TAKSHASHILA INSTITUTION

WHO Pandemic Treaty – Proposed Zero Draft

Annotated Explainer

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Takshashila Discussion Document 2023-04
Version 1.0, February 2023

The World Health Organization (WHO) has proposed a new international treaty to strengthen global cooperation and preparedness for future pandemics. The treaty would establish a framework for sharing data, resources, and technologies, and would also aim to improve early warning systems, research, and development of medical countermeasures. This document examines various provisions of the zero draft and sets the context for the reader.

Recommended Citation:
Saurabh Todi, Shambhavi Naik, "WHO Pandemic Treaty – Proposed Zero Draft - Annotated Explainer," Takshashila Discussion Document No. 2023-04, February 2023, The Takshashila Institution.

Executive Summary

This document analyses the provisions of the Zero draft of the WHO CA+ for the consideration of the Intergovernmental Negotiating Body at its fourth meeting scheduled to be held between 27 February - 3 March 2023.

How To Read This Document

The Zero draft of the WHO CA+ for the consideration of the Intergovernmental Negotiating Body at its fourth meeting is reproduced in full in Section A of this document along with annotations highlighting the various issues with these provisions using sidenotes. The objective here is to set context for the reader of the treaty. Sidenote format has been used to comment on the specific proposals and claims in the treaty text, which have been made bold and coloured in **dark maroon** colour. Our notations can be classified into two broad categories:

1. Summary of existing treaties or documents referenced in the Zero Draft wherever relevant.
2. Comments on proposed provisions and highlighting discussion points wherever relevant.

This document has been formatted to be read conveniently on screens with landscape aspect ratios. Please print only if necessary.

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A.Zero Draft, For The Consideration Of The Intergovernmental Negotiating Body At Its Fourth Meeting [1]

Preamble[I]

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

Measuring equity as an indicator is a noble idea. However, a discussion is needed on what parameters will be needed, how real-time data will be gathered and analysed, and how pre-committed resources might be re-purposed to achieve equitable outcomes. Equity as a guiding principle is reasonable, but as an indicator might not be achievable.

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

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. Recognizing the central role of WHO, as the directing and coordinating authority on international health work, in pandemic prevention, preparedness, response and recovery of health systems, and in convening and generating scientific evidence, and, more generally, fostering multilateral cooperation in global health governance,
6. 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;
7. 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;
8. 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

The crucial factor here will be the definition of pandemic. The WHO says a pandemic is simply "the worldwide spread of a new disease". In the absence of clear criteria, the effectiveness of this treaty may be tempered. In the past, WHO has been criticised[2] for calling a pandemic prematurely (2009 H1N1)[3] or too late (COVID-19). Since the implementation of the treaty hinges on this announcement, a clearer definition would be needed[4].

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. They create rights and obligations for countries, including the requirement to report public health events. The Regulations also outline the criteria to determine whether a particular event constitutes a "public health emergency of international concern"[5].

risks, and which avoid unnecessary interference with international traffic and trade;

9. 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;
10. 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";
11. 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 East respiratory syndrome and monkeypox, and with a view to addressing and closing gaps and improving future response;
12. 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;
13. 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;

14. Noting that in 2021 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;
15. 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;
16. Expressing concern that those affected by conflict and insecurity are particularly at risk of being left behind during pandemics;
17. 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;
18. 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,

This wording could signal that a special emphasis is needed to improve preparedness for the urban centres. Data however show that though overall case numbers may be higher in more populated urban areas, normalised fatalities may be higher in rural areas. In addition, less developed economies may not have had enough infrastructure or manpower to adequately detect COVID-19 in remote areas. There is a need for a global study to understand health disparities and resource allocation in pandemic settings and how to guard against inequitable resource allocation in a time of humanitarian crisis.

"Whole-of-government 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. It 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". While these are ideal approaches, this framework has been thought about in high income countries with universal health systems. Their application to other economies which suffer from health delivery disparities, even for humans, need to be thought through.

require a multisectoral whole-of-society approach to pandemic prevention, preparedness, response and recovery of the health systems;

19. 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;
20. 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;
21. 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;
22. Reaffirming the importance of access to timely information, as well as efficient risk communication that manages to counteract pandemics;
23. Understanding that most emerging infectious diseases originate in animals, including wildlife and domestic animals, then spill over to people;
24. 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;

25. Noting that **antimicrobial resistance** is often described as a silent pandemic and that it could be an aggravating factor during a pandemic;
26. 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.
27. 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;
28. 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;
29. 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;

COVID-19 has demonstrated that several underlying diseases may lead to aggravation of sickness during a pandemic. Further, reduced healthcare access may lead to the aggravation of underlying diseases. Both these factors, along with rising AMR could lead to the exacerbation of the pandemic.

30. 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;
31. 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;
32. Acknowledging that there are significant differences in countries' capacities to prevent, prepare for, respond to, and recover from pandemics;
33. 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;
34. 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;

35. 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;
36. 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;
37. Recalling the **Doha Declaration** on the TRIPS Agreement and Public Health of 2001 and reiterating that the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) does not and should not prevent Members of the World Trade Organization from taking measures to protect public health,
38. 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;
39. 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;

The Doha Declaration of 2001 recognises that though intellectual property protection is important for the development of new medicines, the TRIPS Agreement does not and should not prevent members from taking measures to protect public health. Each member has the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted. Each member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria, and other epidemics, can represent a national emergency or other circumstances of extreme urgency.

40. 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,
41. 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,
42. 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,
43. Recognizing the concerns that intellectual property on life-saving medical technologies continues to **pose threats 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

IP rights impact both prices and access to life-saving technologies. The fees for buying licences can directly preclude low-income economies from purchasing them. In addition, IP holders can reject licensure, and thereby hinder access to their technologies.

a future pandemic prevention, preparedness and response mechanism that is not based on a charity model,

44. Reaffirming the flexibilities and safeguards contained in the TRIPS Agreement and their importance for removing barriers to production of, and access to, pandemic-related 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,
45. Reaffirming the flexibilities and safeguards contained in the TRIPS Agreement and their importance for ensuring access to technologies, knowledge and full transfer of technology and know-how for production and supply of pandemic-related products, as well as their equitable distribution,
46. 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;
47. Recognizing that publicly funded research and development plays an important role in the development of pandemic response products, and, as such, requires conditionalities;
48. 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

Resolution WHA61.21 emphasized the importance of intellectual property protection and acknowledged the role of the World Intellectual Property Organization (WIPO) in this regard. However, it also highlighted the need for a balance between intellectual property rights and public health concerns. The resolution also called for the promotion of research and development of new drugs, diagnostics, and vaccines, especially for diseases that disproportionately affect developing countries, and for the development of new incentive mechanisms to encourage research in these areas.

During COVID-19 pandemic, rapid sharing of genomic data of various variants of the pathogen helped in shaping the tailored response.

into account relevant national and international laws, regulations, obligations and frameworks, including the International Health Regulations, 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;

49. 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.

The CBD and its Nagoya Protocol provide a framework for fair and equitable sharing of the benefits arising from the use of genetic resources. The protocol requires prior informed consent and mutually agreed terms for access and benefit-sharing arrangements, including financial and non-financial benefits, technology transfer, and capacity building, to promote conservation and sustainable use of biodiversity.

Have agreed as follows:

The world together equitably

Vision: The WHO CA+ aims for a world where pandemics are effectively controlled 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, while recognizing the sovereign rights of countries, acknowledging the differences in levels of development among countries, respecting
their national context and recognizing existing relevant international instruments. The WHO CA+ aims to achieve greater equity and effectiveness for pandemic prevention, preparedness and response through the fullest national and international cooperation.

Chapter I. Introduction

Article 1. Definitions and use of terms

For the purposes of this WHO CA+:

a. "genomic sequences" means the order of nucleotides identified in a molecule of DNA or RNA. They contain the full genetic information that determines the biological characteristics of an organism or a virus;
b. "**pandemic**" means the global spread of a pathogen or variant that infects human populations with limited or no immunity through sustained and high transmissibility from person to person, overwhelming health systems with severe morbidity and high mortality, and causing social and economic disruptions, all of which

This pandemic definition appears based on the spread of COVID-19 – using this disregards other potential forms of a pandemic and basically calls for the kickstarting of this treaty under a crisis situation. A pandemic treaty should prepare for a pandemic under non-crisis times, not wait for the situation to become critical.

require effective national and global collaboration and coordination for its control[II];

c. "pandemic-related products" means products that may be needed for pandemic prevention, preparedness, response and/or recovery, and which may include, without limitation, diagnostics, therapeutics, medicines, vaccines, personal protective equipment, syringes and oxygen;
d. "persons in vulnerable situations" includes indigenous peoples, persons belonging to national or ethnic, religious or linguistic minorities, refugees, migrants, asylum seekers, 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, and those living in fragile areas, such as Small Island Developing States;
e. "pathogen with pandemic potential" means...;
f. "One Health approach" means...;
g. "One Health surveillance" means...;
h. "infodemic" means...;
i. "inter-pandemic" means...;

[II] The INB is encouraged to conduct discussions on the matter of the declaration of a "pandemic" by the WHO Director-General under the WHO CA+ and the modalities and terms for such a declaration, including interactions with the International Health Regulations and other relevant mechanisms and instruments. In this connection see Article 15.2 hereof.

j. "current health expenditure" means...;
k. "universal health coverage" means...; and
l. "recovery" means...

Article 2. Relationship with international agreements and instruments

1. The implementation of the WHO CA+ shall be guided by the Charter of the United Nations and the Constitution of the World Health Organization. The WHO CA+ and other relevant international instruments, including the International Health Regulations, should be interpreted so as to be complementary, compatible and synergistic, and the WHO CA+ should be interpreted in a manner that promotes and supports the implementation and operationalization of the International Health Regulations and other relevant international instruments[III]. 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, response and health system recovery.

[III] The INB is encouraged to conduct discussions on the matter of making explicit the synergies and concrete complementarity of the WHO CA+ with the International Health Regulations and other relevant mechanisms and instruments.

2. The provisions of the WHO CA+ shall not affect the rights and obligations of any Party under other existing international instruments and shall respect the competencies of other organizations and treaty bodies.
3. 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 their obligations under the WHO CA+. The Parties concerned shall communicate such instruments to the Governing Body for the WHO CA+ through the Secretariat.

Chapter II. Objective(s), principles, and scope

Article 3. Objective(s)

The objective of the WHO CA+, guided by the vision and principles and rights set out herein, is to **prevent pandemics**, save lives, reduce disease burden 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 comprehensively and effectively 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, progressive realization of universal health coverage and ensuring coordinated, collaborative and evidence-based pandemic response and resilient recovery of health systems at community, national, regional and global levels.

To prevent pandemics, strengthening health systems, encouraging technology transfers, and building resilient supply chains must be performed in advance and the global community should not wait for an onset of pandemic to initiate these efforts.

How to measure the scale and severity of a pandemic? And how does the WHO CA+ proactively take measures?

Article 4. Guiding principles and rights

To achieve the objective(s) of the WHO CA+ and to implement its provisions, the Parties will be guided, inter alia, by the principles and rights 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 – The absence of unfair, avoidable or remediable differences, including in their capacities, among and within countries, including between groups of people, whether those groups are defined socially, economically, demographically, geographically or by other dimensions of inequality, is central to equity. Effective pandemic prevention, preparedness, response and recovery cannot be achieved without political will and commitments in addressing the structural challenges in inequitable access to fair, equitable and timely access to affordable, safe and efficacious pandemic-related products and services, essential

health services, information and social support, as well as tackling the inequities in terms of technology, health workforce, infrastructure and financing, among other aspects.

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 – States are 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 cooperate with other States and relevant international organizations, 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 – All States are responsible for the health of their people, including pandemic prevention, preparedness, response and recovery, and previous pandemics have demonstrated that no one is safe until everyone is safe. Given that the health of all peoples is dependent on the fullest cooperation of individuals and States, all Parties are bound by the obligations of the WHO CA+. States that hold more resources relevant to pandemics, including pandemic-related products and manufacturing capacity, should bear, where appropriate, a commensurate degree of differentiated responsibility with regard to global pandemic prevention, preparedness, response and recovery. With the aim of supporting every Party to achieve the highest level of proven and sustained capacity, 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. potentially bear a disproportionately high 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 and transdisciplinary actions** should recognize the interconnection between people, animals, plants and their shared environment, for which a coherent, integrated and unifying approach should be strengthened and applied with an aim 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 and zoonotic diseases.

How would this work? We will not know how much to attribute the prevention of pandemics to particular measures. Mostly because we will not be able to assess the potential of a pandemic that has been prevented. Even with COVID-19, the gravity of the situation became measurable only much after its massive global spread.

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 **data** should inform all public health decisions and the development and implementation of guidance for pandemic prevention, preparedness, response and recovery of health systems.

Anonymized, population-level and contextualized data would be helpful in this regard as well.

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 regular monitoring and policy evaluation, to ensuring that the impacts of measures aimed at preventing, preparing for and responding to pandemics are proportionate to their intended objectives and that the benefits arising therefrom outweigh costs.

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. Predictable global supply chain and logistics network.

1. The Parties, recognizing the shortcomings of the preparedness for and response to the COVID-19 pandemic, agree on the need for an adequate, equitable, transparent, robust, agile, effective and diverse global supply chain and logistics network for pandemic prevention, preparedness, response and recovery.
2. The WHO Global Pandemic Supply Chain and Logistics Network (the "Network") is hereby established.
3. The Parties shall support the Network's development and operationalization, and participate in the Network, within the framework of WHO, including through sustaining it in inter-pandemic times as well as appropriate scale-up in the event of a pandemic. In that regard, the Parties shall:
    a. determine the types and size of products needed for robust pandemic prevention, preparedness and response, including costs and logistics for establishing and maintaining strategic stockpiles of such products, by working with relevant stakeholders and

experts, guided by scientific evidence and regular epidemiological risk assessments;

b. assess anticipated demand for, and map sources of, manufacturers and suppliers, including raw materials and other necessary inputs, for sustainable production of pandemic-related products (especially active pharmaceutical ingredients), including manufacturing capacities, and identify the most efficient multilateral and regional purchasing mechanisms, including pooled mechanisms and in-kind contributions, as well as promoting transparency in cost and pricing of all elements along the supply chain;

c. develop a mechanism to ensure the fair and equitable allocation of pandemic-related products based on public health risks and needs;

d. **map** existing delivery and distribution options, and establish or operationalize, as appropriate, 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; and

e. develop a **dashboard** for pandemic-related product supply capacity and availability, with regular reporting, and conduct regular tabletop exercises to test the functioning of the Network.

4. The Parties commit not to impose regulations that unduly interfere with the trade in, or of, pharmaceutical raw materials and ingredients,

Mapping would be a critical exercise that would help global preparedness. However, this must include traders and the comparative selling options traders have in times of crisis. A seller in India may prefer to sell internationally at higher prices, even if there is a domestic health crisis. Information on locally held stocks within larger countries such as US may not be available with the US government.

A dashboard may work for government-held supplies; private stocks and pricing changes very dynamically in the middle of a crisis.

mindful of the need for unhindered access to pandemic-related products.

5. The Parties commit to safeguard the humanitarian principles of humanity, neutrality, impartiality and independence, and to facilitate the **unimpeded access** of humanitarian staff and cargo. The commitment to facilitate such access is understood to be legally binding and to apply in all circumstances, consistent with humanitarian principles.
6. The Parties, working through the Governing Body for the WHO CA+, shall take all appropriate measures to establish and start functioning of the Network no later than XX. It is understood that giving effect to this Article immediately upon adoption of the WHO CA+ shall be considered pursuant to, and within the meaning of, Article 35 of the WHO CA+.

Unimpeded access may be subject to conditions – health checks, for example.

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

1. The Parties recognize that inequitable access to pandemic-related products (including but not limited to vaccines, therapeutics and diagnostics) should be addressed by **increased manufacturing capacity** that is more equitably, geographically and strategically distributed.
2. The Parties, working through the Governing Body for the WHO CA+, shall strengthen existing and develop innovative multilateral

Completely agree – and India can help with setting up this manufacturing capacity both domestically and internationally.

mechanisms that promote and incentivize relevant transfer of technology and know-how for production of pandemic-related products, on mutually agreed terms, to capable manufacturers, particularly in developing countries.

3. During inter-pandemic times, all Parties commit to establish these mechanisms and shall:
    a. coordinate, collaborate, facilitate and incentivize manufacturers of pandemic-related products to transfer relevant technology and know-how to capable manufacturer(s) (as defined below) on mutually agreed terms, including through technology transfer hubs and product development partnerships, and to address the needs to develop new **pandemic-related products** in a short time frame;
    b. strengthen coordination, with relevant international organizations, including 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;
    c. encourage entities, including manufacturers within their respective jurisdictions, that conduct research and development of pre-pandemic and pandemic-related products, in particular those that receive **significant public financing** for that purpose, to grant, on mutually agreed terms, licences to capable manufacturers, notably from developing countries, to use their

What products qualify as pandemic-related products? Is there a consolidated list for the same? If not, will these products be specific to the pandemic in question and who will formulate this list?

A well-intentioned provision, but the question remains how this will operationalize? COVID-19 vaccines were also built on technologies which were majorly publicly funded, yet waiving or managing royalties or patents did not materialize.

intellectual property and other protected substances, products, technology, know-how, information and knowledge used in the process of pandemic response product research, development and production, in particular for pre-pandemic and pandemic-related products; and

d. collaborate to ensure equitable and affordable access to health technologies that promote the strengthening of national health systems and mitigate social inequalities.

4. In the event of a pandemic, the Parties:
   a. will take appropriate measures to support **time-bound waivers** of intellectual property rights that can accelerate or scale up manufacturing of pandemic-related products during a pandemic, to the extent necessary to increase the availability and adequacy of affordable pandemic-related products;
   b. will apply the full use of the flexibilities provided in the TRIPS Agreement, including those recognized in the Doha Declaration on the TRIPS Agreement and Public Health of 2001 and in **Articles 27, 30 (including the research exception and "Bolar" provision), 31 and 31bis of the TRIPS Agreement**;
   c. shall encourage all holders of patents related to the production of pandemic-related products to waive, or manage as appropriate, payment of royalties by developing country manufacturers on the use, during the pandemic, of their technology for production of pandemic-related products, and shall require, as appropriate,

The experience of the process to agree on the proposal by India and South Africa for vaccine IP waivers during COVID-19 can be instructive in this regard[6].

Articles 27, 30, 31, and 31bis of the TRIPS Agreement govern patentability, limitations on patent rights, compulsory licensing, and access to medicines. Article 27 sets out minimum patent standards and allows for limitations on patentability; Article 30 permits the use of patented inventions for research purposes and to produce generic drugs for export; The "Bolar" provision allows for the use of patented inventions for regulatory approval of generic drugs; Article 31 covers compulsory licensing in certain circumstances; and Article 31bis allows for the importation of generic medicines produced under compulsory license from other countries for public health reasons.

those that have received public financing for the development of pandemic-related products to do so; and

d. shall encourage all research and development institutes, including manufacturers, in particular those receiving significant public financing, to waive, or manage as appropriate, royalties on the continued use of their technology for production of pandemic-related products.

5. For purposes of this Article, "capable manufacturer" refers to an entity that operates in a manner that is consistent with national and international guidelines and regulations, including biosafety and biosecurity standards.

Article 8. Regulatory strengthening

1. The Parties shall strengthen the capacity and performance of national regulatory authorities and increase the harmonization of regulatory requirements at the international and regional level, including, as applicable, through mutual recognition agreements.
2. Each Party shall build and strengthen its country regulatory capacities and performance for timely approval of pandemic-related products and, in the event of a pandemic, accelerate the process of approving and licensing pandemic-related products for emergency use in a timely manner, including the sharing of regulatory dossiers with other institutions.

3. The Parties shall, as appropriate, monitor and regulate against substandard and falsified pandemic-related products, through existing Member State mechanisms on substandard and falsified medical products.

Article 9. Increasing research and development capacities.

1. The Parties recognize the need to build and strengthen capacities and institutions for innovative research and development for pandemic-related products, particularly in developing countries, and the need for information sharing through open science approaches for rapid sharing of scientific findings and research results.
2. With a view to promoting greater sharing of knowledge and transparency, each Party, when providing public funding for research and development for pandemic prevention, preparedness, response and recovery of health systems, shall, taking into account the extent of the public funding received:
    a. promote the free, public dissemination of the results of publicly and government-funded research for the development of pandemic-related products;
    b. endeavour to include terms and conditions on **prices of products**, allocation, data sharing and transfer of technology, as appropriate, and publication of contract terms;

Pricing will vary greatly in manufacturer-driven and supplier-driven markets. There must be better transparency in the logistics of pandemic products to protect from price gouging or hoarding.

c. ensure that promoters of research for pandemic-related products assume an appropriate level of the associated risk;
d. promote and incentivize technology co-creation and joint venture initiatives; and
e. establish appropriate conditions for publicly funded research and development, including on distributed manufacturing, licensing, technology transfer and pricing policies.

3. Parties shall increase the transparency of information about funding for research and development for pandemic-related products by:
   a. disclosing information on public funding for research and development of potential pandemic-related 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;
   b. making it compulsory for manufacturers that receive public funding for the production of pandemic-related products to disclose prices and contractual terms for public procurement in times of pandemics, taking into account the extent of the public funding received; and
   c. encouraging manufacturers that receive other funds, external to the manufacturer, for the production of pandemic-related products to disclose prices and contractual terms for public procurement in times of pandemics.

4. Each Party should encourage non-State actors to participate in and accelerate innovative research and development for addressing novel pathogens, pathogens resistant to antimicrobial agents and emerging and re-emerging diseases with pandemic potential.
5. The Parties shall establish, no later than XX, with reference to existing models, a global compensation mechanism for injuries resulting from pandemic vaccines.
6. Pending establishment of such global compensation mechanism, each Party shall, in contracts for the supply or purchase of pandemic-related products, endeavour to exclude buyer/recipient indemnity clauses of indefinite or excessive duration.
7. In the conclusion of contracts for the supply or purchase of pandemic-related products, each Party shall endeavour to exclude confidentiality provisions that serve to limit disclosure of terms and conditions.
8. Each Party shall, as applicable, implement and apply international standards for, **oversight of and 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.
9. The Parties are encouraged to promote and strengthen knowledge translation and evidence-based communication tools and strategies relating to pandemic prevention, preparedness, response and recovery, at local, national, regional and international levels.

Certain aspects of this work, including gain-of-function research on pathogens may fall under the remit of the Biological Weapons Convention (BWC). A coordinated effort between BWC and WHO would help create better standards and biosafety measures.

Furthermore, these reporting requirements should also include sources of funding for research on pathogens. US Congressional Research Service has released a report[7] that covers funding related governance for gain-of-function research from the US perspective. Specific funding guidance should be developed at the international level.

10. The Parties acknowledge the need to take steps, individually and collectively, to develop strong, resilient national, regional and international clinical research ecosystems. In that regard, the Parties, as appropriate, commit to:
    a. **fostering and coordinating clinical research and clinical trials**, including, as appropriate, through existing coordination mechanisms;
    b. ensuring equitable access to resources (funding or in-kind), clinical research and clinical trials, so that resources are deployed optimally and efficiently;
    c. supporting transparent and rapid reporting of clinical research and clinical trial results, to ensure evidence is available in a timely manner to inform national, regional and international decision-making; and
    d. disclosing disaggregated information, for instance by gender and age, to the extent possible and as appropriate, on the results of clinical research and clinical trials relating to pandemic prevention, preparedness, response and recovery.

Clinical trials must be globally representative, so that the approved products can be used worldwide without the requirement for further trials.

Article 10. WHO Pathogen Access and Benefit-Sharing System

1. The need for a multilateral, fair, equitable and timely system for sharing of, on an equal footing, **pathogens with pandemic potential** and genomic sequences, and benefits arising therefrom, that applies and

This should ideally be done in collaboration with the BWC because with the advent of gene editing, all pathogens have some pandemic potential.

operates in both inter-pandemic and pandemic times, is hereby recognized. In pursuit thereof, it is agreed to establish the WHO Pathogen Access and Benefit-Sharing System (the "PABS System") under this WHO CA+. The Parties are mindful that the PABS System, or parts thereof, could be adopted under Article 21 of the WHO Constitution, should such an approach be agreed. The terms of the PABS System shall be developed no later than XX with a view to their provisional application consistent with Article 35 hereof.

2. The PABS System shall cover all pathogens with pandemic potential, including their genomic sequences, as well as access to benefits arising therefrom, and ensure that it operates synergistically with other relevant access and benefit-sharing instruments.
3. The PABS System shall include the following elements and shall be regulated as follows:

Access to pathogens with pandemic potential

a. Each Party, through its relevant and authorized laboratories, shall, in a rapid, systematic and timely manner: (i) provide pathogens with pandemic potential from early infections due to pathogens with pandemic potential or subsequent variants to a laboratory recognized or designated as part of an established WHO coordinated laboratory network; and (ii) upload the genomic sequence of such pathogens with pandemic potential to one or more publicly accessible databases of its choice. For

purposes hereof, "rapid" shall be understood to mean within XX hours from the time of identification of a pathogen with pandemic potential;

b. The PABS System will be consistent with international legal frameworks, notably those for collection of patient specimens, material and data, and will promote effective, standardized, real-time global and regional platforms that promote findable, accessible, interoperable and reusable data available to all Parties;
c. Access shall be accorded expeditiously by the laboratory recognized or designated as part of an established WHO coordinated laboratory network, subject to conclusion of a Standard Material Transfer Agreement, developed for the purposes of the PABS System, with the recipient in accordance with subsection (i) below. Any such access shall be subject to applicable biosafety and biosecurity rules and standards, and free of charge, or, when a fee is charged, it shall not exceed the minimal cost involved;
d. Recipients of materials shall not claim any intellectual property or other rights that limit the facilitated access to pathogens with pandemic potential, or their genomic sequences or components, in the form received; and
e. Access to pathogens with pandemic potential protected by intellectual and other property rights shall be consistent with

relevant international agreements and with relevant national laws.

Fair and equitable benefit-sharing

f. The Parties agree that benefits arising from facilitating access to pathogens with pandemic potential shall be shared fairly and equitably in accordance with the provisions of the PABS System. Accordingly, it is understood that production of pandemic vaccines or other pandemic-related products, irrespective of the technology, information or material used, implies use of pathogens with pandemic potential, including the genomic sequence;

g. Facilitated access shall be provided pursuant to a Standard Material Transfer Agreement, the form of which shall be set out in the PABS System and that shall contain the benefit-sharing options available to entities accessing pathogens with pandemic potential; and

h. Such options shall include, but not be limited to: (i) **real-time access by WHO to 20% of the production** of safe, efficacious and effective pandemic-related products, including diagnostics, vaccines, personal protective equipment and therapeutics, to enable equitable distribution, in particular to developing countries, according to public health risk and need and national plans that identify priority populations. The pandemic-related

There are multiple questions here:

1. Is the 20% of existing stocks or production line? 20% of production of line in normal times or a ramped-up production in response to a pandemic?
2. When should access be give? Is 20% of each day's production or at the beginning 20% of a batch or the last 20%?
3. If the manufacturer of a particular product is also the worst hit, should they not prioritize domestic need?

products shall be provided to WHO on the following basis: 10% as a donation and 10% at affordable prices to WHO; (ii) commitments by the countries where manufacturing facilities are located that they will facilitate the shipment to WHO of these pandemic-related products by the manufacturers within their jurisdiction, according to schedules to be agreed between WHO and manufacturers.

Recognition of the PABS System as a specialized international instrument

i. The PABS System, adopted under the WHO Constitution, is established with a view to its recognition as a specialized international access and benefit-sharing instrument within the meaning of the Nagoya Protocol;
j. Upon adoption, each Party shall, in accordance with its national law, adopt and implement effective legislative, executive, administrative or other measures to give effect to such recognition at the domestic level and/or with respect to its relations with all other States and regional economic integration organizations, as appropriate; and
k. The Parties shall support the further development and operationalization of the PABS System, including appropriate governance mechanisms, and participate in its operation, including through sustaining it in inter-pandemic times as well as appropriate scale-up in the event of a pandemic.

4. The Parties, working through the Governing Body for the WHO CA+, shall develop and finalize additional elements and tools necessary to fully implement, operationalize and sustain the PABS System, no later than XX.

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

Article 11. Strengthening and sustaining preparedness and health systems' resilience.

1. The Parties recognize the need for resilient health systems, rooted in universal health coverage, to mitigate the shocks caused by pandemics and to ensure continuity of health services, thus preventing health systems from becoming overwhelmed.
2. The Parties are encouraged to enhance financial, technical and technological support, assistance and cooperation, in particular to developing countries, to strengthen health emergency prevention and preparedness consistent with the goal of universal health coverage. The Parties shall strive to accelerate the achievement of universal health coverage.
3. The Parties are encouraged to establish global, regional and national collaborative genomics networks that are dedicated to epidemiological genomic surveillance and the global sharing of emerging pathogens with pandemic potential.

4. Each Party shall, in accordance with national law, adopt policies and strategies, supported by implementation plans, across the public and private sectors and relevant agencies, consistent with relevant tools, including, but not limited to, the International Health Regulations, and strengthen and reinforce public health functions for:
    a. continued provision of quality routine and essential health services during pandemics, including clinical and mental health care and immunization, with a focus on primary health care and community-level interventions, and management of the backlog of and waiting lists for the diagnosis and treatment of, and interventions for, other illnesses, including care for patients with long-term effects from the pandemic disease;
    b. strengthening human resource capacities during inter-pandemic times and during pandemics;
    c. surveillance (including using a One Health approach), outbreak investigation and control, through interoperable early warning and alert systems;
    d. sustained laboratory capacity for genomic sequencing, as well as for analysing and sharing such information;
    e. prevention of epidemic-prone diseases, and emerging, growing or evolving public health threats with pandemic potential, notably at the human-animal-environment interface;
    f. post-emergency health system recovery strategies;

g. strengthening public health laboratory and diagnostic capacities, and national, regional and global networks, including standards and protocols for infection prevention and control, and public health laboratory biosafety and biosecurity; and
h. creating and maintaining 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 12. Strengthening and sustaining a skilled and competent health workforce.

1. Each Party shall take the necessary steps to safeguard, protect, invest in and sustain a skilled, trained, competent and committed health and care workforce, at all levels, in a gender-responsive manner, with due protection of its employment, civil and human rights and well-being, consistent with international obligations and relevant codes of practice, with the aim of increasing and sustaining capacities for pandemic prevention, preparedness and response, while maintaining essential health services. This includes, subject to national law:
    a. strengthening in- and post-service training, deployment, remuneration, distribution and retention of the health and care workforce, including community health workers and volunteers; and

b. addressing gender disparities and inequalities within the health and care workforce, to ensure meaningful representation, engagement, participation and empowerment of all health and care workers, while addressing discrimination, stigma and inequality and eliminating bias, including unequal remuneration, and noting that women still often face significant barriers to taking leadership and decision-making roles.

2. The Parties are encouraged to enhance financial and technical support, assistance and cooperation, in particular to developing countries, to strengthen and sustain a skilled and competent health and care workforce at the national level.
3. The Parties shall invest in establishing, sustaining, coordinating and mobilizing an available, **skilled and trained global public health emergency workforce** that is deployable to support Parties upon request, based on public health need, in order to contain outbreaks and prevent an escalation of small-scale spread to global proportions.
4. The Parties will support the development of a network of training institutions, national and regional facilities and centres of expertise in order to establish common guidance to enable more predictable, standardized, timely and systematic response missions and **deployment of the aforementioned public health emergency workforce**.

Potential roadblock in this effort would be issues with freedom of working internationally, travel requirements etc. especially during the pandemic. So, instituting a special pandemic stamp process wherein these restrictions are relaxed during crisis would be helpful.

Who will be responsible for deploying this emergency workforce? Will it be handled by the WHO, or individual member states, or international NGOs like Doctors Without Borders, among others?

Article 13. Preparedness monitoring, simulation exercises and peer reviews

1. Each Party shall undertake regular and systematic capacity assessments in order to identify capacity gaps and develop and implement comprehensive, inclusive, multisectoral national plans and strategies for pandemic prevention, preparedness and response, based on relevant tools developed by WHO.
2. Each Party shall periodically assess the functioning, readiness and gaps of its preparedness and multisectoral response, logistics and supply chain management, through appropriate simulation or tabletop exercises, that include risk and vulnerability mapping. Such exercises may consist of after-action reviews of actual public health emergencies that can support identifying gaps, share lessons learned and improve national pandemic prevention, preparedness and response.
3. The Parties will convene multi-country or regional tabletop exercises every two years, with technical support from the WHO Secretariat, with an aim **to identify gaps in multi-country** response capacity.
4. Each Party shall provide annual (or biennial) reporting, building on existing relevant reporting where possible, on its pandemic prevention, preparedness, response and health systems recovery capacities.
5. The Parties shall develop and implement a transparent, effective and efficient pandemic prevention, preparedness and response monitoring and evaluation system, which includes targets and national and global

Can this information also not be misused for targeting a particular country's weaknesses?

standardized indicators, with necessary funding for developing countries for this purpose.

6. The Parties should establish, regularly update and broaden implementation of a universal 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 strengthen 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.
7. The Parties shall endeavour to implement the recommendations generated from review mechanisms, including prioritization of activities for immediate action.

Article 14. Protection of human rights

1. The Parties shall, in accordance with their national laws, incorporate non-discriminatory measures to protect human rights as part of their pandemic prevention, preparedness, response and recovery, with a particular emphasis on the rights of persons in vulnerable situations.
2. Towards this end, each Party shall:
    a. incorporate into its laws and policies human rights protections during public health emergencies, including, but not limited to,

requirements that any limitations on human rights are aligned with international law, including by ensuring that: (i) any restrictions are non-discriminatory, necessary to achieve the public health goal and the least restrictive necessary to protect the health of people; (ii) all protections of rights, including but not limited to, provision of health services and social protection programmes, are non-discriminatory and take into account the needs of people at high risk and persons in vulnerable situations; and (iii) people living under any restrictions on the freedom of movement, such as quarantines and isolations, have sufficient access to medication, health services and other necessities and rights; and

b. endeavour to develop an independent and inclusive advisory committee to advise the government on human rights protections during public health emergencies, including on the development and implementation of its legal and policy framework, and any other measures that may be needed to protect human rights.

Chapter V. Coordination, collaboration and cooperation for pandemic prevention, preparedness, response and health system recovery

Article 15. Global coordination, collaboration and cooperation.

1. The Parties recognize the need to coordinate, collaborate and cooperate, in the spirit of international solidarity, with 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, and to this end shall:
   a. promote **global, regional and national political commitment, coordination** and leadership for pandemic prevention, preparedness, response and recovery by means that include establishing appropriate governance arrangements;
   b. support mechanisms that ensure global, regional and national policy decisions are science and evidence-based;
   c. develop, as necessary, and implement global policies that recognize the specific needs, and ensure the protection of, persons in vulnerable situations, indigenous peoples, and those living in

Well-intentioned goal, but how does global co-operation and coordination resolve protectionist policies of individual member countries, especially during a crisis such as a pandemic.

fragile environments or areas, such as Small Island Developing States, who face multiple threats simultaneously, by gathering and analysing data, including data disaggregated by gender, to show the impact of policies on different groups;

d. promote equitable gender, geographical and socioeconomic status, representation and participation, as well as the participation of youth and women, in global and regional decision-making processes, global networks and technical advisory groups;
e. ensure solidarity with, and prevent stigmatization of, countries that report public health emergencies, as an incentive to facilitate transparency and timely reporting and sharing of information; and
f. facilitate WHO with rapid access to outbreak areas within the Party's jurisdiction or control, including through the deployment of rapid response and expert teams, to assess and support the response to emerging outbreaks.

2. Recognizing the central role of WHO as the directing and coordinating authority on international health work, and mindful of the need for coordination with regional organizations, entities in the United Nations system and other intergovernmental organizations,

the WHO Director-General shall, in accordance with terms set out herein, declare pandemics[IV].

Article 16. Whole-of-government and whole-of-society approaches at the national level

1. The Parties recognize that pandemics begin and end in communities and are encouraged to adopt a whole-of-government and whole-of-society approach, including to empower and ensure communities' ownership of, and contribution to, community readiness and resilience for pandemic prevention, preparedness, response, and recovery of health systems.
2. Each Party shall establish, implement and adequately finance an effective national coordinating multisectoral mechanism with meaningful representation, engagement and participation of communities.
3. Each Party should promote effective and meaningful engagement of communities, civil society and non-State actors, including the private sector, as part of a whole-of-society response in decision making, implementation, monitoring and evaluation, as well as effective feedback mechanisms.

[IV] Reference is made to footnote 1 (Article 1), which invites the INB to propose and consider the development of modalities and terms for this provision.

4. Each Party shall develop, in accordance with its national context, comprehensive national pandemic prevention, preparedness, response and recovery plans pre-, post- and inter-pandemic that, inter alia: (i) identify and prioritize populations for access to pandemic-related products and health services; (ii) support timely and scalable mobilization of multidisciplinary surge capacity of human and financial resources, and facilitate timely allocation of resources to the frontline pandemic response; (iii) review the status of stockpiles and surge capacity of essential public health and clinical resources, and surge capacity in production of pandemic-related products; (iv) facilitate rapid and equitable restoration of public health capacities following a pandemic; and (v) promote collaboration with non-State actors, the private sector and civil society.
5. Each Party will take steps to address the social, environmental and economic determinants of health, and vulnerability conditions 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.
6. Each Party should strengthen its national public health and social policies to facilitate a rapid, resilient response, especially for persons in

vulnerable situations, including mobilizing social capital in communities for mutual support.

Article 17. Strengthening pandemic and public health literacy

1. The Parties commit to increase science, public health and pandemic literacy in the population, as well as access to information on pandemics and their effects, and tackle false, misleading, misinformation or disinformation, including through promotion of international cooperation. In that regard, each Party is encouraged to:
    a. 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, by informing the public, communicating risk and managing infodemics through effective channels, including social media;
    b. conduct regular social listening and analysis to identify the prevalence and profiles of misinformation, which contribute to design communications and messaging strategies for the public to counteract misinformation, disinformation and false news, thereby strengthening public trust; and
    c. promote communications on scientific, engineering and technological advances that are relevant to the development and implementation of international rules and guidelines for

pandemic prevention, preparedness, response and recovery of health systems, based on science and evidence.

2. The Parties will contribute to research and inform policies on factors that hinder adherence to public health and social measures, confidence and uptake of vaccines, use of appropriate therapeutics and trust in science and government institutions.
3. The Parties shall promote science and evidence-informed effective and timely risk assessment, including the uncertainty of data and evidence, when communicating such risk to the public.

Article 18. One Health

1. The Parties, recognizing that the majority of emerging infectious diseases and pandemics are caused by zoonotic pathogens, commit, in the context of pandemic prevention, preparedness, response and recovery of health systems, to promote and implement a One Health approach that is coherent, integrated, coordinated and collaborative among all relevant actors, with the application of existing instruments and initiatives.
2. The Parties, with an aim of safeguarding human health and detecting and preventing health threats, shall promote and enhance synergies between multisectoral and transdisciplinary collaboration at the national level and cooperation at the international level, in order to identify, conduct risk assessment of and share pathogens with pandemic

potential at the interface between human, animal and environment ecosystems, while recognizing their interdependence.

3. The Parties will identify and integrate into relevant pandemic prevention and preparedness plans interventions that address the drivers of the emergence and re-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.
4. The Parties commit to regularly assess One Health capacities, insofar as they relate to pandemic prevention, preparedness, response and recovery of health systems, and to identify gaps, policies and the funding needed to strengthen those capacities.
5. The Parties commit to **strengthen synergies** with other existing relevant instruments that address the drivers of pandemics, such as climate change, biodiversity loss, ecosystem degradation and increased risks at the human-animal-environment interface due to human activities.
6. The Parties commit to strengthen multisectoral, coordinated, interoperable and integrated One Health surveillance systems and strengthen laboratory capacity to identify and assess the risks and emergence of pathogens and variants with pandemic potential, in order to minimize spill-over events, mutations and the risks associated with zoonotic neglected tropical and vector-borne diseases, with a view to preventing small-scale outbreaks in wildlife or domesticated animals from becoming a pandemic.

These areas are ripe for implementing whole-of-government and whole-of-society approaches by promoting afforestation, reducing biodiversity loss, identifying wet markets etc.

7. Each Party shall:
    a. 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**;
    b. foster actions at national and community levels that encompass whole-of-government and whole-of-society approaches to control zoonotic outbreaks (in wildlife and domesticated animals), including engagement of communities in surveillance that identifies zoonotic outbreaks and antimicrobial resistance at source;
    c. develop and implement a national One Health action plan on antimicrobial resistance that strengthens antimicrobial stewardship in the human and animal sectors, optimizes antimicrobial 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 sanitation and biosecurity in livestock farms, and provides technical support to developing countries;
    d. enhance surveillance to identify and report on pathogens resistant to antimicrobial agents in humans, livestock and aquaculture that have pandemic potential, building on the existing global reporting systems; and

It might be useful to clearly institutionalise the participation of Quadripartite organisations (UNEP, FAO, OIE and WHO) in the consultative body of this treaty by granting status of permanent invitees to these organisations.

e. 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 19. Sustainable and predictable financing

1. The Parties recognize the important role that financial resources play in achieving the objective of the WHO CA+ and the primary financial responsibility of national governments in protecting and promoting the health of their populations. In that regard, each Party shall:
    a. cooperate with other Parties, within the means and resources at its disposal, to raise financial resources for effective implementation of the WHO CA+ through bilateral and multilateral funding mechanisms;
    b. plan and provide adequate financial support in line with its national fiscal capacities for: (i) strengthening pandemic prevention, preparedness, response and recovery of health systems; (ii) implementing its national plans, programmes and priorities; and (iii) strengthening health systems and progressive realization of universal health coverage;

c. commit to prioritize and increase or maintain, including through greater collaboration between the health, finance and private sectors, as appropriate, domestic funding by allocating in its annual budgets **not lower than 5%** of its current health expenditure to pandemic prevention, preparedness, response and health systems recovery, notably for improving and sustaining relevant capacities and working to achieve universal health coverage; and commit to allocate, in accordance with its respective capacities, XX% of its gross domestic product for international cooperation and assistance on pandemic prevention, preparedness, response and health systems recovery, particularly for developing countries, including through international organizations and existing and new mechanisms.

Perhaps the initial starting points should be a threshold of GDP spent on health systems.

2. The Parties shall ensure, through innovative existing and/or new mechanisms, sustainable and predictable financing of global, regional and national systems, capacities, tools and global public goods, while avoiding duplication, promoting synergies and enhancing transparent and accountable governance of these mechanisms, to support strengthening pandemic prevention, preparedness, response and recovery of health systems, based on public health risk and need, particularly in developing countries.

Lack of funding has been a consistent problem in implementing the WHO's mandate effectively. Novel mechanisms or a more concrete commitments under existing funding mechanisms are needed.

3. The Parties shall promote, as appropriate, the use of bilateral, regional, subregional and other appropriate and relevant channels to provide funding for the development and strengthening of pandemic

prevention, preparedness, response and health system recovery programmes of developing country Parties.

4. The Parties will 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.
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 to support them in meeting their obligations under the WHO CA+, without limiting their participation in or membership of these organizations

Chapter VII. Institutional arrangements

Article 20. Governing body for the WHO CA+

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, composed of the Parties and constituting the supreme decision making organ; and
    b. The Officers of the Parties (OP), which shall be the administrative organ of the Governing Body.
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 WHO CA+. The COP shall:
    a. Be composed of delegates representing Parties;
    b. Convene regular 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 special 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 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 and two rapporteurs, serving in their individual capacity and elected by the COP for XX years; and;

   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 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 21. Consultative Body for the WHO CA+

1. A consultative body for the WHO CA+ (the "Consultative Body") is established to provide advice and technical inputs for the decision-making processes of the COP, without participating in any decision-making.
2. The Consultative Body will provide opportunity for broad, fair and equitable input to the COP for the decision-making processes of the COP. Further, the Consultative Body will provide opportunity for facilitation of implementation of COP decisions through modalities to be established by the COP. For the avoidance of doubt, it is understood that the Consultative Body will not participate in any decision-making, whether by consensus, voting or otherwise, of the COP.
3. The Consultative Body shall be composed of (i) delegates representing Parties; and (ii) 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 WHO CA+. Further, representatives of any body or organization, whether national or international, governmental or nongovernmental, private sector or public sector, which is qualified in matters covered by the WHO CA+, may be admitted upon formal application, in accordance with terms and conditions to be adopted by the COP, renewable every three years, unless at least one third of the Parties object.

4. The Consultative Body shall be subject to the oversight of the COP, including rules of procedure adopted by the COP

Article 22. Oversight mechanisms for the WHO CA+.

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 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 23. Assessment and review

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 24. Secretariat

1. A Secretariat for the WHO CA+ shall be provided by the Director-General of the World Health Organization. Secretariat functions shall be:
    a. to make arrangements for sessions of the Governing Body and any subsidiary bodies and to provide them with services as required;
    b. to transmit reports received by it pursuant to the WHO CA+;
    c. to provide support to the Parties, on request, in the compilation and communication of information required in accordance with the provisions of the WHO CA+;
    d. to prepare reports on its activities under the WHO CA+ under the guidance of the Governing Body, and submit them to the Governing Body;
    e. to ensure, under the guidance of the Governing Body, the necessary coordination with the competent international and regional intergovernmental organizations and other bodies;
    f. to enter, under the guidance of the Governing Body, into such administrative or contractual arrangements as may be required for the effective discharge of its functions; and
    g. to perform other secretariat functions specified by the WHO CA+ and such other functions as may be determined by the Governing Body.

Chapter VIII. Final provisions

Article 25. Reservations

1. No reservations or exceptions may be made to this WHO CA+ unless expressly permitted by other articles of this WHO CA+.
2. A reservation incompatible with the object and purpose of the WHO CA+ shall not be permitted.
3. Reservations that are receivable in accordance with the above, once made, may be withdrawn at any time by notification to this effect addressed to the Depositary, who shall then inform all Parties thereof. Such notification shall take effect on the date on which it is received.

Article 26. Confidentiality and data protection

Any exchange of data or information by the Parties pursuant to the WHO CA+ shall respect the right to privacy, including as such right is established under international law, and will be consistent with each Party's national law, as applicable, regarding confidentiality and privacy

Article 27. 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 not be considered as having also withdrawn from any protocol to which it is a Party, or from any related instrument, unless such a Party formally withdraws from such other instruments, and does so in accordance with the relevant terms, if any, thereof.

Article 28. 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 29. Amendments to the WHO CA+

1. Any Party may propose amendments to the WHO CA+. Such amendments will be considered by the COP, which may invite views of the Consultative Body.

2. Amendments to the WHO CA+ shall be adopted by the COP. The text of any proposed amendment to the WHO CA+ shall be communicated to the Parties by the Secretariat at least three 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. An amendment adopted in accordance with paragraph 3 of this Article shall enter into force, for those Parties having accepted it, on the ninetieth day after the date of receipt by the Depositary of an instrument of acceptance by at least two-thirds of the Parties.
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 30. Adoption and amendment of annexes to the WHO CA+

1. The COP may adopt annexes to the WHO CA+ and amendments thereto.
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, and shall not be substantive in nature.

Article 31. Protocols to the WHO CA+

1. Any Party may propose protocols to the WHO CA+. Such proposals will be considered by the COP, which may invite the views of the Consultative Body.
2. The COP 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 three 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 32. Signature

The WHO CA+ shall be open for signature by all Members of the World Health Organization, 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, immediately following its adoption by the World Health Assembly at the Seventy-seventh World Health Assembly, from XX May 2024 to XX July 2024, and thereafter at United Nations Headquarters in New York, from XX August 2024 to XX November 2024.

Article 33. 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 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 34. Entry into force

1. The WHO CA+ shall enter into force on the thirtieth day following the date of deposit of the thirtieth instrument of ratification, acceptance, approval, formal confirmation or accession with the Depositary.
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 35. Provisional application by the Parties, and actions to give effect to the provisions of the WHO CA+ by the World Health Assembly

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.
3. Provisions of the WHO CA+ may be given effect as recommendations for all Member States of the World Health Organization under Article 23 of the WHO Constitution, and given effect as policies of the World Health Organization, understood as authoritative with respect to the Director-General, under Articles 18(a), 28(a) and 31 of the WHO Constitution.

Article 36. 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 Depositary that, for a dispute not resolved in accordance with paragraph 1 of this Article, it accepts, as compulsory ipso facto and without special agreement, in relation to any Party accepting the same obligation: (i) submission of the dispute to the International Court of Justice; and/or (ii) 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 37. Depository

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 38. Authentic texts

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.

B. References

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