PROPOSED PANDEMIC TREATY

PLAIN ENGLISH EDITION

January 2023

Based on the Conceptual Zero Draft prepared by the World Health Organisation

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FOREWORD

Apparently, the world needs a new treaty to deal with pandemics. At least so said former UK Prime Minister Boris Johnson in March 2021, and certainly the World Health Organisation (WHO) agrees with him.

The proposed new treaty would be legally binding. It is extraordinarily broad in scope. Supposedly about health, its tentacles extend to everything – because everything including climate change has the potential to impact health.

If any country is careless enough to sign on to the treaty, it will have abdicated its governance role to the WHO. And once you're in, you can't get out for 3 years.

I used to enjoy living in a democracy. Perhaps it's not too late – but ordinary citizens of the world like me need to step up and take notice of this proposal, understand what it means, and demand that their governments reject it and defund the WHO as a matter of urgency.

The proposed treaty is written in dense, flowery language. It's very hard going. Hence, the idea that a paraphrased version might be useful.

You could start with the treaty itself (included at the back of this document); try to figure out what each provision means; and refer to the version in this document as a cross-reference if you get stuck.

Or start with the paraphrased version and then refer to the text of the proposed treaty and read it carefully to see if you agree with my translation.

I make no guarantee that this "translation" of the proposed pandemic treaty is 100% comprehensive and accurate. I've tried my best, but there will be errors. Some of them will be my own – and others will simply be because the provision in the draft treaty is, actually, incomprehensible.

My very sincere thanks to everyone who is contributing to this effort to understand and communicate what is going on with the WHO. I am in awe of these wonderful contributors including James Roguski, Dr Meryl Nass, James Corbett, the World Council for Health, the Australian Medical Network. I'm sure there are many others. Please keep up the good work, tell all your friends, and badger your parliamentarians until they take notice and organise for your nation to opt out of the treaty and withdraw from membership of the WHO. Speak now or forever hold your peace.

Libby Klein
Reclaim Ethical Medicine
Melbourne, Australia
17 January 2023

Notes:

- In the draft treaty itself, there are numerous references to "shall/should". This indicates that the parties are yet to negotiate whether that particular aspect will be legally binding or not. For simplicity I have used "must" throughout the paraphrased version.
- Some comments are included in *italics*.

GUIDE TO WORDS AND PHRASES

Key terms have not yet been defined in the draft treaty.

The WHO have funded the production of a glossary but it does not include all of the terms that are used in the draft treaty.

The UN also has a glossary of terms relating to treaties here.

Term	Definition or description	Source
Antimicrobial resistance	…occurs when microbes evolve mechanisms that protect them from the effects of antimicrobials. "Antimicrobial resistance (AMR) threatens the effective prevention and treatment of an ever-increasing range of infections caused by bacteria, parasites, viruses and fungi. AMR occurs when bacteria, viruses, fungi and parasites change over time and no longer respond to medicines making infections harder to treat and increasing the risk of disease spread, severe illness and death. As a result, the medicines become ineffective and infections persist in the body, increasing the risk of spread to others. Antimicrobials - including antibiotics, antivirals, antifungals and antiparasitics - are medicines used to prevent and treat infections in humans, animals and plants. Microorganisms that develop antimicrobial resistance are sometimes referred to as "superbugs"."	Wikipedia WHO
CA+	A WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response. This document uses "treaty", "draft treaty" and "proposed treaty" interchangeably.	WHO
Censorship	See Misinformation	
Climate change	"Climate change is the biggest threat to global health." Climate change is said to "fuel the spread of antimicrobial resistance, infectious diseases like cholera, malaria and dengue, and contributes to humanitarian emergencies…"	World Health Summit WHO Director General Tedros Adhanom Ghebreyesus
Common but differentiated responsibilities (**CBDR-RD**)	A principle that was formalized in the United Nations Framework Convention on Climate Change (UNFCCC) of Earth Summit in Rio de Janeiro, 1992.	Wikipedia

	It is unclear exactly what this phrase means in the context of the treaty (and also in Article 3 of the proposed amendments to the International Health Regulations.) The phrase appears in the preamble to the draft treaty (para 34) as follows: "*Emphasizing* that improving pandemic prevention, preparedness, response and recovery of health systems relies on a commitment to mutual accountability, transparency and common but differentiated responsibility by all States Parties and relevant stakeholders" It also appears in Article 4 of the draft treaty, as principle 8: **Common but differentiated responsibilities and capabilities in pandemic prevention, preparedness, response and recovery of health systems** – Full consideration and prioritization are required of the specific needs and special circumstances of developing country Parties, especially those that (i) are particularly vulnerable to adverse effects of pandemics; (ii) do not have adequate capacities to respond to pandemics; and (iii) would have to bear a disproportionate or abnormal burden.	
Disinformation	See Information	
Health	"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".	WHO Constitution
Health in all Policies (**HiAP**)	"an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. It improves accountability of policymakers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being."	WHO
Infodemic	"An infodemic is too much information including false or misleading information in digital and physical environments during a disease outbreak. It causes confusion and risk-taking behaviours that can harm health. It also leads to mistrust in health authorities and undermines the public health response. An infodemic can intensify or lengthen outbreaks when people are unsure about what they need to do to protect their health and the health of people around them. With growing	WHO

	digitization – an expansion of social media and internet use – information can spread more rapidly. This can help to more quickly fill information voids but can also amplify harmful messages."	
Infodemic management	"Infodemic management applies evidence-based interventions by analyzing concerns, questions, narratives, information voids and misinformation to promote adherence to health guidance and public health and social measures, and uptake of vaccines, diagnostics and therapeutics during health emergencies." "Infodemic management aims to enable good health practices through 4 types of activities: • Listening to community concerns and questions • Promoting understanding of risk and health expert advice • Building resilience to misinformation • Engaging and empowering communities to take positive action"	WHO
Information, disinformation, misinformation	**Disinformation:** Information that is false and deliberately created to harm a person, social group, organisation or country. **Misinformation:** Information that is false, but not created with the intention of causing harm.	United Nations Development Programme (UNDP)
	The WHO describes these terms as follows: **Information** is what we call things that are accurate to the best of our current knowledge. For instance, COVID-19 stands for coronavirus disease 2019 and is caused by the SARS-CoV-2 virus. One of the difficulties with any new pathogen, like this coronavirus, is that information changes over time as we learn more about the science. **Misinformation**, on the other hand, is *false information*. Importantly, it is false information that was not created with the intention of hurting others. Misinformation is often started by someone who genuinely wants to understand a topic and cares about keeping other people safe and well. It is then shared by others who feel the same. Everyone believes they are sharing good information – but unfortunately, they are not. And depending on what is being shared, the	WHO

	misinformation can turn out to be quite harmful. *Ie something which is false, but shared innocently* At the other end of the spectrum is **disinformation**. Unlike misinformation, this is *false information created with the intention of profiting from it or causing harm.* That harm could be to a person, a group of people, an organization or even a country. Disinformation generally serves some agenda and can be dangerous. During this pandemic, we are seeing it used to try to erode our trust in each other and in our government and public institutions.	
	A new Californian law defines **misinformation** as "false information that is contradicted by contemporary scientific consensus contrary to the standard of care" and **disinformation** as 'misinformation that the licensee deliberately disseminated with malicious intent or an intent to mislead'.	See also Children's Health Defence
International Health Regulations (**IHR**)	"While disease outbreaks and other acute public health risks are often unpredictable and require a range of responses, the International Health Regulations (2005) (IHR) provide an overarching legal framework that defines countries' rights and obligations in handling public health events and emergencies that have the potential to cross borders. The IHR are an instrument of international law that is legally-binding on 196 countries, including the 194 WHO Member States. The IHR grew out of the response to deadly epidemics that once overran Europe. They create rights and obligations for countries, including the requirement to report public health events. The Regulations also outline the criteria to determine whether or not a particular event constitutes a "public health emergency of international concern"."	WHO See also this Substack article
Misinformation	See Information	
One Health	"One Health is an integrated, unifying approach that aims to sustainably balance and optimize the health of people, animals and ecosystems. It recognizes that the health of humans, domestic and wild animals, plants, and the wider environment (including ecosystems) are closely linked and interdependent. While health, food, water, energy and environment are all wider topics with sector-specific concerns, the collaboration across sectors and disciplines contributes to protect health,	WHO WHO joint plan of action

	address health challenges such as the emergence of infectious diseases, antimicrobial resistance, and food safety and promote the health and integrity of our ecosystems. By linking humans, animals and the environment, One Health can help to address the full spectrum of disease control – from prevention to detection, preparedness, response and management – and contribute to global health security. The approach can be applied at the community, subnational, national, regional and global levels, and relies on shared and effective governance, communication, collaboration and coordination. Having the One Health approach in place makes it easier for people to better understand the co-benefits, risks, trade-offs and opportunities to advance equitable and holistic solutions."	
Whole of government (WoG)	The Australian government cautions its public servants against using the phrase Whole of government (but doesn't explain what it means!) It seems to mean "all governments" for example in Australia both the federal government and State and Territory governments. (Incidentally, it also advises that if shortened form must be used, the preferred abbreviation is WofG, explaining that "[t]his is an initialism, pronounced as 'double u of gee'. Do not use the acronyms WOG or WoG as these are offensive to some people.") "WoG is defined as an approach 'in which public service agencies work across portfolio boundaries' to develop integrated policies and programmes towards the achievement of shared or complementary, interdependent goals."	Australian government style manual BMJ GLobal Health
Whole of society (WoS)	"WoS represents a broader approach, moving beyond public authorities and engaging 'all relevant stakeholders, including individuals, families and communities, intergovernmental organizations, religious institutions, civil society, academia, the media, voluntary associations and […] the private sector and industry'. These terms are also used interchangeably without rigid demarcation, and it is contestable whether they truly have greater or differing specificity as compared with 'multisectoral', 'intersectoral' or 'cross-sectoral'."	BMJ GLobal Health See also Substack article
World Health Organisation (**WHO**)	A specialised agency of the United Nations.	Wikipedia
Zoonosis	"any disease or infection that is naturally transmissible from vertebrate animals to humans"	WHO

EXECUTIVE SUMMARY OF THE PROPOSED PANDEMIC TREATY

The WHO is to control everyone and everything, everywhere,

in the name of health, equity and global solidarity

Problem: Because of climate change and the likely increase in diseases crossing over from animals to humans, and increasing resistance to antibiotics, we are likely to have more pandemics in the future.

Assumptions: If we centralise decision-making about pandemics right across the globe, and if everyone falls into line, everyone can be healthier. Vaccines and other new medical products are the solution to pandemics and the proposed treaty.

Solution: The proposed treaty will make sure everyone can access vaccines and other new pandemic products. The WHO is the right body to control everything centrally, because it is the directing and coordinating authority for:

- international health work;
- convening and generating scientific evidence; and
- fostering international cooperation in global health governance.

Implications: Everything can impact health, so WHO has to be in charge of everything.

Actions: The world needs WHO to control and oversee:

- a global system for production and distribution of medical products
- supplies of medical products
- fast-tracking of research and development, and licensing of new products
- sharing of pathogen samples, genetic sequences, and benefits arising
- increased surveillance of diseases
- implementation of digital health
- a system of peer reviews and table-top exercises
- public health and social measures necessary for dealing with pandemics and situations that might give rise to pandemics
- censorship

Obligations of parties to the treaty:

- All must cooperate with the WHO in relation to all of the above measures.
- Wealthy nations must provide funding for the WHO and for developing countries
- Nations maintain their sovereignty - except where that means other nations are at risk
- Communities must be primed to accept public health measures and social measures

Implementation: This treaty is urgent and important, so:

- Start date is fast-tracked
- Once in, you can't get out for 3 years
- The treaty can be amended by majority vote and amendments will apply to everyone.
- No adjudication by a court of law if parties are in dispute.

WORLD HEALTH ORGANISATION PANDEMIC TREATY - PARAPHRASED IN PLAIN ENGLISH

BACKGROUND

1. In December 2021, the World Health Assembly decided to start drafting a treaty.
2. The Intergovernmental Negotiating Body (INB) was established to draft and negotiate the treaty.
3. The INB is open to all Member States and Associate Members.
4. The treaty is likely to adopted under Article 19 of the WHO Constitution but it could also be adopted under Article 21.
5. The long name for the proposed treaty is "WHO Convention, Agreement or other international instrument on pandemic prevention, preparedness and response" (CA+).
6. The INB agreed that some elements of the treaty should be legally binding.

METHODOLOGY AND APPROACH

7. The WHO has established a "Bureau" to support the work of the INB including to draft the treaty.
8. The Bureau has produced various early drafts of the treaty: first, a "Working Draft" then a "Conceptual Zero Draft"; next a "Zero Draft".
9. Input into the Conceptual Zero Draft included:
    a. Comments from the 2nd meeting of the INB
    b. 30 Submissions made by Member States
    c. 2 regional submissions
    d. 36 relevant stakeholders
    e. Input from regional consultations conducted in 2022
    f. Outcomes from four "informal focused consultations" on the following topics:
        i. legal matters;
        ii. operationalizing and achieving equity;

iii. intellectual property, and production and transfer of technology and know-how;

iv. One Health in the context of strengthening pandemic prevention, preparedness and response, with reference to antimicrobial resistance, climate change and zoonoses

g. Outcomes from the second round of public hearings conducted in September 2022.

10. The working draft was the starting point for the Conceptual Zero Draft.

11. The Conceptual Zero Draft now also refers to recovery of health systems from a pandemic: pandemic prevention, preparedness, and response and health system recovery"

12. Some text which overlapped with the International Health Regulations was removed from the working draft.

13. The working draft has been reordered and some duplication removed, in the Conceptual Zero Draft.

14. The Conceptual Zero Draft is written on the basis that the treaty will be an instrument under Article 19 of the World Health Organisation Constitution.

15. The Conceptual Zero Draft is a document for discussion at the 3rd meeting of the INB, prior to the production of a Zero Draft.

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PREAMBLE

20. States' sovereignty is reaffirmed.

21. International cooperation is critical.

22. States are obliged to act in accordance with international law.

23. International legal obligations include obligations to protect and promote human rights.

24. Equity should be "a principle, an indicator and an outcome of pandemic prevention, preparedness and response."

25. The WHO's governing document (Constitution) states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

26. When there's a pandemic, the situation is extraordinary and Member States need to cooperate more than usual with "development partners and other relevant stakeholders"

27. The international spread of disease is so serious that a coordinated international response is required.

28. The International Health Regulations (IHR) require a risk-based approach to public health risks which avoids unnecessary interference with international traffic and trade.

29. National action plans for dealing with pandemics should take everyone into account, including vulnerable people.

30. Pandemics can be catastrophic especially for vulnerable people, so we need a whole-of-government and whole-of-society approach.

31. Member States should commit to investing in pandemic preparedness rather than continue in a cycle of "panic and neglect."

32. We need to learn from prior outbreaks including COVID-19, HIV, Ebola, Zika, Middle East Respiratory syndrome and MonkeyPox.

33. We need to "close gaps" and improve future responses.

34. Cities are particularly vulnerable to pandemics.

35. Communities play an important role in dealing with pandemics.

36. Cities were underprepared for COVID-19.

37. Women were impacted by COVID-19 more than men, because women make up more than 70% of the global health care workforce.

38. In public health decision-making, there should be representation which is diverse, gender-balanced and equitable; there should also be expert input.

39. People affected by conflict and insecurity are particularly at risk of being left behind during pandemics.

40. Widespread collaboration is required if we are to achieve sustainable improvements in how we deal with pandemics.

41. Pandemics affect everything, not just health, so we need to have a holistic response.

42. Vulnerable people are particularly at risk in a pandemic.

43. Pandemics know no borders, so we need to cooperate globally, and have good governance globally.

44. Collective action and solidarity is required to deal with pandemics.

45. How we deal with pandemics should be based on the best available scientific evidence.

46. How we deal with pandemics needs to take into account what resources are available in a particular place.

47. Access to timely information is important.

48. Efficient risk communication is needed to counteract a pandemic.

49. Most infectious diseases originate in animals and then spill over to people.

50. Things that could potentially become drivers of future pandemics need to be addressed under the banner of public health.

51. Anti-microbial resistance is a silent pandemic and could aggravate a pandemic.

52. A One Health approach is critical.

53. We need a globally coordinated approach to deal with health threats at the animal and human interface.

54. We need to sustainably balance and optimize the health of people, animals and ecosystems.

55. A Quadripartite of organisations has been formed to better address any issues relating to One Health.

56. We need to make health systems more resilient so that pandemics don't make access to health care even harder for disadvantaged people.

57. Health is a precondition for achievement of the Sustainable Development Goals (SDGs)

58. Health is an outcome of the Sustainable Development Goals (SDGs).

59. Health is an indicator of the Sustainable Development Goals (SDGs).

60. Pandemics disproportionately impact frontline workers, the poor and vulnerable.

61. The disproportionate impact of pandemics on some groups hampers achievement of universal health coverage and the SDGs.

62. Global solidarity and effective global coordination is necessary to avoid serious negative impacts of pandemics, especially in countries with limited capacities and resources.

63. Accountability and transparency is necessary to avoid serious negative impacts of pandemics, especially in countries with limited capacities and resources.

64. There are significant differences in countries' capacities to deal with pandemics.

65. There were gross inequities in timely access to pandemic response products, notably vaccines, oxygen, personal protective equipment, diagnostics and therapeutics, and this is deeply concerning.

66. We are determined to achieve health equity by tackling every dimension of society including "employment and decent work and social protection".

67. Health equity can only be achieved through a comprehensive approach across all sectors including social, environmental, cultural, political and economic determinants of health.

68. We need equitable access to high quality health services without financial hardship.

69. We need well trained, skilled health workers providing quality, people-centred care.

70. We need committed policymakers with adequate investment in health.

71. We all need to be mutually accountable and transparent.

72. We all have common but differentiated responsibility.

73. The Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement doesn't prevent Member States from taking measures to protect public health.

74. The TRIPS agreement is to be interpreted in a way that promotes rather than restricts access to medicines by everyone.

75. WTO members have the right to fully utilise the flexibility around intellectual property rights which has previously been agreed.

76. Protecting intellectual property rights is important for the development of new medical products.

77. The protection of intellectual property rights has a concerning effect on the price of new medical products.

78. International organisations have been discussing innovative options for production and distribution of medical products including local production.

79. The flexibility and safeguards around intellectual property rights are important.

80. We need mechanisms for the transfer of technology and know-how in order to achieve equitable access to medical products.

81. The WHO developed a roadmap in 2008 for a global research and development system to support access to medical countermeasures in a pandemic.

82. Publicly funded research and development into pandemic response products should be regulated.

83. It is important to share samples and genetic sequence data of pathogens, and that this is done early, safely, transparently and rapidly.

84. Benefits from the sharing of samples and genetic sequence data must be shared fairly and equitably.

85. Numerous international conventions and agreements regulate the sharing of samples and genetic sequence data.

86. Work is being undertaken in other areas relevant to the sharing of samples and genetic sequence data.

87. The United Nations and multilateral organisations or agencies are doing work on the sharing of samples.

88. The WHO has the central role in dealing with pandemics.

89. The WHO is the directing and coordinating authority on international health work.

90. The WHO is the directing and coordinating authority for convening and generating scientific evidence.

91. The WHO is the directing and coordinating authority for fostering international cooperation in global health governance.

92. Funding and other resources are required particularly in developing countries.

93. The treaty recognizes the sovereign rights of countries and respects their national contexts.

94. The treaty recognizes that different countries have differing capacities and levels of development.

95. We need the fullest national and international cooperation in order to strengthen capacities around the world for dealing with pandemics.

96. The end goal is 'unhindered, timely and equitable access to pandemic response products, and resilient health systems recovery.

CHAPTER I – INTRODUCTION

Article 1 – Definitions And Use Of Terms

KEY POINTS - KEY TERMS HAVE NOT BEEN DEFINED

The Parties apparently agreed that it would be better to wait until a later draft to define key terms such as pandemic, whole-of-government, whole-of-society, misinformation, disinformation, false information, information, infodemic, falsified pandemic response products, CA+ (which is the abbreviation they use for the draft treaty), common but differentiated responsibilities, multi-sectoral collaboration, One Health, solidarity, universal health coverage, etc etc.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

97. Key terms have not yet been defined.

Article 2 – Relationship With International Agreements And Instruments

KEY POINTS – THE TREATY IS NOT SUPPOSED TO CREATE OVERLAPPING AND INCONSISTENT OBLIGATIONS UNDER INTERNATIONAL LAW

It is not yet at all clear how any inconsistencies between the treaty and other international legal obligations will be dealt with.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

98. The treaty is complementary to existing international instruments.

99. Member States must report any agreements between themselves to the WHO.

100. The Parties to the treaty can decide to add other documents to it.

CHAPTER II. OBJECTIVE(S), PRINCIPLES AND SCOPE

Article 3 - Objectives

KEY POINTS – THE OBJECTIVE IS OSTENSIBLY TO SAVE LIVES AND LIVELIHOODS

The objective of the treaty is to centrally coordinate the way the whole world deals with pandemics, ostensibly to "save lives and protect livelihoods".

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

101. The objective of the treaty is to save lives and protect livelihoods.

102. The treaty aims to proactively strengthen the world's ability to deal with pandemics.

103. The treaty aims to address systemic issues.

104. The treaty aims to reduce the risk of pandemics, and increase our ability to deal with them.

105. The treaty aims to ensure pandemic responses are coordinated, collaborative and evidence-based.

Article 4 - Principles

KEY POINTS

Who is to control everyone and everything, everywhere, in the name of health, equity and global solidarity.

Matters which are repeating what is set out in the preamble:

Principles:

- full respect for the dignity, human rights and fundamental freedom of persons
- the right to enjoy the highest attainable standard of health, defined as a state of complete physical, mental and social well-being
- sovereignty is to be preserved except to the extent this might damage another nation
- ensure equitable access to medical products
- solidarity
- transparent sharing of information.

Countries must be able to enforce pandemic measures.

International cooperation is vital.

Countries who can afford it will need to provide significant funding so every country can be well prepared.

Special focus on women and girls.

Everyone must have access to medical products.

Resistance to antibiotics has the potential to create pandemics and needs to be addressed.

WHO is the directing and coordinating authority in global health.

*Principles **not** already set out in the preamble:*

The aim is to sustainably balance and optimise the health of people, animals and ecosystems.

Only data which meets the definition of "Findable, accessible, interoperable and reusable (FAIR) should inform public health decisions and pandemic responses.

Pandemic responses should be proportionate to their intended objectives and evaluated on an ongoing basis.

Community engagement is critical for promoting trust in government and compliance with public health and social measures.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

106. The principles for implementing the treaty are:

    a. Full respect for the dignity, human rights and fundamental freedom of persons

    b. The right to enjoy the highest attainable standard of health, defined as a state of complete physical, mental and social well-being.

    c. Member States can maintain their sovereignty but only to the extent that they don't damage other States and their peoples.

    d. Equitable access to pharmaceutical products.

    e. Solidarity - Everyone acting together, for everyone's benefit.

    f. Transparency ie timely sharing of information, data and other elements.

107. Countries need to have legislative, executive, administrative and other measures in place for dealing with pandemics, and be accountable for doing so.

108. Countries' arrangements for dealing with pandemics needs to be aimed at dealing with pandemics in ways which are fair, equitable, effective and timely.

109. All Parties must cooperate with other States and relevant international organisations, especially those who are at the frontline of humanitarian settings and fragile and conflicted areas.

110. Some countries will need to step up to assist other countries who are more vulnerable and less capable of dealing with pandemics.

111. All relevant stakeholders and partners must be actively engaged in order to mobilise resources and capacities for dealing with pandemics.

112. Community engagement is important to mobilise social capital and resources.

113. The aim is to include women and girls in decision-making.

114. Everyone should have access to pandemic products.

115. We must make a point of ensuring that everyone has access to health services.

116. A coherent, integrated and unifying approach is important.

117. The aim is to sustainably balance and optiminse the health of people, animals and ecosystems.

118. Resistance to antibiotics has the potential to create pandemics and needs to be addressed.

119. The aim is to achieve universal health coverage.

120. Strong and resilient health systems are of key importance to achieving universal health coverage.

121. Universal health coverage is important for achieving the Sustainable Development Goals.

122. Findable, accessible, interoperable and reusable (FAIR) data should inform all public health decisions and pandemic responses.

123. WHO is the directing and coordinating authority in global health.

124. Who is the leader of multilateral cooperation in global health governance.

125. WHO Is fundamental to dealing with pandemics.

126. The effectiveness of responses to pandemics should be evaluated on an ongoing basis.

127. Pandemic responses should be proportionate to their intended objectives.

Article 5 - Scope

KEY POINTS

Health encompasses everything

The treaty ostensibly deals with "pandemic prevention, preparedness, response and health systems recovery at national, regional and international levels".

Pandemic has not yet been defined. The substance of the rest of the document expands the scope of WHO's powers significantly beyond a narrow definition of pandemic – for example by encompassing all the social determinants of health.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

128. The WHO CA+ applies to pandemic prevention, preparedness, response and health systems recovery at national, regional and international levels.

CHAPTER III. ACHIEVING EQUITY IN, FOR AND THROUGH PANDEMIC PREVENTION, PREPAREDNESS, RESPONSE AND RECOVERY OF HEALTH SYSTEMS

Article 6 - Global Supply Chain And Logistics Network

KEY POINTS

WHO to control a global system for production and distribution of medical products

The WHO will control a centralised global supply chain and distribution network for rollout of medical products.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

129. Parties must gear up to produce and distribute pandemic products.

130. Parties must ensure a concerted and coordinated approach to getting pandemic products to everyone on the globe by:

    a. Building on existing capabilities

    b. Being transparent about costs and pricing of pandemic products

    c. Facilitating the distribution of products into humanitarian situations.

131. When countries request essential supplies, those needs will be met in a coordinated way, as a matter of priority.

132. Pandemic products will be strategically stockpiled.

133. Raw materials for medicines, especially active ingredients, will be centrally controlled.

134. Distribution of medicines will be centrally controlled.

135. An international distribution network will be built.

Article 7 - Access To Technology: Promoting Sustainable And Equitably Distributed Production And Transfer Of Technology And Know-How

KEY POINTS

WHO will control supplies of medical products

Various UN entities including the WHO will control the production and distribution of medical products.

Financial incentives will help fast-track the development, manufacturing and licensing of medical products. New vaccines will be approved ever faster than before.

WHO will decide what treatments must be banned.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

136. The WHO, WTO and WIPO and other UN agencies will coordinate everything to do with manufacturing and distribution of pandemic products.

137. Product manufacturers will be compensated for the sharing of their intellectual property.

138. Developing countries will be offered financial incentives to develop pandemic products.

139. If a country asks for it, their local people will be trained up to enable local manufacturing.

140. Regulators will approve new medical treatments faster.

141. The Parties must:

    a. Strengthen regulatory authorities.

    b. Harmonise regulatory requirements internationally.

    c. Find ways to approve new products faster.

142. Regulators must share dossiers to enable faster licensing of new products.

143. The Parties must:

    a. Ensure sub-standard pandemic products can be banned.

    b. Ensure fake treatments can be banned.

Article 8 - Increase research and development capacities

KEY POINTS

Fast-tracking of Research and Development

Nothing is to get in the way of research and development (R&D) of new medical products:

- limits on **gain of function research** must not create unnecessary administrative burden, and
- product manufacturers must be allowed to insist on **complete indemnity** in exchange for granting access to medical products.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

144. Scientific and technical expertise will be shared with developing countries to help them ramp up their R&D.

145. There will be restrictions on pricing, allocation, data sharing and transfer of technology for all publicly funded research.

146. Developing countries will be assisted to ramp up their capacity to produce pandemic products.

147. More and more human and financial resources are to be applied to developing new pandemic products.

148. Financial incentives will be provided to the private sector to develop pandemic products.

149. Anything that could potentially be treated with a "pandemic response product" is included in the scope of the treaty including: novel pathogens, resistant pathogens, emerging diseases with pandemic potential, re-emerging diseases with pandemic potential, neglected tropical diseases.

150. Publicly funded research and development must comply with common principles around equitable access and affordability.

151. Publicly funded research must involve conditions on distributed manufacturing, licensing, technology transfer and pricing policies.

152. There must be limits on indemnity and confidentiality clauses in commercial contracts for the production of pandemic products.

153. Promoters of research for pandemic products must assume part of the risk (liability) when the products or supplies are in the research phase.

154. Making access to pandemic products conditional on a waiver of liability is discouraged.

155. Developing countries will be incentivized to engage in research and development of new pandemic products.

156. Gain of function research is allowed.

157. Gain of function research is to be regulated by international standards.

158. Measures to reduce the risk of accidental release of genetically altered organisms must not create any unnecessary administrative hurdles for research.

159. "Open science" approaches will be adopted for rapid sharing of scientific findings and research results, irrespective of outcome.

160. Research funded by government or other public funds will be promoted.

161. Ways will be found to "promote and strengthen knowledge translation and evidence communication tools and strategies."

162. Coordinate international clinical trials.

163. Ensure equitable access to funding for clinical trials.

164. Transparent and rapid reporting of the results of clinical trials.

165. Disclosure of disaggregated information on research and development and clinical trials.

166. Public funding for research and development of pandemic products to be disclosed.

167. Enhance the availability and accessibility of the results of publicly funded research and development.

168. Relevant patents to be publicly reported.

Article 9 - Fair, equitable and timely access and benefit-sharing

KEY POINTS

Sharing of pathogen samples, genetic sequences, and benefits arising

Pathogens and genetic sequencing will be shared globally on a centralised system. Benefits arising will be shared globally.

Safety measures around the sharing of pathogens are to be agreed - and do not have to be consistent with existing treaties.

Patient data, specimens and material *(what's material?)* will be shared globally within existing privacy constraints.

Countries must prioritise vulnerable people when making medical products available.

Developing countries must be given priority access to pandemic products.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

169. The Parties must agree how they will share access to pathogens and genetic sequence data.

170. The Parties must agree how they will share benefits from sharing pathogens and genetic sequence data.

171. There will be a comprehensive system for access to pathogens and benefits from sharing pathogens.

172. The Convention on Biological Diversity and its Nagoya Protocol will be relevant in determining how pathogens and genetic sequence data will be shared, and on what basis in terms of who reaps the benefits.

173. The Parties can agree to deviate from any of the provisions, including the principles, in existing or previous treaties including:

    a. the FAO International Treaty on Plant Genetic Resources for Food and Agriculture

    b. the WHO Pandemic Influenza Preparedness Framework and

    c. any other treaty.

174. The Parties must ensure everyone can access affordable, safe, efficacious and effective pandemic response products, particularly developing countries.

175. Access to pandemic products will be prioritized for

    a. healthcare workers

    b. other frontline workings

    c. indigenous peoples

    d. refugees

    e. migrants

    f. asylum seekers and stateless persons

g. the elderly

h. people with disabilities

i. the sick

j. pregnant women

k. infants

l. children

m. adolescents and

n. other vulnerable people.

176. There will be a centralized system for sharing access to and benefits of pathogens and genetic sequence data.

177. All relevant actors will be involved in designing, developing and implementing the system for access and benefit sharing.

178. All countries will have real-time access to the system for access and benefit sharing.

179. Pathogens and genetic sequence data and relevant metadata will be shared internationally on a global system.

180. Patient specimens will be shared internationally on a global system, within the constraints of international legal frameworks.

181. Patient material will be shared internationally on a global system, within the constraints of international legal frameworks.

182. Patient data will be shared internationally on a global system, within the constraints of international legal frameworks.

183. Laboratories must handle pathogens safely in accordance with international best practice guidelines.

184. Sharing of pathogens and genetic sequence data will be subject to biosafety and biosecurity requirements.

CHAPTER IV. STRENGTHENING AND SUSTAINING CAPACITIES FOR PANDEMIC PREVENTION, PREPAREDNESS, RESPONSE AND RECOVERY OF HEALTH SYSTEMS

Article 10. Strengthening and sustaining preparedness and health systems' resilience

KEY POINTS

Gearing up disease surveillance and digital health

The parties must be able to identify and control new outbreaks in humans, animals and the environment.

Countries must be able to do statistical modelling and genomic sequencing, and must share that data.

Countries must make sure their health systems can cope with pandemics and resultant long-term health conditions.

Wealthy countries with financial technical and technological resources must share them with developing countries.

Uptake of Digital Health must increase.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

185. The Parties must build and reinforce surveillance systems including One Health.

186. The Parties must build and reinforce surveillance systems including outbreak investigation and control.

187. The Parties must use interoperable early warning and alert systems across public and private sectors and relevant agencies.

188. The Quadripartite will play a key role in international surveillance of outbreaks.

189. The International Health Regulations regulate the surveillance of outbreaks.

190. The Parties must build capacity in genomic sequencing, and in analysing and sharing genomic sequencing.

191. The Parties will look for potential threats at the human-animal-environment interface and implement preventative measures.

192. The Parties must share their health technologies with other countries so everyone can have access.

193. The Parties must make sure their health systems can cope during a pandemic.

194. The Parties must have plans in place for recovering from future pandemics and learning from them.

195. The Parties must gear up to look after patients with long-term effects from future pandemics.

196. The Parties must gear up their health laboratories and diagnostic capacities, and ensure they meet biosafety and biosecurity standards.

197. Parties who have financial, technical and technological resources must/should share them with other Parties.

198. The Parties must increase their use of digital health and data science for forecasting and sharing information.

Article 11. Strengthening and sustaining a skilled and competent health workforce

KEY POINTS

Upskilling health workforces

Parties must build up their health workforces and be able to deploy health workers to other countries.

Parties must train people up to do genomic sequencing on a bigger scale.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

199. The Parties must/should ensure they have adequate health workforce.

200. The wellbeing of health workers must be protected.

201. Health workers' employment, civil and human rights must be protected.

202. Parties must mobilise human resources for countries affected by outbreaks.

203. Parties must mobilise financial resources, and other necessary resources, for countries affected by outbreaks.

204. Parties must train up community health workers with basic public health competencies.

205. Parties must invest in training up their health workforce ready for deployment in other countries.

206. Parties must provide ongoing funding to enhance their laboratory capacity including for conducting genomic sequencing.

207. Parties must create SWAT teams of health workers who can be deployed to other countries.

208. Parties must build training facilities for SWAT teams.

209. SWAT teams are to be trained according to a standardized international syllabus.

210. Parties must improve working environments and opportunities for health workers especially women.

Article 12 - Preparedness monitoring, simulation exercises and peer reviews

KEY POINTS

Peer reviews and table-top exercises

Parties must conduct regular table-top exercises in preparation for pandemics.

Parties must measure and report to their peers on the implementation of their pandemic preparedness strategy.

Parties must provide financing and other resources for developing countries to do the same.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

211. The Parties must conduct regular simulation exercises to monitor their readiness to cope with pandemics.

212. The Parties must engage in peer review exercises to monitor their readiness to cope with pandemics.

213. Each Party must develop its own national pandemic strategy which is comprehensive, inclusive and multi-sectoral.

214. Each Party must develop metrics for measuring preparedness for dealing with public health emergencies.

215. Each Party must develop metrics for measuring preventative strategies.

216. National action plans for dealing with pandemics must/should be rehearsed ("drilled") periodically..

217. Parties must

    a. help developing countries to conduct regular simulation exercises and help them plug gaps in their ability to respond, for example in relation to logistics and supply chain management.

    b. learn from pandemics.

    c. conduct regular peer reviews to make sure no country is under-prepared or ill-equipped for dealing with a pandemic.

    d. provide technical and financial support to help other countries prevent and prepare for pandemics.

    e. ensure all countries are willing and able to share health data globally.

    f. implement recommendations made by other countries as a result of a peer review.

    g. regularly report on prevention, preparedness, and ability to respond to and recover from pandemics.

CHAPTER V. PANDEMIC PREVENTION, PREPAREDNESS, RESPONSE AND HEALTH SYSTEM RECOVERY COORDINATION, COLLABORATION, AND COOPERATION

Article 13 - Coordination, collaboration and cooperation

KEY POINTS

Centralised global effort against pandemics

The Parties must coordinate their pandemic plans, and the science upon which those plans are based.

Input into global decision-making should involve equitable input on the basis of gender, geography, and socioeconomic status.

Centralised pandemic management will cater for everyone, everywhere on the planet - including fragile areas such as small island developing States.

The WHO is the central directing and coordinating authority for public health globally.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

218. The Parties must cooperate in the spirit of international solidarity to formulate cost-effective pandemic plans.

219. The Parties must work with a variety of other government and non-government actors as they see fit to formulate cost-effective pandemic plans.

220. The Parties must establish new global governance arrangements.

221. Pandemic policy must be based on science and evidence.

222. Experts, scientific bodies, academic institutions and networks should work more closely together.

223. Pandemic policies should cater for vulnerable people, indigenous peoples and those living in fragile areas such as small island developing States.

224. Global and regional decision-making should involve equitable input on the basis of gender, geography, and socioeconomic status.

225. Young people should have the chance to be represented and participate in global and regional decision-making.

226. Countries should be able to report on the impact of policies on different groups (eg by gender).

227. Support countries who report public health emergencies so as to encourage prompt and transparent reporting.

228. The WHO is the central directing and coordinating authority on international health work.

229. Enhance WHO's role in directing and coordinating international health work.

230. Give WHO's expert teams prompt access to outbreak areas, so they can evaluate and support the local response.

Article 14 - Whole-of-government and other multisectoral actions

KEY POINTS

Whole-of-government approach

Parties must take a holistic approach to pandemics and be able to mobilise resources for dealing with pandemics.

Strong public health policies and social policies need to be in place so they can be activated quickly, especially for vulnerable people.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

231. The Parties must adopt a whole-of-government approach to dealing with pandemics.

232. The Parties must collaborate with a whole variety of public and private bodies to develop plans for dealing with and recovering from pandemics.

233. Parties must tackle the wide variety of factors which influence health including environmental and economic factors.

234. Parties must mitigate the socioeconomic impacts of pandemics.

235. Parties must be able to mobilise resources to respond to pandemics.

236. Parties must strengthen public health policies and social policies to facilitate a rapid response.

Article 15 - Community engagement and Whole-of-society actions

KEY POINTS

Communities to be primed to accept public health measures and social measures

Communities must be primed to accept the imposition of public health and social measures to deal with pandemics.

Mechanisms must be in place to implement public health and social measures across the whole of society.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

237. Communities won't comply with public health measures and social measures unless governments engage with them and allow them a sense of participation.

238. Parties must communicate regarding risks based on science and evidence, noting when data is uncertain.

239. Parties must encourage communities to support each other.

240. Some opportunities need to be found for communities to be involved in decision-making and to enable communities to provide feedback.

241. Parties must have a mechanism in place to facilitate community engagement across different sectors.

242. Parties must have a mechanism in place to implement public health and social measures across the whole of society.

Article 16 - Strengthening pandemic and public health literacy

KEY POINTS

Censorship

Strict censorship will be enforced.

Public messaging will be manipulated.

Psychological techniques will be used to manipulate people into trusting government and complying with health measures.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

243. The Parties must:

a. educate people about pandemics.

b. cooperate globally to tackle false, misleading, misinformation and disinformation.

c. use social media to manage infodemics.

d. analyse what's being said on social media, and design communications to counteract misinformation, disinformation and false news.

e. prime people to be able to understand advances in science, engineering and technology so that they can understand the rules being imposed to deal with pandemics.

f. roll out communication strategies on pandemics and their effects.

g. research the relationship between misinformation/ disinformation, and public trust, to better inform policies.

h. use behavioural science to increase trust in government institutions and to promote compliance with health measures.

Article 17 - One Health

KEY POINTS

Everything can impact health, so who has to be in charge of everything

The WHO is in charge not just of human health, but also the health of: plants, animals, and the environment.

The WHO can dictate measures to mitigate climate change.

The WHO dictates infection prevention and control measures.

Parties must engage in ongoing surveillance to identify diseases crossing over between animals and humans, and cases of resistance to antibiotics.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

244. The Parties need to take action in all of the following areas because they have the potential to give rise to pandemics as a result of diseases crossing between animals and people:

    a. Climate change

    b. Land use change

    c. Wildlife trade

    d. Desertification

    e. Antimicrobial resistance.

245. The Parties must:

    a. institute widespread monitoring to identify when diseases cross between animals and people, and to identify when antimicrobial resistance is occurring.

    b. provide sufficient funding for widespread surveillance for outbreaks and antimicrobial resistance.

    c. take action on antimicrobial resistance.

    d. participate in global reporting of antimicrobial resistance.

    e. take action on climate change in the name of public health.

    f. produce "science-based evidence" taking the One Health approach into account.

    g. institute the correct infection prevention and control measures.

CHAPTER VI. FINANCING

Article 18 - Sustainable and predictable financing

KEY POINTS

Compulsory transfer of wealth

The Parties must stump up massive amounts of funding on an ongoing basis and be ready to contribute even more on an *ad hoc* basis as required.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

246. The Parties must:

   a. provide more funding for dealing with pandemics domestically.

   b. provide more funding for international mechanisms for dealing with pandemics.

   c. commit to ongoing increased funding for developing countries to get better prepared for pandemics.

   d. commit to providing additional capital to other countries when they need it to fight a pandemic.

CHAPTER VII. INSTITUTIONAL ARRANGEMENTS

Article 19 - Governing body for the WHO CA+

KEY POINTS

A new global governance body

There will be a new global governance body to oversee compliance with the treaty.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

247. A new governing body will be established to promote the effective implementation of the treaty.

248. The Governing body will consist of:

   a. The Conference of Parties (COP) (the supreme policy-setting organ)

   b. Officers of the Parties (the administrative organ)

   c. The Enlarged Conference of Parties (E-COP) which will include relevant stakeholders and will provide broad input for the decision-making processes of the COP.

249. The COP will regularly review the implementation of the treaty.

250. The COP will make the decisions necessary to promote the effective implementation of the treaty.

251. The COP will consist of delegates appointed by the Parties.

252. The COP will convene meetings of the Governing Body.

253. A Party can call a meeting of the COP provided it is supported by at least a third of the Parties.

254. The COP will have procedural rules for decision-making.

255. The Officers of the Parties will consist of two Presidents and four Vice-Presidents who will be elected by the COP and be the voting members; and two minute takers.

256. The E-COP is a broader consultation forum, consisting of

    a. Delegates representing Parties

    b. UN representatives

    c. UN members and observers who are not party to the treaty.

    d. Anyone the COP chooses if the appointment is supported by a two thirds majority of the COP.

257. The E-COP will have its own procedural rules.

258. The Governing Body might put proposals to the WHO Executive Board, for example in relation to coordinating its work with that of other WHO committees.

Article 20. Oversight mechanisms for the WHO CA+

KEY POINTS

Everyone's accountable to the WHO

Parties will have to lodge compliance reports with the new global governance body and implement actions plans to address any areas of non-compliance.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

259. The very first thing the Governing Body will do is put arrangements in place to promote compliance with the treaty and to deal with cases of non-compliance.

260. Parties will have to submit periodic reports to the Governing Body.

261. COP will conduct reviews and hold parties accountable for remedying any non-compliance.

Article 21. Assessment and review

KEY POINTS

Review of treaty in 4 years

The treaty will be reviewed after four years, but the review doesn't have to be independent.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

262. The relevance and effectiveness of the treaty will be reviewed by the Governing Body (or people appointed by the Governing Body) after the treaty has been in force for four years.

263. The Governing Body will decide on the frequency and format of any further reviews.

Article 22. Financial mechanisms and resources to support WHO CA+

KEY POINTS

Wealthy nations to provide funding

The Parties will provide funding for developing countries to implement the treaty.

264. The Parties recognize they are responsible for funding what needs to be done under the treaty.

265. The Parties will provide the necessary funding.

266. The Parties will provide funding for developing countries.

267. The Parties will try to get intergovernmental organisations, financial institutions and development institutions to provide funding for developing countries.

CHAPTER VIII. FINAL PROVISIONS

Article 23 - Reservations

KEY POINTS

Normal mechanisms for opting out of a treaty do not apply

The only way to avoid the treaty applying to you is not to sign up in the first place.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

268. The only way to avoid the treaty applying to you is not to sign up in the first place.

Article 24 - Withdrawal

KEY POINTS

Once in, you can't get out for 3 years

Parties who sign on to the treaty cannot withdraw within the first three years.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

269. Parties who sign on to the treaty cannot withdraw within the first three years.

Article 25 - Right to vote

270. Each Party under the treaty gets one vote.

Article 26 - Amendments to the WHO CA+

KEY POINTS

The treaty can be amended by majority vote

The Parties can amend the treaty by a 2/3 majority vote.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

271. Any Party may propose amendments to the treaty provided they give 6 months' notice.

272. Amendments must be supported by a two-thirds majority of the Parties who attend the relevant meeting to vote.

273. Amendments supported by a two-thirds majority will apply to all Parties whether they voted for it or not.

Article 27 - Adoption and amendment of annexes to the WHO CA+

274. Procedural, scientific, technical or administrative matters may be set out in annexes to the treaty.

Article 28 - Protocols to the WHO CA+

KEY POINTS

Parties can piggy-back other things onto the treaty

The Parties can agree on additional protocols beyond the scope of the treaty.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

275. Additional provisions can be added to the treaty by the Governing Body in the form of "protocols", if a two-thirds majority of Parties voting at a meeting vote in favour.

276. These additional protocols only apply to countries which are parties to them.

277. You can sign up to a protocol even if you're not a part to the treaty.

Article 29 - Signature

KEY POINTS

The treaty is open to almost everybody

All 194 existing members of the WHO can sign up for the treaty.

Members of the UN and regional economic organisations can also sign up.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

278. Members of the WHO or the UN are eligible to sign on to the treaty.

279. Certain regional economic integration organizations which are under the umbrella of the WHO or the UN can also sign on to the treaty.

Article 30 - Ratificatzon, acceptance, approval, formal confirmation or accession

280. Countries can sign up to the treaty and will lodge their formal documentation with the Secretary-General of the United Nations.

281. Regional economic integration organisations can sign up to the treaty even if none of their member States do.

Article 31 - Entry into force

KEY POINTS

Start date is fast-tracked

The treaty comes into force for a country only 30 days after it signs up.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

282. The treaty will be live 30 days after 40 countries have formally signed on.

283. The treaty comes into force for a country 30 days after it signs up.

Article 32 - Provisional application

Countries can sign up to the treaty provisionally, with immediate effect.

284. Countries can sign up to the treaty provisionally, with immediate effect.

Article 33 - Settlement of disputes

KEY POINTS

No adjudication by a court of law

Unresolved disputes between parties will be resolved by compulsory arbitration.

PLAIN ENGLISH PARAPHRASING OF THE TREATY PROVISIONS

285. Any disputes which can't be settled by Parties to the treaty will be settled by compulsory arbitration conducted in accordance with procedures set by the Governing Body.

Article 34 - Depository

286. Formal documentation is to be lodged with the Secretary-General of the United Nations.

Article 35 - Authentic texts

287. There will be formal versions of the treaty published in Arabic, Chinese, English, French, Russian and Spanish.

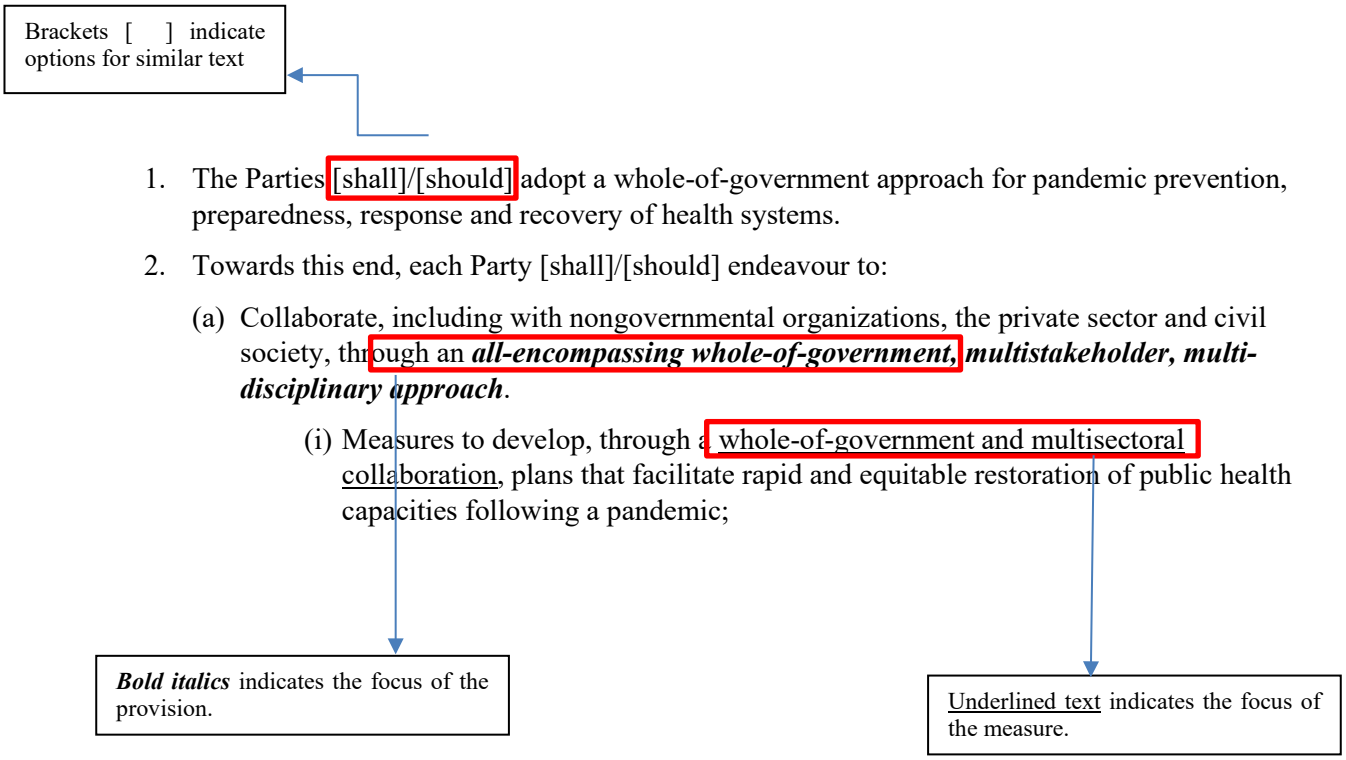
THIRD MEETING OF THE INTERGOVERNMENTAL NEGOTIATING BODY TO DRAFT AND NEGOTIATE A WHO CONVENTION, AGREEMENT OR OTHER INTERNATIONAL INSTRUMENT ON PANDEMIC PREVENTION, PREPAREDNESS AND RESPONSE
Provisional agenda item 2

A/INB/3/3
25 November 2022

Conceptual zero draft for the consideration of the Intergovernmental Negotiating Body at its third meeting

This conceptual zero draft was developed by the Bureau of the Intergovernmental Negotiating Body and reflects input from five sources, as set out in the section on page 3 entitled "Background, Methodology and Approach". The conceptual zero draft is presented as a bridge between the working draft and the future zero draft of the WHO CA+. It is not a draft of the WHO CA+.

Reader's guide



The formatting of selected text in ***bold italics*** or underline is done solely to facilitate the reading of this document.

BACKGROUND, METHODOLOGY AND APPROACH

Background

At its second special session in December 2021, the World Health Assembly established an Intergovernmental Negotiating Body (INB) open to all Member States and Associate Members (and regional economic integration organizations as appropriate) to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response, with a view to its adoption under Article 19, or other provisions of the WHO Constitution as deemed appropriate by the INB; see decision SSA2(5) (2021), paragraph (1).

In furtherance of the above mandate, at its second meeting, the INB agreed that the instrument should be legally binding and contain both legally binding as well as non-legally binding elements. In that regard, the INB identified Article 19 of the WHO Constitution as the comprehensive provision under which the instrument should be adopted, without prejudice to also considering as work progressed, the suitability of Article 21. At its second meeting, the INB requested the Bureau to develop a conceptual zero draft of the instrument for discussion at the third meeting of the INB.

Accordingly, the Bureau has prepared a conceptual zero draft for consideration by the INB at its third meeting.

Methodology and approach

The INB requested the Bureau to develop a conceptual zero draft that reflected the following inputs:

- Comments from the second meeting of the INB;
- Written inputs on the working draft from Member States (30), regional submissions (2), and relevant stakeholders (36);
- Input from regional consultations organized during the six regional committee meetings in 2022;
- Outcomes from the four informal focused consultations held by the INB Bureau during the intersessional period between the second and third INB meetings, which addressed the following topics: legal matters; operationalizing and achieving equity; intellectual property, and production and transfer of technology and know-how; and One Health in the context of strengthening pandemic prevention, preparedness and response, with reference to antimicrobial resistance, climate change and zoonoses; and
- Outcomes from the second round of public hearings, conducted in September 2022, by the WHO Secretariat to support the work of the INB.

In preparing a conceptual zero draft, the Bureau started by integrating the above-mentioned input into the working draft (document A/INB/2/3) as a basis for developing the conceptual zero draft. Consistent with the requests made by Member States during the second meeting of the INB, the Bureau then consolidated the text to reduce overlaps and duplication and increase coherence, including through streamlining and grouping similar topics. In this process:

- The topic of "recovery" was added insofar as it relates to the recovery of health systems from a pandemic;
- Areas covered by the International Health Regulations (2005) were removed;
- Reordering and grouping of similar areas/concepts was carried out, including deletion of duplications and repetitions;
- Mindful of the identification, at the second meeting of the INB, of Article 19 of the WHO Constitution as the comprehensive provision under which the instrument should be adopted, without prejudice to also considering, as work progressed, the suitability of Article 21, potential, non-exclusive, indicative text is provided in Chapters VII and VIII, for consideration in that regard, based on the approach of an instrument under Article 19 of the WHO Constitution, and with reference to existing international instruments, particularly within the WHO framework.

Similar to the working draft, this conceptual zero draft is provided as a flexible, "living" document, with a view to moving it towards a zero draft. This process will be informed by Member States' discussions during the third meeting of the INB.

Contents

CONCEPTUAL ZERO DRAFT FOR THE CONSIDERATION OF THE INTERGOVERNMENTAL NEGOTIATING BODY AT ITS THIRD MEETING

Preamble[1]

1. *Reaffirming* the principle of sovereignty of States Parties in addressing public health matters, notably pandemic prevention, preparedness, response and health systems recovery;

2. *Recognizing* the critical role of international cooperation and obligations for States to act in accordance with international law, including to respect, protect and promote human rights;

3. *Recognizing* that all lives have equal value, and that therefore equity should be a principle, an indicator and an outcome of pandemic prevention, preparedness and response;

4. *Recalling* the preamble to the Constitution of the World Health Organization, which states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition, and that unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger;

5. *Noting* that a pandemic situation is extraordinary in nature, requiring States Parties to prioritize effective and enhanced cooperation with development partners and other relevant stakeholders to address extraordinary challenges;

6. *Recognizing* that the international spread of disease is a global threat with serious consequences for public health, human lives, livelihoods, societies and economies that calls for the widest possible international cooperation and participation of all countries and relevant stakeholders in an effective, coordinated, appropriate and comprehensive international response;

7. *Recalling* the International Health Regulations (2005) of the World Health Organization and the role of States Parties and other stakeholders in preventing, protecting against, controlling and providing a public health response to the international spread of disease in ways that are commensurate with, and restricted to, public health risks, and which avoid unnecessary interference with international traffic and trade;

8. *Recognizing* that national action plans for pandemic prevention, preparedness, response and recovery of health systems should take into account all people, including communities and persons in vulnerable situations, places and ecosystems;

9. *Recognizing* that the threat of pandemics is a reality and that pandemics have catastrophic health, social, economic and political consequences, especially for persons in vulnerable situations, pandemic prevention, preparedness, response and recovery of the health system must be systemically integrated into whole-of-government and whole-of-society approaches, to ensure adequate political commitment, resourcing and attention across sectors, and thereby break the cycle of "panic and neglect";

10. *Reflecting* on the lessons learned from coronavirus disease (COVID-19) and other outbreaks with global and regional impact, including, inter alia, HIV, Ebola virus disease, Zika virus disease, Middle

[1] The Bureau proposes, consistent with Member State submissions, that the preambular section be discussed at the appropriate point in the negotiations.

East respiratory syndrome and monkeypox, and with a view to addressing and closing gaps and improving future response;

11. *Recognizing* that urban settings are especially vulnerable to infectious diseases and epidemics, and the important role that communities have in preventing, preparing for and responding to health emergencies;

12. *Noting* with concern that the COVID-19 pandemic has revealed serious shortcomings in preparedness – especially at city and urban levels – for timely and effective prevention and detection of, as well as response to, potential health emergencies, indicating the need to better prepare for future health emergencies;

13. *Noting* that women comprise more than 70% of the global health care workforce and an even higher proportion of the informal health workforce, and during the COVID-19 response were disproportionately impacted by the burden of pandemics, notably on health workers;

14. *Reaffirming* the importance of diverse, gender-balanced and equitable representation and expertise in pandemic prevention, preparedness, response and health system recovery decision-making, as well as in the design and implementation of activities;

15. *Expressing* concern that those affected by conflict and insecurity are particularly at risk of being left behind during pandemics;

16. *Recognizing* the synergies between multisectoral collaboration – through whole-of-government and whole-of-society approaches at the country and community level – and international, regional and cross-regional collaboration, coordination and global solidarity, and their importance to achieving sustainable improvements in pandemic prevention, preparedness and effective response;

17. *Acknowledging* that the repercussions of pandemics, beyond health and mortality, on socioeconomic impacts in a broad array of sectors, including economic growth, employment, trade, transport, gender inequality, food insecurity, education, environment and culture, require a multisectoral whole-of-society approach to pandemic prevention, preparedness, response and recovery of the health system;

18. *Acknowledging* the impacts of determinants of health across different sectors and communities on the vulnerability of communities, especially persons in vulnerable situations, to the spread of pathogens and the evolution of an outbreak;

19. *Underscoring* that multilateral and regional cooperation and good governance are essential to prevent, prepare for, respond to, and the recovery of health systems from, pandemics that by definition know no borders and require collective action and solidarity;

20. *Emphasizing* that policies and interventions on pandemic prevention, preparedness, response and recovery of health systems should be supported by the best available scientific evidence and adapted to take into account resources and capacities at subnational and national levels;

21. *Reaffirming* the importance of access to timely information, as well as efficient risk communication that manages to counteract the pandemic;

22. *Understanding* that most emerging infectious diseases originate in animals, including wildlife and domestic animals, then spill over to people;

23. *Recognizing* the importance of working synergistically with other relevant areas, under a One Health Approach, as well as the importance and public health impact of growing possible drivers of pandemics, which need to be addressed as a means of preventing future pandemics and protecting public health;

24. *Noting* that antimicrobial resistance is often described as a silent pandemic and that it could be an aggravating factor during a pandemic;

25. *Reaffirming* the importance of a One Health approach and the need for synergies between multisectoral and cross-sectoral collaboration at national, regional and international levels to safeguard human health, detect and prevent health threats at the animal and human interface, in particular zoonotic spill-over and mutations, and sustainably balance and optimize the health of people, animals and ecosystems, and, in this respect, acknowledging the creation of the Quadripartite, (WHO, the Food and Agriculture Organization (FAO), the World Organisation for Animal Health (WOAH) and the United Nations Environment Programme (UNEP)) to better address any One Health-related issue;

26. *Reiterating* the need to work towards building and strengthening resilient health systems to advance universal health coverage, as an essential foundation for effective pandemic prevention, preparedness, response and recovery of health systems, and to adopt an equitable approach to prevention, preparedness, response and recovery activities, including to mitigate the risk that pandemics exacerbate existing inequities in access to services;

27. *Recognizing* that health is a precondition for, and an outcome and indicator of, the social, economic and environmental dimensions of sustainable development and the implementation of the 2030 Agenda for Sustainable Development;

28. *Recognizing* that pandemics have a disproportionately heavy impact on frontline workers, notably health workers, the poor and persons in vulnerable situations, with repercussions on health and development gains, in particular in developing countries, thus hampering the achievement of universal health coverage and the Sustainable Development Goals, with their shared commitment to leave no one behind;

29. *Recognizing* the need to enhance global solidarity and effective global coordination, as well as accountability and transparency, to avoid serious negative impacts of public health threats with pandemic potential, especially on countries with limited capacities and resources;

30. *Acknowledging* that there are significant differences in countries' capacities to prevent, prepare for, respond to, and recover from pandemics;

31. *Deeply concerned* by the gross inequities that hindered timely access to medical and other COVID-19 pandemic response products, notably vaccines, oxygen supplies, personal protective equipment, diagnostics and therapeutics;

32. *Reiterating* the determination to achieve health equity through resolute action on social, environmental, cultural, political and economic determinants of health, such as eradicating hunger and poverty, ensuring access to health and proper food, safe drinking water and sanitation, employment and decent work and social protection in a comprehensive intersectoral approach;

33. *Emphasizing* that in order to make health for all a reality, individuals and communities need: equitable access to high quality health services without financial hardship; well trained, skilled health workers providing quality, people-centred care; and committed policymakers with adequate investment in health to achieve universal health coverage;

34. *Emphasizing* that improving pandemic prevention, preparedness, response and recovery of health systems relies on a commitment to mutual accountability, transparency and common but differentiated responsibility by all States Parties and relevant stakeholders;

35. *Recalling* the Doha Declaration on the TRIPS Agreement and Public Health of 2001 and reiterating that the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health;

36. *Reaffirming* that the TRIPS Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health, and, in particular, to promote access to medicines for all;

37. *Reaffirming* that WTO Members have the right to use, to the full, the TRIPS Agreement and the Doha Declaration on the TRIPS Agreement and Public Health of 2001, which provide flexibility to protect public health including in future pandemics;

38. [Proposal: *Recognizing* that protection of intellectual property rights is important for the development of new medical products, but also recognizing concerns about its effects on prices, as well as noting discussions/deliberations in relevant international organizations on, for instance, innovative options to enhance the global effort towards the production of, timely and equitable access to, and distribution of health technologies and know-how, by means that include local production;]

> [38. Proposal: *Recognizing* that protection of intellectual property rights is important for the development of new medicines, and also recognizing concerns about the negative effect on prices and on the production of, timely and equitable access to, and distribution of vaccines, treatments, diagnostics and health technologies and know-how;]
>
> [38. Proposal: *Recognizing* that intellectual property protection is important for the development of new medicines, and also recognizing concerns about its effect on prices, as well as noting discussions on enhancing global efforts towards the production of, timely and equitable access to, and distribution of health technologies and products;]
>
> [38. Proposal: *Recognizing* the concerns that intellectual property on life-saving medical technologies continue to pose threat and barriers to the full realization of the right to health and to scientific progress for all, particularly the effect on prices, which limits access options and impedes independent local production and supplies, as well as noting structural flaws in the institutional and operational arrangements in the global response to the COVID 19 pandemic, and the need to establish a future pandemic prevention, preparedness and response mechanism that is not based on a charity model;]

39. [Proposal: *Reaffirming* the flexibilities and safeguards contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights and their importance for removing barriers to production of, and access to, pandemic response products, as well as sustainable supply-chains for their equitable distribution, while also recognizing the need for sustainable mechanisms to support transfer of technology and know-how to support the same;]

[39. Proposal: *Reaffirming* the flexibilities and safeguards contained in the Agreement on Trade Related Aspects of Intellectual Property Rights and their importance for ensuring access to technologies, knowledge and full transfer of technology and know-how for production and supply of pandemic response products, as well as their equitable distribution;]

40. *Recalling* resolution WHA61.21 (2008) on the global strategy and plan of action on public health, innovation and intellectual property, which lays out a road map for a global research and development system supportive of access to appropriate and affordable medical countermeasures, including those needed in a pandemic;

41. *Recognizing* that publicly funded research and development plays an important role in the development of pandemic response products, and, as such, requires conditionalities;

42. *Underscoring* the importance of promoting early, safe, transparent and rapid sharing of samples and genetic sequence data of pathogens, as well as the fair and equitable sharing of benefits arising therefrom, taking into account relevant national and international laws, regulations, obligations and frameworks, including the International Health Regulations (2005), the Convention on Biological Diversity and its Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization to the Convention on Biological Diversity, and the Pandemic Influenza Preparedness Framework, and also mindful of the work being undertaken in other relevant areas and by other United Nations and multilateral organizations or agencies;

43. *Recognizing* the central role of WHO in pandemic prevention, preparedness, response and recovery of health systems as the directing and coordinating authority on international health work, and in convening and generating scientific evidence, and, more generally, fostering multilateral cooperation in global health governance;

44. *Acknowledging* that pandemic prevention, preparedness, response and recovery of health systems at all levels and in all sectors, particularly in developing countries, require predictable, sustainable and sufficient financial, human, logistical and technical resources.

Vision

The WHO CA+[1] aims to protect present and future generations from pandemics and their devastating consequences, and to advance the enjoyment of the highest attainable standard of health for all peoples, on the basis of equity, human rights and solidarity, with a view to achieving universal health coverage, and recognizing the sovereign rights of countries and respect for their national context, as well as the differences in capacities and levels of development among them, through the fullest national and international cooperation in order to strengthen capacities to prevent, prepare for and respond to pandemics, with unhindered, timely and equitable access to pandemic response products, and resilient health systems recovery.

[1] WHO CA+: At its second meeting in July 2022, the INB identified that Article 19 of the WHO Constitution is the comprehensive provision under which the instrument should be adopted, without prejudice to also considering, as work progressed, the suitability of Article 21.

Chapter I. Introduction

Article 1. Definitions and use of terms

To be developed: *This article would define or explain, as appropriate, all relevant terms and phrases, for example, technical terms, institutions, organizations and other terms, for the purposes of this WHO CA+.*

Article 2. Relationship with international agreements and instruments

(1) The Parties recognize that the WHO CA+ and other relevant international instruments should be interpreted so as to be complementary and synergistic. The provisions of the WHO CA+ shall not affect the rights and obligations of any Party deriving from other existing international instruments and shall respect the competencies of other organizations and treaty bodies.

(2) In furtherance of the foregoing, it is expressly noted that the WHO CA+ is developed to be consistent with the Charter of the United Nations and the Constitution of WHO, and to be complementary and synergistic with the International Health Regulations (2005) (and any later editions). In that regard, reference is made to Article 57 of the International Health Regulations (2005) (IHR (2005)), pursuant to which States Parties recognize that the IHR (2005) and other relevant international agreements should be interpreted so as to be compatible.

(3) In the event that any part of the WHO CA+ addresses areas or activities that may bear on the field of competence of other organizations or treaty bodies, appropriate steps will be taken to avoid duplication and promote synergies, compatibility and coherence, with a common goal of strengthened pandemic preparedness, prevention and response.

(4) The provisions of the WHO CA+ shall in no way affect the right of Parties to enter into bilateral or multilateral instruments, including regional or subregional instruments, on issues relevant or additional to the WHO CA+, provided that such instruments are compatible with, and do not conflict with, their obligations under the WHO CA+. The Parties concerned shall communicate such instruments through the Governing Body for the WHO CA+.

For the purpose of this Article, the term "WHO CA+" includes the WHO CA+ and any protocols thereto, as well as annexes, guidelines and other related instruments as the Parties may deem integral to the WHA CA+, whether presently existing or established at a later date, established under the WHO CA+.

Chapter II. Objective(s), principles and scope

Article 3. Objective(s)

The objective of the WHO CA+, guided by the vision and principles set out therein, is to save lives and protect livelihoods, through strengthening, proactively, the world's capacities for preventing, preparing for and responding to, and recovery of health systems from pandemics. The WHO CA+ aims to address systemic gaps and challenges that exist in these areas, at national, regional and international levels, through substantially reducing the risk of pandemics, increasing pandemic preparedness and response capacities, and ensuring coordinated, collaborative and evidence-based pandemic response and resilient recovery of health systems.

Article 4. Principles

To achieve the objective(s) of the WHO CA+ and to implement its provisions, the Parties will be guided, as applicable by the context, inter alia, by the principles set out below:

1. **Respect for human rights** – The implementation of the WHO CA+ shall be with full respect for the dignity, human rights and fundamental freedoms of persons, and each Party shall protect and promote such freedoms.

2. **The right to health** – The enjoyment of the highest attainable standard of health, defined as a state of complete physical, mental and social well-being, is one of the fundamental rights of every human being without distinction of age, race, religion, political belief, economic or social condition.

3. **Sovereignty** – States have, in accordance with the Charter of the United Nations and the principles of international law, the sovereign right to determine and manage their approach to public health, notably pandemic prevention, preparedness, response and recovery of health systems pursuant to their own policies and legislation provided that activities within their jurisdiction or control do not cause damage to other States and their peoples. Sovereignty also covers the rights of States over their biological resources.

4. **Equity** – An effective response to pandemics requires ensuring fair, equitable and timely access to affordable, safe and efficacious pandemic response products, among and within countries, including between groups of people irrespective of their social or economic status.

5. **Solidarity** – The effective prevention of, preparedness for, and response to, pandemics require national, international, multilateral, bilateral, and multisectoral collaboration, coordination and cooperation in order to achieve a fairer, more equitable and better prepared world.

6. **Transparency** – The effective prevention of, preparedness for, and response to, pandemics depends on transparent and timely sharing of information, data and other elements at all levels, notably through a whole-of-government and whole-of-society approach, based on, and guided by, the best-available scientific evidence, consistent with national, regional and international privacy and data protection rules, regulations and laws.

7. **Accountability** – Countries are responsible and accountable for strengthening and sustaining their health systems' capacities and public health functions to provide adequate health and social measures by adopting and implementing legislative, executive, administrative and other measures for fair, equitable, effective and timely pandemic prevention, preparedness, response and recovery of health systems. All Parties [shall] / [should] cooperate with other States and relevant international organizations, with particular reference to entities at the frontline of humanitarian settings and fragile and conflict-affected areas, in order to collectively strengthen, support and sustain capacities for global prevention, preparedness, response and recovery of health systems.

8. **Common but differentiated responsibilities and capabilities in pandemic prevention, preparedness, response and recovery of health systems** – Full consideration and prioritization are required of the specific needs and special circumstances of developing country Parties, especially those that (i) are particularly vulnerable to adverse effects of pandemics; (ii) do not have adequate capacities to respond to pandemics; and (iii) would have to bear a disproportionate or abnormal burden.

9. **Inclusiveness** – The active engagement with, and participation of, all relevant stakeholders and partners across all levels, consistent with relevant and applicable international and national guidelines,

rules and regulations (including those relating to conflicts of interest), is fundamental for mobilizing resources and capacities to support pandemic prevention, preparedness, response and health systems recovery.

10. **Community engagement** – Full engagement by communities in prevention, preparedness, response and recovery of health systems is essential to mobilize social capital, resources, adherence to public health and social measures, and to gain trust in government.

11. **Gender equality** – Pandemic prevention, preparedness, response and recovery of health systems will be guided by the aim of equal participation and leadership of men and women in decision-making with a particular focus on gender equality, taking into account the specific needs of all women and girls, using a country-driven, gender responsive/transformative, participatory and fully transparent approach.

12. **Non-discrimination and respect for diversity** – All individuals should have fair, equitable and timely access to pandemic response products and health services, without fear of discrimination or distinction based on race, religion, political belief or economic or social condition.

13. **Rights of individuals and groups at higher risk and in vulnerable situations** – Nationally determined and prioritized actions, including support, will take into account communities and persons in vulnerable situations, places and ecosystems. Indigenous peoples, refugees, migrants, asylum seekers, and stateless persons, persons in humanitarian settings and fragile contexts, marginalized communities, older people, persons with disabilities, persons with health conditions, pregnant women, infants, children and adolescents, for example, are particularly impacted by pandemics, owing to social and economic inequities, as well as legal and regulatory barriers, that may prevent them from accessing health services.

14. **One Health** – Multisectoral actions should recognize the importance of a coherent, integrated and unifying approach that aims to sustainably balance and optimize the health of people, animals and ecosystems, including through, but not limited to, attention to the prevention of epidemics due to pathogens resistant to antimicrobial agents.

15. **Universal health coverage** – The WHO CA+ will be guided by the aim of achieving universal health coverage, for which strong and resilient health systems are of key importance, as a fundamental aspect of achieving the Sustainable Development Goals through promoting health and well-being for all at all ages.

16. **Science and evidence-informed decisions** – Science, evidence and findable, accessible, interoperable and reusable (FAIR) data should inform all public health decisions and the development and implementation of guidance for pandemic prevention, preparedness, response and recovery of health systems.

17. **Central role of WHO** – As the directing and coordinating authority in global health, and the leader of multilateral cooperation in global health governance, WHO is fundamental to strengthening pandemic prevention, preparedness, response and recovery of health systems.

18. **Proportionality** – Due consideration should be given, including through continuous policy evaluation, to ensuring that the impacts of measures aimed at preventing, preparing for and responding to pandemics are proportionate to their intended objectives.

Article 5. Scope

The WHO CA+ applies to pandemic prevention, preparedness, response and health systems recovery at national, regional and international levels.

Chapter III. Achieving equity in, for and through pandemic prevention, preparedness, response and recovery of health systems

Article 6. Global supply chain and logistics network

1. The Parties [shall]/[should] build and sustain an equitable, transparent, rapid, resourced, coordinated, uninterrupted and reliable global supply chain and logistics network for pandemic response products.

2. Towards this end, each Party [shall]/[should]:

(a) Ensure a ***concerted and coordinated approach*** to the availability and distribution of, and equitable access to, pandemic response products, by means that include:

(i) measures that leverage well-established and proven systems, processes and mechanisms, notably the supply chain and logistics experience from across the United Nations system, mindful of the need to build on respective strengths

(ii) measures to promote and encourage transparency in cost and pricing of pandemic response products, including development, production and distribution costs

(iii) measures to safeguard the humanitarian principles of humanity, neutrality, impartiality and independence, and to facilitate the unimpeded access of humanitarian staff and cargo

(b) Prioritize and coordinate ***country requests for essential supplies*** based on public health needs and updated national action plans for pandemic prevention, preparedness, response and recovery of health systems;

(c) Enhance countries' and regional logistical capacities to ***establish and maintain strategic stockpiles*** of pandemic response products;

(d) Allocate ***supplies, raw materials and other necessary inputs for sustainable production of pandemic response products*** (especially active pharmaceutical ingredients) including for stockpiling purposes, through the most efficient multilateral and regional purchasing mechanisms, including pooled mechanisms and in-kind contributions, based on public health needs, by means that include:

(i) measures that address the restriction of distribution of pandemic response products

(e) Establish and operationalize ***international consolidation hubs, as well as regional staging areas***, to ensure that transport of supplies is streamlined and uses the most appropriate means for the products concerned.

Article 7. Access to technology: promoting sustainable and equitably distributed production and transfer of technology and know-how

1. The Parties [shall]/[should] develop multilateral mechanisms, particularly during inter-pandemic times, that promote and provide relevant transfer of technology and know-how, in a manner consistent with international legal frameworks, to potential manufacturers in developing countries/all regions to increase and strengthen regional and global manufacturing capacity.

2. Towards this end, each Party [shall]/[should]:

(a) Strengthen local capacity, particularly in developing countries and regional groups, to manufacture pandemic response products through ***transfer of technology and know-how*** in order to ensure rapid and equitable access to adequate global supplies that meet surge demand, including by encouraging innovative options, by means that include:

(i) measures to strengthen coordination, including trilateral cooperation among the World Health Organization, the World Trade Organization and the World Intellectual Property Organization, as well as other relevant United Nations agencies, on issues related to public health, intellectual property and trade, including timely matching of supply to demand, and mapping manufacturing capacities and demand

(ii) innovative mechanisms and incentives to promote transfer of technology and know-how, including through technology transfer hubs and product development partnerships, and to address the short timeframe in which new pandemic response products are developed and needed, by means that include:

(a) measures to incentivise the development of pandemic response products, including incentives targeted at developing countries

(iii) measures to encourage, incentivize, and facilitate participation of private-sector entities in voluntary transfer of technology and know-how through collaborative initiatives and multilateral mechanisms

(iv) measures to support time-bound waivers of protection of intellectual property rights that are a barrier to manufacturing of pandemic response products during pandemics

(v) measures to fully reflect the flexibilities provided in the TRIPS Agreement, including those recognized in the Doha Declaration on the TRIPS Agreement and Public Health and in Articles 27, 30 (including the research exception and "Bolar" provision), 31 and 31bis of the TRIPS Agreement

(vi) measures to ensure an available, skilled and trained manufacturing workforce that is ready to support local production, through scaling up of training and capacity of training institutions, upon request

(b) Bolster and strengthen national, and, where appropriate, regional ***regulatory authorities' capacities***, to prepare for and accelerate emergency licensing and approval procedures, grounded in evidence-based procedures and evaluation, to allow for the timely availability of essential pandemic response products, by means that include:

(i) measures to build and strengthen the capacity of regulatory authorities and increase the harmonization of regulatory requirements at the international and regional level, including through mutual recognition agreements

(ii) measures to build and strengthen country regulatory capacities for timely approval of products for pandemic prevention, preparedness, response and recovery of health systems

(iii) measures to accelerate the process of licensing and approving pandemic response products for emergency use in a timely manner, including the sharing of regulatory dossiers

(iv) measures to monitor and regulate against sub-standard and falsified pandemic response products, through existing Member State mechanisms.

Article 8. Increase research and development capacities

1. The Parties [shall]/[should] build and strengthen capacities and institutions for innovative research and development, particularly in developing countries, by means that include scientific and technical cooperation, collaboration and communication, consistent with national and international biosafety and biosecurity standards, guidelines and regulations. Publicly funded research and development for pandemic prevention, preparedness, and response [shall]/[should] include conditions on prices of products, allocation, data sharing and transfer of technology, as appropriate.

2. Towards this end, each Party [shall]/[should]:

(a) Promote and align international, regional and national ***scientific and technical cooperation*** and action in research and the development of technology, by means that include:

(i) measures to strengthen research and development processes and capacities for rapid and timely development and production, at national, regional and global levels, of pandemic response products, such as but not limited to, diagnostics, medicines and vaccines, particularly in developing countries

(ii) measures to encourage the sharing and gradual increase of resources (human and financial), including from public sources, for research and development of pandemic response products

(iii) measures to encourage non-State actors, including the private sector, to participate in and accelerate innovative research and development for novel and resistant pathogens and emerging and re-emerging diseases with pandemic potential, as well as neglected tropical diseases

(a) measures to support the collective development and use of principles and norms and sets of practices that ensure that public financing of research and development for pandemic response products results in more equitable access and affordability, including through conditions on distributed manufacturing, licensing, technology transfer and pricing policies

(b) measures to limit indemnity or confidentiality clauses in commercial pandemic response product contracts between countries and manufacturers, taking into account public financing in research and development

(c) measures to ensure that promoters of research for pandemic response products assume part of the risk (liability) when the products or supplies are in the research phase, and that making access to such pandemic response products or supplies conditional on a waiver of such liability is discouraged

(iv) measures to promote and incentivize technology co-creation and joint venture initiatives aimed at strengthening research and development capacities, particularly in developing countries, including through regional hubs or centres of excellence

(v) measures to provide international standards for, and oversight of, as well as reporting on, laboratories and research facilities that carry out work to genetically alter organisms to increase their pathogenicity and transmissibility, in order to prevent accidental release of these pathogens, while ensuring that these measures do not create any unnecessary administrative hurdles for research

(b) Foster ***information sharing*** through open science approaches for rapid sharing of scientific findings and research results, irrespective of the outcome, by means that include:

(i) measures to promote the dissemination of the results of publicly and government-funded-research for the development of pandemic response products

(ii) measures to promote and strengthen knowledge translation and evidence communication tools and strategies at local, national, regional and international levels

(c) Develop strong, resilient national, regional and international ***clinical research ecosystems***, by means that include:

(i) measures to foster and coordinate national, regional and international high quality clinical research/trials

(ii) measures to ensure equitable access to investment in clinical trials, so that resources are deployed optimally and efficiently

(iii) measures to support the transparent and rapid reporting of clinical research/trial results, to ensure evidence is available in a timely manner to inform national, regional and international decision-making

(iv) measures related to disclosure of disaggregated information on research and development and clinical trials of vaccines, diagnostics, pharmaceuticals and other products relevant to pandemic preparedness and response

(d) Increase the ***transparency of information about funding*** for research and development for pandemic response products, by means that include:

(i) measures related to the disclosure of information on public funding for research and development of potential pandemic response products and provisions to enhance the availability and accessibility of the resulting work, including freely available and publicly accessible publications and public reporting of the relevant patents

(ii) recommendations to make it compulsory for companies that produce pandemic response products to disclose prices and contractual terms for public procurement in times of pandemics.

Article 9. Fair, equitable and timely access and benefit-sharing

1. The Parties [shall]/[should] develop provisions on access and benefit-sharing to promote rapid and transparent sharing, in a safe and secure manner, of pathogens with pandemic potential and genetic sequence data on the one hand, and fair and equitable access to benefits arising from such sharing on the other, by establishing a comprehensive system for access and benefit-sharing, taking into account relevant elements of the Convention on Biological Diversity and its Nagoya Protocol, including by building upon or adapting mechanisms and/or principles contained in existing or previous instruments, such as, but not limited to, the FAO International Treaty on Plant Genetic Resources for Food and Agriculture and the WHO Pandemic Influenza Preparedness Framework.

2. Towards this end, each Party [shall]/[should]:

(a) Ensure ***timely access to affordable, safe, efficacious and effective pandemic response products***, including diagnostics, vaccines, personal protective equipment and therapeutics, by means that include:

(i) measures to ensure their equitable distribution, in particular to developing countries according to public health risk and need

(ii) measures to develop national plans that identify priority populations and prioritize access to pandemic response products by health care workers, other frontline workers and persons in vulnerable situations, such as, indigenous peoples, refugees, migrants, asylum seekers and stateless persons, the elderly, persons with disabilities, persons with health conditions, pregnant women, infants, children and adolescents

(b) Promote and facilitate recognition of the system as a ***specialized system for access and benefit-sharing***, by means that include:

(i) measures to engage with all relevant actors in the design, development and implementation of the system for access and benefit-sharing

(ii) commitments to facilitate real-time access by all countries to pandemic response products, based on public health need

(c) Promote rapid, regular and timely ***sharing of pathogens, genetic sequence data*** and relevant metadata through effective standardized real-time global and regional platforms, by means that include:

(i) measures to ensure that platforms are standardized, effective, real-time, and promote findable, accessible, interoperable and reusable (FAIR) data available to all Parties

(ii) measures to ensure consistency with international legal frameworks, notably those for collection of patient specimens, material and data

(iii) measures to ensure that laboratories handling pathogens of pandemic potential do so safely, securely, and in accordance with international best practice guidelines

(iv) measures to support and enhance biosafety and biosecurity as a prerequisite for sharing of pathogens and genetic sequence data.

Chapter IV. Strengthening and sustaining capacities for pandemic prevention, preparedness, response and recovery of health systems

Article 10. Strengthening and sustaining preparedness and health systems' resilience

1. The Parties [shall]/[should] promote and strengthen resilient health systems for pandemic prevention, preparedness, response and recovery of health systems.

2. Towards this end, each Party [shall]/[should]:

(a) Strengthen ***public health functions*** for pandemic prevention and preparedness to ensure robust pandemic response and recovery of health systems, by means that include:

(i) measures to build and reinforce surveillance systems, including One Health, outbreak investigation and control, through interoperable early warning and alert systems, across public and private sectors and relevant agencies, notably the Quadripartite, and consistent with relevant tools, including, but not limited to, the International Health Regulations (2005)

(ii) measures to build capacities in genomic sequencing, as well as in analysing and sharing such information, in order to inform risk assessment and trigger rapid response to public health threats with pandemic potential, including emerging and re-emerging zoonoses

(iii) measures to develop prevention strategies for epidemic-prone diseases, and emerging, growing or evolving public health threats with pandemic potential, notably at the human–animal–environment interface

(iv) measures to ensure equitable and affordable access to health technologies to promote the strengthening of national health systems and mitigate social inequalities

(b) Strengthen ***public health capacities to ensure availability of quality routine health services***, including immunization, during pandemics, and ***continuity of essential health service provision*** during the response, notably with a focus on primary health care and community level interventions, to mitigate the shocks caused by emergencies and prevent the health system from becoming overwhelmed, by means that include:

(i) measures to ensure continuity of primary health care and universal health coverage by maintaining the availability of, and timely access to, efficacious, quality, safe, effective, affordable and equitable health services, including clinical and mental health care

(ii) measures to address the backlog in the diagnosis and treatment of, and interventions for, other illnesses during pandemics

(c) Ensure ***recovery and restoration of resilient national health systems*** through universal health coverage, including systems for a rapid and scalable response, by means that include:

(i) measures to strengthen post-emergency health system recovery strategies in order to share the lessons learned and to improve countries' capacity in prevention, preparation, surveillance and response

(ii) measures related to resources and training at national level in order to care for patients with long-term effects from the disease

(d) Strengthen ***public health laboratory and diagnostic capacities, and national, regional and global networks***, including standards and protocols for public health laboratory biosafety and biosecurity;

(e) Enhance ***financial, technical and technological support, assistance and cooperation*** among Member States to strengthen health systems consistent with the goal of universal health coverage;

(f) Develop and ***sustain up-to-date, universal platforms and technologies*** for forecasting and timely information sharing, through appropriate capacities, including building ***digital health and data science capacities***.

Article 11. Strengthening and sustaining a skilled and competent health workforce

1. The Parties [shall]/[should] strengthen and sustain an adequate, skilled, trained, competent and committed health workforce, with due protection of their employment, civil and human rights and well-being, consistent with relevant codes of practice, including at the frontline of pandemic prevention, preparedness, response and recovery of the health system.

2. Towards this end, each Party [shall]/[should]:

(a) Mobilize and coordinate ***adequate human, financial and other necessary resources*** for affected countries, based on public health need, in order to contain outbreaks and prevent an escalation of small-scale spread to global proportions;

(b) Strengthen in- and post-service training of adequate numbers of ***health workers***, including community health workers equipped with public health core competencies, and ensure adequate laboratory capacity, including for conducting genomic sequencing, through sustainable funding support, and deployment and retention of a health workforce that can be mobilized for pandemic response in all settings;

(c) Establish an available, skilled and trained ***global public health emergency workforce*** that is deployable to support affected countries upon request, through scaling up of training and capacity of training institutions, by means that include:

(i) measures to support the development of a network of training institutions, national and regional facilities and centres of expertise in order to establish common protocols to enable more predictable, standardized and systematic response missions and deployment of surge staff

(d) Provide ***better opportunities and working environments for health workers***, notably women, to ensure their role and leadership in the health sector, with a view to increasing the meaningful representation, engagement, participation and empowerment of all health workers, while addressing discrimination, stigma and inequality and eliminating bias, including unequal

remuneration, while also noting that women still often face significant barriers to taking leadership and decision-making roles.

Article 12. Preparedness monitoring, simulation exercises and peer reviews

1. The Parties [shall]/[should] develop and implement effective and efficient monitoring of pandemic prevention and preparedness, through regular simulation exercises and peer review.

2. Towards this end, each Party [shall]/[should]:

(a) Develop and implement ***comprehensive, inclusive, multisectoral national pandemic prevention, preparedness, response and health system recovery strategies***;

(b) Map and develop ***monitoring and evaluation plans*** for health interventions related to outbreaks and public health emergencies

(i) measures to ensure dynamic preparedness capacity assessment is undertaken and national action plans are developed

(ii) measures to develop, incorporate from, or build on, existing global and national indicators for monitoring prevention and preparedness

(c) Periodically ***drill the national action plans***, through global, regional and national simulation and tabletop exercises, which include risk and vulnerability mapping;

(i) measures to support Parties, particularly in developing countries, to regularly conduct simulation exercises to assess readiness and gaps, including logistics and supply chain management, as well as to plan and implement measures for strengthening and sustaining preparedness capacity

(ii) measures to support countries to conduct after action reviews of any public health emergency event in order to identify gaps, share lessons learned, and improve national pandemic prevention and preparedness

(d) Establish, regularly update and broaden implementation of a ***global peer review mechanism*** to assess national, regional and global preparedness capacities and gaps, by bringing nations together to support a whole-of-government and whole-of-society approach to strengthening national capacities for pandemic prevention, preparedness, response and health systems recovery, through technical and financial cooperation, mindful of the need to integrate available data, and to engage national leadership at the highest level;

(e) Implement the ***recommendations generated from review mechanisms***, including prioritization of activities for immediate action;

(f) Provide ***regular reporting***, building on existing relevant reporting where possible, on pandemic prevention, preparedness, response and health systems recovery capacities.

Chapter V. Pandemic prevention, preparedness, response and health system recovery coordination, collaboration, and cooperation

Article 13. Coordination, collaboration and cooperation

1. The Parties [shall]/[should] coordinate, collaborate and cooperate, in the spirit of international solidarity, with other Parties and competent international and regional intergovernmental organizations and other bodies in the formulation of cost-effective measures, procedures and guidelines for pandemic prevention, preparedness, response and recovery of health systems.

2. Towards this end, each Party [shall]/[should]:

(a) Promote global, regional and national ***political commitment, coordination and leadership*** for pandemic prevention, preparedness, response and recovery of the health system, by means that include establishing appropriate governance arrangements/[good governance principles] rooted in the Constitution of the World Health Organization;

(b) Support mechanisms that ensure global, regional and national ***policy decisions are science and evidence-based***, through enhanced coordination, collaboration and sharing of information among experts, scientific bodies, academic institutions and networks;

(c) Develop ***policies that are inclusive;***

(i) measures to recognize the specific needs of persons in vulnerable situations, indigenous peoples, and those living in fragile areas, such as small island developing States facing multiple threats simultaneously

(ii) measures to promote equitable gender, geographical and socioeconomic status, representation and participation in global and regional decision-making processes, global networks and technical advisory groups, as well as the participation of youth

(a) measures to gather and analyse data, including data disaggregated by gender, on the impact of policies on different groups

(d) Promote ***solidarity with countries that report public health emergencies*** as an incentive to facilitate transparency and timely reporting of public health events;

(e) Enhance ***WHO's central role as the directing and coordinating authority*** on international health work, mindful of the need for coordination with entities in the United Nations system and other intergovernmental organizations;

(i) facilitate WHO rapid access to outbreak areas, including through the deployment of expert teams to evaluate and support the response to emerging outbreaks.

Article 14. Whole-of-government and other multisectoral actions

1. The Parties [shall]/[should] adopt a whole-of-government approach to pandemic prevention, preparedness, response and recovery of health systems.

2. Towards this end, each Party [shall]/[should]:

(a) Collaborate, including with non-State actors, the private sector and civil society, through an ***all-encompassing whole-of-government, multistakeholder, multi-disciplinary and multi-level approach***, by means that include:

(i) measures to develop, through whole-of-government and multisectoral collaboration, plans that strengthen pandemic preparedness, prevention, response capacities and which facilitate rapid and equitable restoration of public health capacities following a pandemic

(b) Tackle the ***social, environmental and economic determinants of health*** that contribute to the emergence and spread of pandemics, and prevent or mitigate the socioeconomic impacts of pandemics, including but not limited to, those affecting economic growth, the environment, employment, trade, transport, gender equality, education, social assistance, housing, food insecurity, nutrition and culture, and especially for persons in vulnerable situations;

(c) Support timely and scalable ***mobilization of multi-disciplinary surge capacity*** of human and financial resources and facilitate timely allocation of resources to the frontline pandemic response;

(d) Strengthen ***national public health and social policies to facilitate a rapid, resilient response***, especially for persons in vulnerable situations.

Article 15. Community engagement and whole-of-society actions

1. Recognizing that pandemics begin and end in communities, for effective pandemic prevention, preparedness, response and recovery of health systems, the Parties [shall]/[should] promote, empower and strengthen the engagement/participation of communities to ensure their ownership of, and contribution to, community readiness and resilience, including public health and social measures.

2. Towards this end, each Party [shall]/[should]:

(a) Engage with ***communities, civil society, academia and non-State actors, including the private sector***, as part of a whole-of-society approach to pandemic prevention, preparedness, response and recovery of health systems;

(b) Promote ***science and evidence-based/informed effective and timely risk assessment***, including the uncertainty of data when communicating such risk to the public;

(c) Mobilize *social capital in* ***communities for mutual support***, especially to persons in vulnerable situations;

(d) Promote two-way ***engagement of civil society, communities and non-State actors, including the private sector***, as part of a whole-of-society response that involves communities in decision making and uses feedback mechanisms;

(e) Establish or reinforce and adequately finance ***an effective national coordinating multisectoral mechanism*** with meaningful representation, engagement, participation and empowerment of communities, for pandemic prevention, preparedness, response and recovery of health systems.

Article 16. Strengthening pandemic and public health literacy

1. The Parties [shall]/[should] increase science, public health and pandemic literacy, as well as access to information on pandemics and their effects, and tackle false, misleading, misinformation or disinformation, including through promotion of international cooperation.

2. Towards this end, each Party [shall]/[should]:

(a) ***Inform the public, communicate risk and manage infodemics*** through effective channels, including social media;

(b) Conduct regular social media analysis to identify and ***understand misinformation, and design communications and messaging*** to the public to counteract misinformation, disinformation and false news;

(c) Foster ***health, science and media literacy, and promote communications on scientific, engineering and technological advances*** relevant to the development and implementation of international rules and guidelines for pandemic prevention, preparedness, response and recovery of health systems;

(d) Promote and facilitate, at all appropriate levels, in accordance with national laws and regulations, ***development and implementation of educational and public awareness programmes*** on pandemics and their effects;

(e) Strengthen ***public trust and counter misinformation and disinformation***, including through providing timely, simple, clear, coherent, accurate, transparent and effective global and national communications, based on science and evidence, promoting media literacy and ethical professional journalism, and strengthening research on misinformation and disinformation and its relationship to public trust in order to inform policies;

(f) Strengthen ***research into the behavioural barriers and drivers*** of adherence to public health measures, confidence and uptake of vaccines, use of therapeutics and trust in science and government institutions.

Article 17. One Health

1. In the context of pandemic prevention, preparedness, response and recovery of health systems, the Parties [shall]/[should] promote and enhance synergies between multisectoral collaboration at national level and cooperation at the international level, in order to safeguard human health and detect and prevent health threats at the interface between animal, human and environment ecosystems, while recognizing their interdependence.

2. Towards this end, each Party [shall]/[should]:

(a) Promote and implement a ***One Health approach that is coherent, coordinated and collaborative*** among all relevant actors, existing instruments and initiatives, by means that include:

(i) measures to identify and integrate into relevant pandemic prevention and preparedness plans, drivers for the emergence of disease at the human–animal–

environment interface, including but not limited to climate change, land use change, wildlife trade, desertification and antimicrobial resistance;

(b) Implement actions to ***prevent pandemics from pathogens resistant to antimicrobial agents***, taking into account relevant tools and guidelines, through a One Health approach, and collaborate with relevant partners, including the Quadripartite;

(c) Strengthen ***multisectoral, coordinated, interoperable, integrated One Health surveillance systems*** to minimize spill-over events and mutations and prevent small scale outbreaks in wildlife or domesticated livestock from becoming a pandemic, by means that include:

(i) measures to ensure that actions at national and community levels encompass whole-of-government and whole-of-society perspectives, including engagement of communities in surveillance that identifies zoonotic outbreaks and antimicrobial resistance

(d) Develop and implement a ***national One Health Action Plan on antimicrobial resistance*** which improves antimicrobial stewardship in the human and animal sectors; optimizes consumption; increases investment in, and promotes equitable and affordable access to, new medicines, diagnostic tools, vaccines and other interventions; strengthens infection prevention and control in health care settings; and provides technical support to developing countries;

(e) Enhance the ***surveillance and reporting of antimicrobial resistance*** in human, livestock and aquaculture of pathogens which have pandemic potential, building on the existing global reporting systems;

(f) Regularly ***assess One Health capacities***, insofar as they relate to pandemic prevention, preparedness, response and recovery of health systems, to identify gaps, policies and the funding needed to strengthen those capacities;

(g) Strengthen ***synergies with other existing relevant instruments*** which address the drivers of pandemics, such as climate change, biodiversity loss, ecosystem degradation and increased risks at the animal–human–environment interface due to human activities;

(h) Take the One Health approach into account at national, subnational and facility levels in order to produce science-based evidence, and support, facilitate and/or oversee the correct, ***evidence-based and risk-informed implementation of infection prevention and control***.

Chapter VI. Financing

Article 18. Sustainable and predictable financing

1. The Parties [shall]/[should] ensure, through existing and/or new mechanisms, sustainable and predictable financing, while enhancing transparency and accountability, to achieve the objective of the WHO CA+.

2. Towards this end, each Party [shall]/[should]:

(a) Strengthen and prioritize ***domestic financing*** for pandemic prevention, preparedness, response and health systems recovery, including through greater collaboration between the health, finance and private sectors, in support of primary health care and universal health coverage;

(b) Finance, through ***new or established international mechanisms***, regional and global capacity-building for pandemic prevention, preparedness, response and recovery of health systems;

(c) Measures to ensure/enhance ***sustainable, [equitable, fair,] and predictable financing*** of global, regional and national systems and tools and global public goods for pandemic prevention, preparedness, response and recovery of health systems, through existing or new mechanisms, while avoiding duplication and ensuring synergies, in order to guarantee equitable access to preparedness financing;

(d) Facilitate rapid and effective mobilization of ***adequate financial resources***, including from international financing facilities, to affected countries, based on public health need, to maintain and restore routine public health functions during and in the aftermath of a pandemic response.

Chapter VII. Institutional arrangements

Article 19. Governing body for the WHO CA+[1]

1. A governing body for the WHO CA+ is established to promote the effective implementation of the WHO CA+ (hereinafter, the "Governing Body").

2. The Governing Body shall be composed of:

(a) The Conference of the Parties (COP), which shall be the supreme organ of the Governing Body;

(b) The Officers of the Parties (OP), which shall be the administrative organ of the Governing Body; and

(c) The Enlarged Conference of the Parties (E-COP), which will include relevant stakeholders and will provide broad input for the decision-making processes of the COP.

3. The COP, as the supreme policy setting organ of the WHO CA+, shall keep under regular review the implementation of the WHO CA+ and any related legal instruments that the COP may adopt, and shall make the decisions necessary to promote the effective implementation of the Convention. The COP shall:

(a) Be composed of delegates representing Parties;

(b) Convene ordinary sessions of the Governing Body; the first of which shall take place not later than one year after the date of entry into force of the Convention, at a time and place to be determined by the WHO Secretariat, with the time and place of subsequent ordinary sessions to be determined by the COP upon a proposal of the Officers of the Parties;

(c) Convene extraordinary sessions of the Governing Body at such other times as may be deemed necessary by the COP, or at the written request of any Party, provided that, within 30

[1] *This and subsequent articles provide a conceptual approach for the governing body for the WHO CA+.*

days of such a request being communicated to the Parties by the Secretariat, it is supported by at least one third of the Parties; and

(d) Adopt its rules of procedure, as well as those of the other bodies of the Governing Body, which shall include decision-making procedures. Such procedures may include specified majorities required for the adoption of particular decisions.

4. The Officers of the Parties, as the administrative organ of the Governing Body, shall:

(a) Be composed of two Presidents and four Vice-Presidents, serving in their individual capacity and elected by the COP, as well as two rapporteurs elected by the E-COP;

(b) Endeavour to make decisions by consensus; however, if efforts to reach consensus are deemed by the Presidents to be unavailing, decisions may be taken by voting by the President and Vice-Presidents.

5. The E-COP, as the polylateral diplomacy venue for encouraging broad input for the decision-making processes of the COP, shall:

(a) Be composed of delegates representing Parties;

(b) Be composed of representatives of the United Nations and its specialized and related agencies, as well as any State Member thereof or observers thereto not Party to the CA+;

(c) Be further composed of representatives of any body or organization, whether national or international, governmental or non-governmental, private sector or public sector, which is qualified in matters covered by the WHO CA+, and which, upon nomination by any Party, is supported by a two thirds majority of the COP;

(d) Be subject to the rules of procedure adopted by the COP.

6. The Governing Body may further develop proposals for consideration by the WHO Executive Board, including to promote coordination between its Standing Committee on Health Emergency Prevention, Preparedness and Response and the Governing Body for the CA+.

Article 20. Oversight mechanisms for the WHO CA+[1]

1. The Governing Body, at its first meeting, shall consider and approve cooperative procedures and institutional mechanisms to promote compliance with the provisions of the WHO CA+ and, if deemed appropriate, to address cases of non-compliance.

2. These measures, procedures and mechanisms shall include monitoring provisions and accountability measures to systematically address preparedness for, response to, and the impact of pandemics, by means that include submission of periodic reports, reviews, remedies and actions, and to

[1] *A number of existing universal international agreements, including the United Nations Framework Convention on Climate Change (198 Parties, including 197 countries and the EU) and Paris Agreement (194 Parties, including 193 countries and the EU), as well as the 1985 Vienna Convention for the Protection of the Ozone Layer and its Montreal Protocol (both having 198 Parties, including 197 countries and the EU), may provide useful sources for mechanisms regarding oversight, reporting and related processes and bodies for consideration by the INB.*

offer advice or assistance, where appropriate. These measures shall be separate from, and without prejudice to, the dispute settlement procedures and mechanisms under the WHO CA+.

Article 21. Assessment and review

1. The Governing Body shall establish a mechanism to undertake, four years after the entry into force of the WHO CA+, and thereafter at intervals and upon modalities determined by the Governing Body, an evaluation of the relevance and effectiveness of the WHO CA+, and recommend corrective measures, including, if deemed appropriate, amendments to the text of the WHO CA+.

Article 22. Financial mechanisms and resources to support WHO CA+

1. The Parties recognize the important role that financial resources play in achieving the objective(s) of the WHO CA+, and the primary financial responsibility of national governments in protecting and promoting the health of their populations.

2. Each Party shall provide financial support in respect of its national activities intended to achieve the objective(s) of the WHO CA+, in accordance with its national plans, priorities and programmes.

3. Each Party shall plan and provide financial support in line with its national fiscal capacities for the effective implementation of the WHO CA+.

4. The Parties shall promote, as appropriate, the use of bilateral, regional, subregional and other appropriate and relevant multilateral channels to provide funding, for the development and strengthening of pandemic prevention, preparedness, response and health system recovery programmes of developing country Parties.

5. The Parties represented in relevant regional and international intergovernmental organizations, and financial and development institutions shall encourage these entities to provide financial assistance for developing country Parties and for Parties with economies in transition, to support them in meeting their obligations under the WHO CA+, without limiting their right to participate in these organizations.

Chapter VIII. Final provisions

Article 23. Reservations

1. No reservations may be made to the WHO CA+.

Article 24. Withdrawal

1. At any time after two years from the date on which the WHO CA+ has entered into force for a Party that Party may withdraw from the WHO CA+ by giving written notification to the Depository.

2. Any such withdrawal shall take effect upon expiry of one year from the date of receipt by the Depository of the notification of withdrawal, or on such later date as may be specified in the notification of withdrawal.

3. Any Party that withdraws from the WHO CA+ shall be considered as also having withdrawn from any protocol to which it is a Party.

Article 25. Right to vote

1. Each Party to the WHO CA+ shall have one vote, except as provided for in paragraph 2 of this Article.

2. Regional economic integration organizations, in matters within their competence, shall exercise their right to vote with a number of votes equal to the number of their Member States that are Parties to the WHO CA+. Such an organization shall not exercise its right to vote if any of its Member States exercises its right, and vice versa.

Article 26. Amendments to the WHO CA+

1. Any Party may propose amendments to the WHO CA+. Such amendments will be considered by the Governing Body.

2. Amendments to the WHO CA+ shall be adopted by the Governing Body. The text of any proposed amendment to the WHO CA+ shall be communicated to the Parties by the Secretariat at least six months before the session at which it is proposed for adoption. The Secretariat shall also communicate proposed amendments to the signatories of the WHO CA+ and, for information, to the Depository.

3. The Parties shall make every effort to reach agreement by consensus on any proposed amendment to the WHO CA+. If all efforts at consensus have been exhausted, and no agreement reached, the amendment shall as a last resort be adopted by a two-thirds majority vote of the Parties present and voting at the session. For purposes of this Article, Parties present and voting means Parties present and casting an affirmative or negative vote. Any adopted amendments shall be communicated by the Secretariat to the Depository, who shall circulate it to all Parties for acceptance.

4. Instruments of acceptance in respect of an amendment shall be deposited with the Depository. An amendment adopted in accordance with paragraph 3 of this Article shall enter into force for all Parties when adopted by a two-thirds vote and accepted by two-thirds of the Parties in accordance with their respective constitutional processes.

5. The amendment shall enter into force for any other Party on the ninetieth day after the date on which that Party deposits with the Depository its instrument of acceptance of the said amendment.

Article 27. Adoption and amendment of annexes to the WHO CA+

1. Annexes to the WHO CA+ and amendments thereto shall be proposed, adopted and shall enter into force in accordance with the procedure set forth in the WHO CA+.

2. Annexes to the WHO CA+ shall form an integral part thereof and, unless otherwise expressly provided, a reference to the WHO CA+ constitutes at the same time a reference to any annexes thereto.

3. Annexes shall be restricted to lists, forms and any other descriptive material relating to procedural, scientific, technical or administrative matters.

Article 28. Protocols to the WHO CA+[1]

1. Any Party may propose protocols to the WHO CA+. Such proposals will be considered by the Governing Body.

2. The Governing Body may adopt protocols to the WHO CA+. In adopting these protocols every effort shall be made to reach consensus. If all efforts at consensus have been exhausted and no agreement reached, the protocol shall as a last resort be adopted by a two-thirds majority vote of the Parties present and voting at the session. For the purposes of this Article, Parties present and voting means Parties present and casting an affirmative or negative vote.

3. The text of any proposed protocol shall be communicated to the Parties by the Secretariat at least six months before the session at which it is proposed for adoption.

4. States that are not Parties to the WHO CA+ may be Parties to a protocol thereof, provided the protocol so provides.

5. Any protocol to the WHO CA+ shall be binding only on the Parties to the protocol in question. Only Parties to a protocol may take decisions on matters exclusively relating to the protocol in question.

6. The requirements for entry into force of any protocol shall be established by that instrument.

Article 29. Signature

1. The WHO CA+ shall be open for signature by all Members of the World Health Organization and by any States that are not Members of the World Health Organization but are members of the United Nations and by regional economic integration organizations at the World Health Organization headquarters in Geneva from [●] [●] 202[●] to [●] [●] 202[●], and thereafter at United Nations Headquarters in New York, from [●] [●] 202[●] to [●] [●] 202[●].

Article 30. Ratification, acceptance, approval, formal confirmation or accession

1. The WHO CA+ shall be subject to ratification, acceptance, approval or accession by States, and to formal confirmation or accession by regional economic integration organizations. It shall be open for accession from the day after the date on which the WHO CA+ is closed for signature. Instruments of ratification, acceptance, approval, formal confirmation or accession shall be deposited with the Depository.

2. Any regional economic integration organization which becomes a Party to the WHO CA+ without any of its Member States being a Party shall be bound by all the obligations under the WHO CA+. In the case of those organizations, where one or more of its Member States is a Party to the WHO CA+, the organization and its Member States shall decide on their respective responsibilities for the performance of their obligations under the WHO CA+. In such cases, the organization and the Member States shall not be entitled to exercise rights under the WHO CA+ concurrently.

3. Regional economic integration organizations shall, in their instruments relating to formal confirmation or in their instruments of accession, declare the extent of their competence with respect to

[1] *Nothing in this Article, or other provisions of this conceptual zero draft, is intended to pre-judge the nature or structure of the final instrument.*

the matters governed by the WHO CA+. These organizations shall also inform the Depository, who shall in turn inform the Parties, of any substantial modification in the extent of their competence.

Article 31. Entry into force

1. The WHO CA+ shall enter into force on the [thirtieth] day following the date of deposit of the [fortieth] instrument of ratification, acceptance, approval, formal confirmation or accession with the Depository.

2. For each State that ratifies, accepts or approves the WHO CA+ or accedes thereto after the conditions set out in paragraph 1 of this Article for entry into force have been fulfilled, the WHO CA+ shall enter into force on the [thirtieth] day following the date of deposit of its instrument of ratification, acceptance, approval or accession.

3. For each regional economic integration organization depositing an instrument of formal confirmation or an instrument of accession after the conditions set out in paragraph 1 of this Article for entry into force have been fulfilled, the WHO CA+ shall enter into force on the thirtieth day following the date of its depositing of the instrument of formal confirmation or of accession.

4. For the purposes of this Article, any instrument deposited by a regional economic integration organization shall not be counted as additional to those deposited by States Members of the Organization.

Article 32. Provisional application

1. The WHO CA+ may be applied provisionally by a Party that consents to its provisional application by so notifying the Depository in writing at the time of signature or deposit of its instrument of ratification, acceptance, approval, formal confirmation or accession. Such provisional application shall become effective from the date of receipt of the notification by the Secretary-General of the United Nations.

2. Provisional application by a Party shall terminate upon the entry into force of the WHO CA+ for that Party or upon notification by that Party to the Depository in writing of its intention to terminate its provisional application.

Article 33. Settlement of disputes

1. In the event of a dispute between two or more Parties concerning the interpretation or application of the WHO CA+, the Parties concerned shall seek through diplomatic channels a settlement of the dispute through negotiation or any other peaceful means of their own choice, including good offices, mediation or conciliation. Failure to reach agreement by good offices, mediation or conciliation shall not absolve Parties to the dispute from the responsibility of continuing to seek to resolve it.

2. When ratifying, accepting, approving, formally confirming or acceding to the WHO CA+, or at any time thereafter, a Party may declare in writing to the Depository that, for a dispute not resolved in accordance with paragraph 1 of this Article, it accepts, as compulsory, ad hoc arbitration in accordance with procedures to be adopted by consensus by the Governing Body.

3. The provisions of this Article shall apply with respect to any protocol as between the Parties to the protocol, unless otherwise provided therein.

Article 34. Depository

1. The Secretary-General of the United Nations shall be the Depository of the WHO CA+ and amendments thereto and of protocols and annexes adopted in accordance with the terms of the WHO CA+.

Article 35. Authentic texts

1. The original of the WHO CA+, of which the Arabic, Chinese, English, French, Russian and Spanish texts are equally authentic, shall be deposited with the Secretary-General of the United Nations.

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