World Health Organization

FIRST MEETING OF THE INTERGOVERNMENTAL NEGOTIATING BODY TO DRAFT AND NEGOTIATE A WHO CONVENTION, AGREEMENT OR OTHER INTERNATIONAL INSTRUMENT ON PANDEMIC PREVENTION, PREPAREDNESS AND RESPONSE
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Outcomes of the first round of public hearings

Report by the Secretariat

BACKGROUND

1. In December 2021, through decision SSA2(5) (2021), the World Health Assembly at its Second special session established an intergovernmental negotiating body (INB) to draft and negotiate a convention, agreement or other international instrument on pandemic prevention, preparedness and response, with a view to adoption under Article 19, or under other provisions of the WHO Constitution as may be deemed appropriate by the INB. In that decision, the World Health Assembly requested the Director-General to support the work of the INB, inter alia, by holding public hearings, in line with standard WHO practice, prior to the second meeting of the INB to inform its deliberations.

2. To encourage participation in the public hearings, the Secretariat used various channels of communication to raise the awareness of stakeholders and the general public about the process. The WHO Constitution provides that informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people. The aim of the public hearings is to advance this critical principle. In recognition of that fact, the Secretariat decided to open the written component of the public hearings to the general public (see paragraphs 25 and 26). The Secretariat is not aware of any other United Nations entity conducting this style of broad public outreach.

3. The first round of public hearings was held over four sessions on 12–13 April 2022. The hearings were comprised of two components: (i) a verbal component held via a virtual platform and supported by interpretation in all WHO official languages; and (ii) a written component, via a dedicated web portal.

4. The Secretariat designed a dedicated webpage for the public hearings [1] where detailed information about the sessions was uploaded, including the terms of participation. This report and all submissions received will also be made available on that webpage.

[1] See https://inb.who.int/ (accessed 26 May 2022)

5. The public hearings were opened by the Director-General and a co-chair of the INB and were moderated by a panel of senior WHO staff, including the Executive Director for External Relations and Governance, the Assistant Director-General for Emergency Preparedness and International Health Regulations, and the Principal Legal Officer for International, Constitutional, and Global Health Law. The guiding question for these sessions focused on: "What substantive elements do you think should be included in a new international instrument on pandemic preparedness and response?".

6. This report summarizes the outcomes of the first round of the public hearings and includes a summary of the verbal and written components.

Verbal contributions to the first round of public hearings

7. There were 123 verbal submissions during the four sessions of the public hearings. The sessions were webcast to ensure full transparency in the process, the recordings of which were immediately made accessible on WHO's website following the close of each session.[1] Contributions were provided by representatives of 119[2] organizations, covering all regions of the world.

8. On the first day, 78 speakers took the floor including representatives from 32 civil society organizations, 11 international organizations, 6 private sector organizations, 15 academic or research bodies, and 14 scientific, medical and public policy institutions. On the second day, 45 speakers took the floor, including representatives from 15 civil society organizations, 6 international organizations, 7 private sector organizations, 2 philanthropic organizations, 10 academic or research bodies, and 5 scientific, medical and public policy institutions.

9. Many of the speakers reflected on their experiences during the coronavirus disease (COVID-19) pandemic, which served to support their recommendations for the substantive elements required for a new international instrument on pandemic prevention, preparedness and response.

Summary of key messages from the verbal contributions to the first round of public hearings

10. Over the course of the four sessions, participants raised many points and recommendations regarding the possible substantive elements of a new international instrument on pandemic prevention, preparedness and response, including those summarized below.

11. Several speakers addressed the **scope of a new international instrument**, stressing that it should cover global diseases and threats such as antimicrobial resistance, HIV, malaria and tuberculosis, and that it should be linked with the global response to noncommunicable diseases. Incorporating the lessons learned from outbreaks and pandemics including COVID-19, Ebola virus disease, HIV and tuberculosis, was also recommended.

12. Several participants indicated that consideration should be given to the potential international instrument's relationship with other agreements, including by ensuring consistency with the process to strengthen the International Health Regulations (2005), as well as the Sustainable Development Goals, the Convention on Biological Diversity, the Pandemic Influenza Preparedness Framework for the

[1] All submissions are accessible via WHO's webpage for the public hearings (https://inb.who.int/ accessed 26 May 2022).

[2] Some organizations took the floor twice with different speakers.

sharing of influenza viruses and access to vaccines and other benefits, applicable human rights conventions, and other relevant international agreements and instruments.

13. Several speakers stressed that the potential international instrument should include a focus on strengthening universal health coverage to ensure resilient health systems during a pandemic. Having the ability to maintain essential health services during a pandemic, including mental and social health care, was seen as a key substantive element of any pandemic instrument. A number of participants also noted the importance of promoting community readiness, resilience and engagement through the inclusion of community health workers. Strengthening the health care workforce at the community, national and international levels, including in terms of the numbers of non-clinical, nursing and palliative care workers and specialists, was also suggested.

14. Participants put forward a variety of technical components of pandemic preparedness and response that should be included as possible substantive elements of a new international instrument. Those included: improvements in early warning systems, risk assessment and rapid response; intelligence and information sharing; addressing infodemics and public information using adequate risk communication mechanisms; enhancing regulatory mechanisms for medical countermeasures; and strengthening laboratory and diagnostic networks. Several speakers underscored the importance of devising evidence-based guidelines and policies for public health and social measures during a pandemic, with the relevant supporting information being made publicly available.

15. Many speakers presented the view that the instrument should include a section that focused on prevention, particularly prevention mechanisms at the human-animal interface to prevent pathogen spillover to humans. One speaker emphasized that a One Health approach should be incorporated into the potential international instrument, including measures to stop animal and wildlife trade and address environmental, climate and biodiversity issues. Many participants also advocated for the involvement of relevant animal and environmental health representatives in both the development and implementation of the international instrument.

16. With respect to financing, many speakers noted that a global pandemic fund and predetermined sustainable financing mechanisms for pandemic response should form substantive elements of the potential international instrument. Some speakers also advocated for increasing national financing for pandemic preparedness and response and strengthening national financing, oversight and accountability of those finance mechanisms. Ensuring sustainable funding for WHO was similarly suggested.

17. Many participants singled out equity as a primary focus and a required substantive element of a new international instrument. Ensuring equity would require upholding human rights and guaranteeing the non-discriminatory scope, implementation and governance of the potential instrument.

18. Many speakers suggested that mechanisms to ensure equitable and timely access to pandemic products, logistics and supply chain capabilities, including diagnostics, vaccines, personal protective equipment and other countermeasures – in particular to low- and middle-income countries, should form a vital component of any new international instrument on pandemic prevention, preparedness and response.

19. Access to scientific and technical expertise, as well as cooperation and collaboration in research and development, were also considered important substantive elements of a new international instrument. That included: the sharing of pathogens and genomic sequences, with appropriate access and benefit-sharing mechanisms; the potential waiving of intellectual property rights for pandemic products; and the fast-tracking of ethics processes for scientific and clinical studies. Bolstering national

and regional manufacturing capacity, particularly in low- and middle-income countries, was also mentioned.

20. Equity considerations also touched on the importance of an inclusive development process for the instrument, with many speakers indicating that the process should be open to representatives of all stakeholders, including those present at the public hearings. Such equitable representation and participation should extend to stakeholder representation in international networks and on technical advisory boards of the potential instrument. Equitable representation of low- and middle-income countries, civil society, health care workers, private organizations, and community health workers, including by gender and socioeconomic status, was also proposed.

21. In terms of governance, participants considered that multisectoral representation and a whole-of-society approach would be essential both for developing and implementing the instrument, with representation from civil society and the private sector in the governance process and consistent community engagement required. There was consensus that the knowledge gained in setting up global pandemic response mechanisms during the COVID-19 pandemic, including COVAX, the vaccines pillar of the Access to COVID-19 Tools (ACT) Accelerator, and the ACT-Accelerator, could be used to develop the global architecture necessary for health emergencies.

22. There were different views expressed in terms of the overall future governance mechanism of a new international instrument. Some participants advocated for the instrument to be non-binding and advisory in nature and for individual countries to be able to implement their own policies in order to respect national sovereignty. Other speakers stressed that nationalism should be prevented, with steps taken to monitor and enforce national compliance to the international instrument. A small number of speakers suggested that an international instrument on pandemic preparedness and response was not needed at all.

23. There were differing views expressed on the role of WHO in the potential new international instrument, ranging from WHO playing an advisory role only to WHO serving as the implementing and regulatory body. One participant suggested that the governance of the potential instrument should be elevated to a higher level within the United Nations system, in recognition of the fact that a pandemic response was larger than the health sector.

24. Numerous speakers considered transparency and accountability as substantive elements of an international instrument on pandemic prevention, preparedness and response and proposed that the new international instrument should incorporate monitoring and evaluation at the global and national levels, with many speakers stating that any evaluation should be conducted independently from WHO with stronger accountability mechanisms for non-compliance. It was suggested that existing monitoring and evaluation frameworks could be adapted for that purpose. Speakers also called for transparency in the development and the different facets of the potential new international instrument, including with regard to: reporting of data; identification of donors and contributors; sharing of pathogens; promotion of research and development; and use of intelligence and evidence to inform decisions. One speaker was of the view that conflict of interest statements from all stakeholders involved in the pandemic response, particularly those that received global funding, should also be made publicly available.

Written contributions to the first round of public hearings

25. There were 36 294 written submissions made via the dedicated online portal on the WHO website during the public hearings.[1] Of those received, only submissions that conformed to the guidelines for written submissions were retained. In due course, those written submissions will be uploaded and archived on the WHO public hearings webpage.

26. A large number of the written submissions reflected on respective COVID-19 experiences, from which recommendations were drawn in relation to the components and scope of a new international instrument on pandemic prevention, preparedness and response, as well as on the role to be played by WHO in such circumstances.

Summary of key messages from the written contributions to the first round of public hearings

27. There were differences in opinions as to whether a new international instrument on pandemic prevention, preparedness and response was required, and if so, its scope and nature. The majority of written contributions proposed that no international instrument should be established. Other contributions suggested that the instrument should be legally binding in nature subject to a review-based time limit on the agreement with the possibility to opt out at that point. Conversely, there were also suggestions that the instrument should offer recommendations and guidelines to be followed by parties to the instrument.

28. A number of submissions referred to respect for national autonomy and sovereignty, noting that subnational and cultural bodies, and local health entities were better placed to make health decisions at the national level. Such a focus on sovereignty was justified by the differences in national health systems.

29. The majority of submissions requested that human rights be respected in the process of drafting and negotiating a convention, agreement or other international instrument, including but not limited to the right to bodily autonomy informed by consent, the freedom of information, the freedom from discrimination, and the freedom to choose medical interventions. Several submissions referred to international instruments such as the Nuremberg Code, the Universal Declaration of Human Rights, the Declaration of Helsinki, the Belmont Report, and the Oviedo Convention and its Protocols. There were suggestions that the limitation of human rights should be legally justified and conform to the Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights.

30. Several submissions suggested that previous definitions of the term “pandemic” should be applied and that the words “with enormous numbers of deaths and illness” should be included. Those suggestions also emphasized that the definition of what constituted a pandemic should be determined by medical professionals, that the medical integrity of health care professionals should be upheld, and that the formulation of infection prevention and control guidelines should uphold the application of the precautionary principle to safeguard health workers.

31. There were several suggestions to strengthen the focus on pandemic prevention vis-à-vis preparedness and response. That included relying on national focal points to coordinate pandemic

[1] The written submissions portal is available at: https://inb.who.int/home/written-submissions (accessed 26 May 2022).

prevention efforts; aligning the proposed instrument with obligations under the International Health Regulations (2005) requiring Member States to strengthen health security systems for detection, notification, reporting, and responding to public health risks; and strengthening community health and primary health care systems as essential services.

32. There was an emphasis on health security being multisectoral, in particular recognizing the linkages between health, climate change, and food security. Furthermore, there was a recognition of the social and economic consequences of a pandemic, including the need to mitigate the adverse economic impacts and address the social determinants of those impacts as they related to socioeconomic status, gender, disability and migration status.

33. There were calls to institutionalize the One Health and One Welfare approaches to pandemic prevention, preparedness and control and to strengthen shared competency, accountability, and coordination mechanisms between ministries of health, agriculture, environment, trade, and finance. Certain submissions similarly noted that One Health surveillance systems should be improved, with the input of community and animal health workers.

34. Numerous submissions urged Member States to participate in knowledge-sharing and technology transfer in accordance with the Doha Declaration on the Agreement on Trade-Related Aspects of Intellectual Property Rights and Public Health. WHO was also urged to strengthen requirements for information sharing.

35. Transparency and accountability were recurrent themes in the written submissions. Many contributions underscored the importance of using the WHO Framework Convention on Tobacco Control as a model for developing a comprehensive accountability structure, notably on conflict of interest, liability, participation of nongovernmental organizations and other members of civil society, and legally binding instruments on business and human rights. A large number of submissions noted the benefits of people being able to vote on interventions to be adopted by their respective governments, in accordance with the provisions of the WHO Constitution. They also stressed that feedback mechanisms should be set up and that dialogue and debate concerning proposed interventions should be incorporated into that process.

36. Suggestions were made as to the development of financial and audit mechanisms for the new instrument. In relation to funding, many contributions focused on sources of funding and on the means for deploying those funds. A number of submissions indicated that WHO should be exclusively funded by governments to the exclusion of private donors, through the establishment of a fair-share mechanism where contributions would be made according to the capacity of and benefits to each country. Other submissions differed by suggesting that mechanisms to finance future pandemic responses should be flexible and multisectoral. One contribution called for global financial and tax architecture reforms such as debt relief, removal of international financing institutions' conditionalities for affected poorer countries, and increased taxes for corporations making excess profits. Some submissions also recommended that WHO should disclose sources of funding, especially during a pandemic.

37. Submissions differed widely on compliance and enforcement of the instrument. Several submissions stressed the importance of national sovereignty, with Member States having sole authority to make decisions on whether to adopt recommendations made by WHO. Other submissions noted that there should be accountability mechanisms for non-compliance.

38. Numerous contributions suggested that health data governance should be considered a substantive element of an international instrument on pandemic prevention, preparedness and response. The

components of health data governance proposed included: the effective use of digital technologies to respond to public health emergencies, the rejection of a centralized biosurveillance system, and the establishment of protocols for the collection, use and sharing of health data.

39. Some submissions placed great emphasis on the amount of scientific data and expertise that would be made available to the public. They called for evidence-based decision-making by WHO for medical and non-pharmaceutical interventions as well as the establishment of a repository of scientific knowledge. Several submissions also suggested that a steering committee to review WHO's decision-making process should be set up, composed solely of medically trained professionals.

40. A number of submissions highlighted the importance of expressly including an obligation for pharmaceutical companies to provide medicines regardless of patent limitations. They also suggested that action should be taken to: effectively monitor systems for the use of novel therapeutics, publish data from all clinical studies, and widely share vaccine information. Pharmaceutical companies were also seen as playing a vital role in equity considerations, specifically in relation to the provision of diagnostics, therapeutics and vaccines to low- and middle-income countries.

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