Most Recent Draft of WHO Pandemic Agreement Raises Concerns

The World Health Organization (WHO) negotiating body of the draft Pandemic Agreement to be voted on in late May produced yet another draft. As the previous text was dealt with in detail in a recent article, it seems relevant to provide a brief summary of the additional changes. As before, the document becomes vaguer but adds more activities to be funded, reinforcing the concerns that this process is being rushed without due review.

Since December 2021, the Intergovernmental Negotiating Body (INB) has been embarking on this project under the WHO Constitution in order to set a global framework for pandemic prevention, preparedness, and response. It has already failed its own deliverable timeline to reach a consensus text by 29 March 2024 (document A/INB/3/4). That two-month period was not a legal requirement *per se*, but intended to give the 194 WHO Member States some time to review the final text against their domestic legal architecture as well as other international

obligations from other treaties to which they are parties. It was scrapped without explanation, demonstrating a far-from-achieved consensus within the INB. However, the WHO still plans to have the vote on the provisional agenda of the 77th World Health Assembly (WHA) starting on 27 May.

The latest draft, proposed by the INB Bureau (comprised of representatives from Brazil, Egypt, Japan, The Netherlands, South Africa, and Thailand being co-chairs, aided by 6 WHO officers from 6 regional offices), dated 22 April 2024, was submitted for negotiations at the 9th INB meeting from 29 April to 10 May. As usual, the Bureau streamlines and consolidates the text previously achieved thanks to various groups tasked to reach consensus under thorny articles. This meeting has just concluded in Geneva without reaching the final text.

Instead of pausing the project, it was reported that negotiating teams will continue 'to resume hybrid and in-person discussions' until the very last minutes before the WHA session. Such a decision is an open disdain for the public, stripping from them the legitimate right to be informed about the laws to be made and ignoring the WHO Constitution's principle according to which "informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people" (Preamble).

All previous iterations contain proposed provisions referencing the International Health Regulations (IHR) draft amendments, also under negotiations and intended to be voted on at the 77th WHA, likely illegitimately, since the 4-month review period required by Article 55 para. 2 of the 2005 IHR hasn't been respected. This latest version isn't an exception. Multiple proposed provisions (articles 5.4, 19.3, 20.1, and 26.2) are expressly interlinked with the IHR draft amendments although the final wording of these is yet to be set in stone. This strange situation is the outcome of a rushed process,

based on unfounded claims of urgency and demanding an additional budget for global health institutions from countries still reeling from the aftermath of a global economic lockdown imposed during the Covid-19 response.

The new draft contains relatively few changes but shuffles several issues around. References to CEDAW (Convention on the Elimination of All Forms of Discrimination against Women), the Sustainable Development Goal 5 on gender equality, and "indigenous people" were added in the Preamble without much consequence on the overall meaning. A new phrase "health systems recovery" made its appearance several times with the probable meaning that pandemics do weaken the health systems.

The commentary below focuses on notable new proposals since the previously assessed text.

Pandemic Agreement Bureau Draft, 22nd April 2024

> *Article 1. Use of Terms*
>
> *(d) "pandemic-related health products" means the safe, effective, quality and affordable products that are needed for pandemic prevention, preparedness and response, which may include, without limitation, diagnostics, therapeutics, vaccines and personal protective equipment;*

The new definition of "pandemic-related health products" now contains additional standards of safeness, quality, and affordability. This recalls repetitive messages from global and national public health authorities about Covid-related products ("safe and effective"). It seems to be a poor choice of wording, as it raises questions such as who and how to define their safeness and effectiveness in order to make this relevant (e.g. must they be transmission-blocking in order to be effective for pandemic interruption?). Clearly, safety and

effectiveness are independent of the actual product type. They are an opinion based on criteria which may vary. In a legally binding document, definitions should be implementable.

> *Article 6. One Health*
>
> *4. The modalities, terms and conditions and operational dimensions of a One Health approach shall be further defined in an instrument that takes into consideration the provisions of the International Health Regulations (2005) and will be operational by 31 May 2026.*

This new paragraph will push States into a "One Health instrument" project by 31 May 2026 – which may or may not be legally binding, presumably as a new program strategy under WHO. It is unclear why the world needs this, and why a similar rush to have it in 2 years time, given the overlap with other public health activities.

> *Article 7. Health and care workforce*
>
> *3. The Parties shall invest in establishing and sustaining a skilled, trained and coordinated multidisciplinary global health emergency workforce deployable to support Parties upon request, based on public health needs, to contain outbreaks and prevent the escalation of a small-scale spread to global proportions.*

This is the first time the "global health emergency workforce" has appeared in Pandemic Agreement texts. The concept bears some resemblance to the current peacekeeping missions intervened under Chapters VI and VII of the UN Charter, and to the GERM (Global Epidemic Response and Mobilization), a 'pandemic fire-fighting force,' advocated by a major donor to the WHO, Mr Bill Gates Jr. In Gates' own words, "running GERM will cost the world around $1 billion a year to cover salaries for the force of 3,000 people we'd need, plus equipment,

travel, and other expenses—money that would come from governments. The work would be coordinated by the WHO, the only group that can give it global credibility, and it needs to be accountable to the public."

This proposal is extremely problematic. If it stays, States will sign up for a new project with little detail but further considerable expenses. Such an idea requires serious thoughts beyond the cost and operational modalities; for example, the organization approving mandates and budget of the workforce, consent procedures of the host country, and the competent jurisdiction under which the workforce will act. Once such bureaucracies are built, it can be very difficult to dismantle them, but they inevitably divert resources – human and financial – from ongoing health problems of higher burden.

> *Article 11. Transfer of technology and know-how for the production of pandemic-related health products*
>
> *1. Each Party shall, in order to enable the sufficient, sustainable and geographically diversified production of pandemic-related health products, and taking into account its national circumstances: (…)*
>
> *(b) publish the terms of its licenses for pandemic-related health technologies in a timely manner and in accordance with applicable law, and shall encourage private rights holders to do the same;*

Although the State's obligation appears weak ("taking into account its national circumstances"), this is a welcoming proposal intended to address the problematic secrecy regarding provisions of Covid response-related licenses claiming 'commercial in-confidence.' States should be bound by transparency and accountability principles at all times, especially when spending public money, though 'applicable law' may still offer an escape clause.

Article 12. Access and benefit-sharing system

2. The PABS System shall have the following foundations:

(f) not seeking to obtain intellectual property rights on PABS material and information;

6. The modalities, terms and conditions, and operational dimensions of the PABS System shall be further defined in a legally binding instrument that will be operational no later than 31 May 2026.

Paragraph 2(f) was likely added to clarify what was already there. The principle only concerns original material and information, excluding derivative and modified material and information.

Paragraph 6 specifies that it will be a legally binding instrument. It will probably engage States in negotiating a protocol under this pandemic agreement should it be passed.

Article 13. Supply chains and logistics

4. During a pandemic, emergency trade measures shall be targeted, proportionate, transparent and temporary, and not create unnecessary barriers to trade or disruptions in supply chains of pandemic-related health products.

6. A multilateral system for managing vaccine and therapeutic-related compensation and liability during pandemics shall be considered.

Paragraph 4 is a more welcoming version of the previous 13bis.3. The language was strengthened from a mere recognition of the importance of the “targeted, proportionate, transparent and temporary” emergency trade measures, to introduce an obligation not to burden supply chains of pandemic-related health products.

Paragraph 6 is considerably watered down from the previous draft (Art.15 on liability and compensation mechanism). Explicit reference to a possible 'no-fault compensation mechanism' regarding pandemic vaccines to be included in national strategies was removed. The plan for States to make recommendations "for the establishment and implementation of national, regional and/or global no-fault compensation mechanisms and strategies for managing liability during pandemic emergencies" was replaced by a vague and weak consideration for a multilateral system to manage vaccine compensation and liability.

Article 13bis. National procurement

1. *Each Party shall publish the relevant terms of its purchase agreements with manufacturers for pandemic-related health products at the earliest reasonable opportunity, and shall exclude confidentiality provisions that serve to limit such disclosure, in accordance with applicable laws, as appropriate. Regional and global purchasing mechanisms shall also be encouraged to do the same.*

6. Each Party shall endeavour to ensure that, in contracts for the supply or purchase of novel pandemic vaccines, buyer/recipient indemnity clauses, if any, are exceptionally provided and are time-bound.

Overall, this is more reasonable. Similar to Article 11.1.b.

Article 14. Regulatory strengthening

3. Each Party shall, in accordance with relevant laws:

(b) publicly disclose information on national and, if applicable, regional processes for authorizing or approving the use of pandemic-related health products, and adopt

regulatory reliance processes or other relevant regulatory pathways, as appropriate, for such pandemic- related health products that may be activated during a pandemic to increase efficiency, and shall update such information in a timely manner.

Another vaguely worded proposal that seems inappropriate for a legally binding agreement. 'Pandemic-related health products' is extremely broad. This reflects much of the Pandemic Agreement and makes one wonder why it is still considered necessary, rather than just relying on the voluntary 2005 version of the IHR.

Article 18. Communication and public awareness

1. The Parties shall strengthen science, public health and pandemic literacy in the population, as well as access to transparent, accurate, science- and evidence-informed information on pandemics and their causes, impacts and drivers, particularly through risk communication and effective community-level engagement.

2. The Parties shall, as appropriate, conduct research to inform policies on factors that hinder or strengthen adherence to public health and social measures in a pandemic and trust in science and public health institutions, authorities and agencies.

This article becomes shorter and more reasonable with only two paragraphs instead of four. The language on Parties' obligations to apply science- and evidence-based approaches to risk assessment (old para. 3) and to cooperate in preventing misinformation and disinformation (old para. 4) were removed. Notably, the reference to "with the aim of countering and addressing misinformation or disinformation" in the old para. 1 was also removed. However, the previous essence still very much remains given the clear approach of the WHO to stifle

access and credibility of opinions contrary to its official line.

> *Article 20. Sustainable financing*
>
> *1. The Parties shall strengthen sustainable and predictable financing, in an inclusive and transparent manner, for implementation of this Agreement and the International Health Regulations (2005).*
>
> *2. In this regard, each Party, within the means and resources at its disposal, shall:*
>
> *(b) mobilize additional financial resources to assist Parties, in particular developing country Parties, in the implementation of the WHO Pandemic Agreement, including through grants and concessional loans;*
>
> *3. A Coordinating Financial Mechanism (the Mechanism) is hereby established to provide sustainable financing support, strengthen and expand capacities for pandemic prevention, preparedness and response, and to provide any surge response necessary for day zero, particularly in developing country Parties. The Mechanism shall, inter alia:(e) leverage voluntary monetary contributions for organizations and other entities supporting pandemic prevention, preparedness and response, free from conflicts of interest, from relevant stakeholders, in particular those active in sectors that benefit from international work to strengthen pandemic prevention, preparedness and response.*

The new text under the Coordinating Financial Mechanism is quite diluted. The reference to the inclusion of an ‘innovative mechanism” including debt relief measures (old para. 20.2(c)) was removed. Subparagraph (f) was added to recognize that contributions from States will not be sufficient, and voluntary monetary contributions will be needed from ‘relevant stakeholders,’ probably private

companies; however this should be ‘free of conflicts of interest’ without going into details as to how this may be ensured but letting the future Conference of Parties sort out operational details.

It is difficult to see how private companies or organizations active in this sector would be free from conflict (i.e. potential benefit) if they are supporting the WHO in expanding work in this sector. Strong arguments could be made for excluding private sector payment (and therefore influence).

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