remit and require strengthened coherence and cooperation across multiple policy areas and institutions. In particular, the PA should seek the establishment of close cooperation with relevant UN bodies, secretariats and other international and regional institutions, which have an essential role in PPR, including, *but not limited to*:

- FAO, Codex Alimentarius and the OIE as regards the risk of zoonoses and AMR, as well as the OIE for a focus on animal welfare and health;

- The Office of the High Commissioner for Human Rights OHCHR, for the protection of human rights during pandemic response;
- UNAIDS in light of their experience in coordinating a multi-sectoral response on HIV, involving community approaches;
- UNDP for mitigating the socio-economic impacts of pandemics;
- UNEP for human interaction with wildlife habitats;
- United Nations Educational, Scientific and Cultural Organization (UNESCO) for the education role in pandemic prevention;
- United Nations Population Fund (UNFPA) for its role in supporting health system with a focus on the most vulnerable groups;
- United Nations High Commissioner for Refugees (UNHCR) and the International Organization for Migration (IOM) for their focus on humanitarian and emergency situations;
- United Nations Children's Fund (UNICEF) in light of its experience in delivering vaccines;
- International Civil Aviation Organization (ICAO), IMO, International Air Transport Association (IATA) and ILO for transport and labour;
- WTO and WCO for trade and customs-related aspects;
- WIPO for matters regarding intellectual property;
- the UN Framework Convention on Climate Change/Intergovernmental Panel on Climate Change for climate induced diseases;
- environmental treaties, such as the Convention on International Trade in Endangered Species of Wild Fauna and Flora (CITES) and the Convention on Biological Diversity (CBD) and the Nagoya Protocol, which have a vital role in reducing the risk of zoonosis;
- the International Atomic Energy Agency (IAEA) to promote the use of nuclear techniques in investigating, detecting, preventing, and containing outbreaks of zoonotic diseases;
- as well as the various international non-governmental health organisations, such as the International Federation of Red Cross and Red Crescent Societies (IFRC) and the International Committee of the Red Cross (ICRC) , GAVI and the Global Fund to fight against AIDS, TB and Malaria (GFATM) for their experience in procurement, funding and working with communities in humanitarian and emergency situations.

64. The PA may provide an opportunity to consider enhancing, when necessary and appropriate, the mandates of several expert and advisory bodies, such as the “One Health High-Level Expert Panel” and SAGO, and establish institutional links with them. The PA should establish new bodies only where a clear need exists and no duplication is created.

5. Future rule-making

65. The PA should aim at laying down substantive provisions and commitments especially in the key areas indicated above, while also charting the course for future negotiations, including by means of supplementary protocols in areas which would likely require a preparation and negotiation period to achieve agreement beyond the 2024 deadline set for the PA. These could be open to the participation of States that may not be party to the PA. While negotiated under the umbrella of the PA, each Protocol should be concluded as a self-standing international agreement. Each Protocol may incorporate by reference provisions of the PA to be applicable to Protocol Parties.

66. The PA should set out provisions facilitating the negotiation of specialised Protocols, including in terms of Secretariat assistance. Protocols may also be negotiated with the support of sector specific international organisations.

67. In keeping with the dynamic and flexible nature of the PA design, the PA Parties (or some among them) may decide to address additional issues through the setting out of non-binding instruments, such as guidelines, standards and indicators.

6. Monitoring, compliance and accountability

68. Monitoring and accountability mechanisms have a key role to play in promoting implementation and compliance of PA's provisions. These mechanisms should allow for an integrated approach across the PA and the IHR, while preventing duplications and inconsistencies.

Possible elements to be considered include:

69. Establishing national and regional focal points on PPR to cover PA commitments (e.g. building on role of the national focal points for the IHR).

70. Setting up permanent national (and, where possible, regional) multi-sectoral pandemic preparedness and response committees, comprising the IHR National Focal Point, and representatives from animal health, environmental health, civil protection, and other relevant public bodies.

71. Establishing a periodic peer review, or using, when appropriate, the tools under discussion and development, such as the Universal Health and Preparedness Review (UHPR),[9] based on independent evaluation (and related country visit) of PA Parties' compliance with relevant international obligations and other commitments[10], aimed at:

a. assessing pandemic PPR capacities, implementation gaps and remediation needs (making use of specific, measurable, achievable, relevant and time-bound indicators),

b. recommending improvement pathways based on objective and verifiable benchmarks, indicators and best practice[11], and

c. backed by assistance and capacity building support.

72. In this context also consider the possible need and advantages of establishing a dedicated external expert body. This could be comprised of independent experts, with diversified geographical origin, expertise and gender composition, to which national and regional authorities would report regulatory actions and policy improvements (for the purpose of transparency as well as advice and technical guidance, if needed) and mandated to carry out country visits in the context of the periodic peer review.

73. Care should be taken to ensure that the participation in monitoring, compliance and accountability mechanisms is accompanied by appropriate support, especially for low and lower middle income countries, to assist them in these processes.

[9] Devising an effective periodic peer review should build upon existing work, data and indicators from already available sources, such as the IHR Monitoring and Evaluation Framework, the State Party Self-Assessment Annual Reports (SPAR), the Joint External Evaluation (JEE), as well as the pilot UHPR. Consideration should be given to ensuring synergies between the PA monitoring mechanism and any similar initiative pursued in the context of possible amendments to the IHR. In accordance with resolution WHA74.7, consultations on the concept note on the UHPR are currently underway. This process will need to be taken into consideration when developing the monitoring mechanism of the PA.

[10] This should include international obligations binding on the PA Parties, as well as other commitments against which the PA Parties would agree to be reviewed (examples could be the AMR Global Action Plan and the One-Health National Action Plans).

[11] Benchmarks, indicators and best practice statements should be prepared by WHO and other relevant organisations, with the support of non-governmental stakeholders.

74. As noted, the PA will include both compulsory and, most likely, also voluntary provisions. As a result, not all provisions of the agreement will be enforceable and preference should be given to incentivise voluntary compliance. Conciliation and mediation mechanisms alongside dispute settlement should be provided for.

7. Provision of implementation support

75. An ambitious PA design requires significant investment in implementation support. This should be linked to gaps identified through the above-mentioned monitoring and accountability mechanism, and integrate both IHR and PA implementation support, including through:

76. Strengthening WHO's mandate and ability to support national and regional core health system capacities for pandemic prevention, detection, preparedness and response, as well as its coordination role at global level.

77. Strengthening country commitment and ownership, as well as "whole of government"/cross-sectoral preparedness approaches leading to better mobilisation of all competencies and resources, and coherence in pandemic prevention and response at global, regional, national and community/local levels.

78. Committing to support, technical assistance and capacity building for low and lower middle income countries[12] aimed at:

- the effective implementation of PA and related IHR commitments,
- the improvement of national and regional mechanisms for pandemic prevention, detection, preparedness, and response (including inter-agency and inter-sectoral coordination mechanisms),
- the strengthening of health systems in the area of pandemic prevention, preparedness and response, including by:

    a) increasing health and social services workforce capabilities (for continuity of essential health services during public health emergencies, and for integrated interdisciplinary surveillance to

[12] As defined by the World Bank.

prevent, detect and respond to public health threats with pandemic potential),

b) developing and deploying digital health and social care tools and infrastructure, as well as
c) improving technical and structural capacity to detect and contain public health threats (e.g. diagnostic equipment, personal protective equipment, isolation facilities and general water, sanitation and hygiene (WASH) infrastructure in health facilities).

79. Considering specific assistance initiatives for upper middle-income countries in need.

80. Seeking to build a (non-binding) cooperative framework across major donors (e.g. international financial institutions and multilateral development banks, bilateral donors, philanthropies) and the private sector. Consider how best to support implementation-related capacity building, as well as both long-term (e.g. local and regional research, development and production of medical and non-medical countermeasures) and emergency interventions for pandemic PPR.[13] This work should align closely with other global health architecture reforms initiatives, including with a view to sustainably financing the WHO.

81. Determining the provisions that low and lower middle income countries can implement after one or more transition periods stipulated in the PA and requiring the prior acquisition of implementation capabilities through the provision of technical assistance and capacity building.

[13] This may provide an opportunity to streamline the participation of PA parties in existing mechanisms aimed to finance and implement PPR, such as the WHO's Contingency Funds for Emergencies and relevant public/private initiatives such as CEPI, GAVI Alliance, etc.