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BENGALI, RUSSIAN, PORTUGUESE, INDONESIAN, URDU, JAPANESE, GERMAN,
PUNJABI, JAVANESE, TELEGU, TURKISH, KOREAN, MARATHI

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IMPORTANT MESSAGE TO

All Heads of State of Sovereign Nations

All Prime Ministers and Ministers of Ruling Governments

All Parliaments and Members of Legislative Bodies

All Judges and Members of Judiciary Bodies

All Leadership and Members of Government Authorities

All Participants in Civil Society of All Nations

In the Name of God to All Believers of All Faiths

All Families and All Children

All Living Human Beings

The **World Health Organization** is preparing the ratification in 2024 of a legally binding accord with 194 states to establish a global health dictatorship for total world population control. We have read and analyzed the conceptual zero draft of such pandemic accord published by the WHO. In this paper, we are issuing a strong warning against and explain the enormous dangers for human rights and dire consequences for all human life emanating from the health dictatorship the WHO is about to establish.



Under the pretext and guise of “international health work” and “protecting the world from future pandemics”, the pandemic accord (WHO CA+) establishes a totalitarian global power architecture dictating the health policies of entire populations aiming to control and suppress all aspects of human life on earth, while bypassing the traditional legislative, executive and judicial powers of governments and thereby directly undermining the sovereignty of nations, the self-determination of its peoples and ultimately threatening human dignity and life itself.

**In the name of human rights and human life –
the pandemic accord WHO CA+ must be stopped!**

Situation Briefing

On 1st December 2021, the 194 members of the World Health Organization (WHO) agreed to begin the process of developing and negotiating an accord under the WHO's constitution to strengthen pandemic prevention, preparedness, and response on a worldwide basis. An intergovernmental negotiating body (INB) was established and met on 1st March 2022 to agree on working procedures and deadlines, and on 1st August 2022 to discuss progress on a working version of the accord. On 7th December 2022, the WHO Member States agreed to develop a zero draft of the legally binding accord («WHO CA+») by February 2023. A conceptual draft zero of the accord has been published [here](#) and [here](#). It will then submit a progress report to the 76th World Health Assembly in 2023, with the goal of adopting the accord by 2024.

Under the guide of the WHO and a worldwide accord on “pandemic preparedness”, the WHO is establishing a new world power architecture, a global health dictatorship for world population control. WHO CA+ will be legally binding and enforceable with signatory governments and will transfer enormous powers and competencies to the WHO. This paper describes the mechanisms of power transfer and the impacts of WHO CA+ on nations, governments, societies, populations and all human life on earth.



WHO CA+ irreversibly transfers fundamental policy setting and decisional powers from governments to the WHO, thereby bringing all aspects of human life under WHO's control

WHO CA+ will centralize enormous and fundamental policy setting and decisional powers into a single “**supreme policy setting organ**” allowing it to issue policies on health and on all other aspects of human life which are legally binding for signatory governments:

- Decide about when a pandemic and emergency status is proclaimed
- Decide about what is considered to be “science” and what is “not science”
- Promulgate definitions of what it means to be “fully vaccinated” or “reach herd immunity”
- Decide about lockdowns, social distancing, masks and other restrictive measures
- Decide about allowed diagnostics and testing procedures, and which are not allowed
- Decide about mandatory quarantine and isolation rules
- Decide about mandatory use of certificates and health passports
- Decide about which treatment protocols must be used and which not
- Decide about which vaccines or other biomaterials must be injected into humans and which not
- Decide about mandatory vaccinations for every human being
- Decide about number and frequency of vaccinations for reaching “fully vaccinated status”
- Decide about the level of population vaccinations for reaching “herd immunity status”
- Decide about freedom of movement of each human being: geographic radius, access to healthcare services, access to work, access to social life, access to basic needs (supermarket, etc.)
- Define communication policies to be followed by all governments and media outlets and channels and guidelines on what is “information” to be promoted and what is “disinformation” to be suppressed
- Direct the health authorities of governments to locally execute all decisions of the WHO governing body in cooperation with all government functions, the private sector, media, civil society, etc.
- Monitor governments on compliance with WHO CA+ and with the decisions and directions of the WHO governing body
- Sanction and discipline governments in case of non-compliance

These decisions of the centralized WHO CA+ “supreme policy setting body” will be taken by a handful of unelected, unaccountable and diplomatically immune bureaucrats and figure heads installed as fronts by their financing masters and true holders of power. This concentration of power into the hands of a cabal of unknown and unaccountable individuals is highly dangerous and must be stopped.

WHO CA+ enshrines the WHO as the “central authority” over the health policies of signatory governments and transfers local government powers into one “supreme policy setting body” at global level under WHO's control

All signatory governments must submit to the policies, directives, definitions, rules and procedures of the WHO with regards to health and irrevocably commit government resources, finances and personnel to an all-encompassing cooperation with the private sector corporations, media and participants in civil society to implement and execute WHO's decisions, all under the pretext and guise of “international health work” and “ensuring pandemic prevention, preparedness and response”. “Pandemic prevention” will be a permanent process which shall never stop, and hence, the WHO's powers and controls over the world's populations shall never stop.

As the WHO is to become the “central authority” under the legally binding framework of the WHO CA+, there is little to no room for self-determination and locally defined policies and actions by signatory governments. There will be no policies other than the policies dictated by the WHO and transmitted to the local governments via the WHO CA+.

All signatory governments will have to periodically report over their adherence to the policies and rules and submit to reviews dictated by the WHO governing body and be treated to helpful suggestions on how to become even better. In case of non-compliance there will be sanctioning mechanisms in place to discipline governments and to enforce “reviews, remedies and actions”, e.g. withdrawal of financial support from the World Bank, IMF and support from other international organizations.

The WHO is not anymore an institution to promote health and well-being of human beings, but rather is an organization designed to control world populations via the establishment of a capillary architecture of power and system of control in all aspects of human health and life down to the last human being living on earth. World population control down to the last human being means control of movement, control of access to healthcare and resources, control of what enters the human body (vaccines and biomaterials) and ultimately control over who shall live and who shall die.

The WHO as “central authority” with legally binding decisional powers on the world populations is dangerous and must be stopped.

WHO CA+ means the takeover of power via the all-encompassing synchronization (“Gleichschaltung”) of government functions, private sector corporations and participants in civil society

WHO CA+ commits signatory governments to establish and collaborate in public-private partnerships globally and locally with private corporations, media outlets and participants in civil society in an all-encompassing approach. Signatory governments must provide infrastructure, material, financial and personnel resources to establish and maintain such partnerships and submit them to the implementation of the decisions of the WHO governing body.

- WHO CA+ imposes an **“all-encompassing whole-of-government approach”** meaning that all entities and functions of a government must collaborate and follow the same policies, directives, rules and procedures emanating from the WHO governing body as the **“supreme policy setting body”**.
- WHO CA+ imposes an **“all-encompassing whole-of-society actions”** meaning that all entities and functions of government, all corporations and the private sector, all the media, and all the participants of civil society (parties, associations, clubs, etc.) must collaborate to act, implement and execute the policies, directives, rules, procedures and communication guidelines emanating from the WHO governing body as the **“supreme policy setting body”**.
- The all-encompassing public-private partnership model to be applied follows the tenets of **“stakeholder capitalism”** as a variety of **corporatism and ultimately fascism**: namely the amalgamation of state and corporate power for world population control.

The all-encompassing **“whole-of-government approach”** and **“whole-of-society-actions”** are reminiscent of the **“Gleichschaltung”** (eng. synchronization) of government, private sector and civil society during the period of National Socialism rule in Germany (1933-1945), where after coming to power the Nazis aligned all entities and functions of governments, i.e. all state departments, parties, associations and clubs with the political goals of National Socialism while imposing their goals and banning everything else, to enforce the control of all spheres of government, society and life. **“Gleichschaltung”** was intended to bring all areas of people’s lives under the control of the National Socialists. In analogous fashion, WHO CA+ is intended to bring all areas of people’s lives under the control of the WHO. Akin to Adolf Hitler imposing National Socialism on Germany in 1933-1945, the WHO wants to impose a healthcare dictatorship on the entire world’s populations. This is dangerous and must be stopped.

WHO CA+ as the Trojan Horse to Undermine Sovereignty of Nations and Its People and establish a Global Health Dictatorship for World Population Control



World Health Organization

Director General

Conference of the Parties (COP)

"governing body as supreme policy setting organ"

WHO CA+ Legally Binding Agreement

"to be ratified by States and regional economic integration organizations"

Sovereign Territory of State

Constitution

President / Head of State

Executive Branch

Legislative Branch

Judicative Branch

Government Departments

Higher Chamber

Higher Courts

Lower Chamber/ Parliament

Lower Courts

Agriculture

Interior

Education

Economy & Commerce

Labor

Finance

Energy

Transportation

Justice

Health

Defense

Exterior/ Foreign Affairs

Pharma Cos

Logistics

Hospitals/ Medical Personnel

...

Media

NGOs

Civil Society

"all-encompassing whole-of-government approach"

"whole-of-society actions" "multi-stakeholder, multi-disciplinary and multilevel approach"



WHO CA+ bypasses the traditional legislative, judicative and executive branches of governments and undermines the sovereignty of nations and its peoples

WHO CA+ provisions and the decisions emanating from the WHO governing body, which will be legally binding for signatory governments, bypass all traditional legislative, judicative and executive branches of governments. WHO CA+ sets rules that prohibit governments to do what a government normally should do: decide its autonomy, decide on rules for all actors within national borders and for its population, and provide protection from and safety mechanisms against abuse of power to protect its citizens.

- There is no recourse mechanism or independent judicial court in place to question the decisions and actions of governments acting under the legally binding framework of WHO CA+
- There is no accountability mechanism in place for pursuing bad decisions, abuses or criminal acts as a consequence of the implementation of legally binding decisions by the WHO governing body, e.g. ineffective and toxic vaccines leading to bodily harm and deaths, unwarranted lockdowns and quarantines, destruction of the economy, etc.
- The local governments, its parliaments and citizens have no means to question or go against decisions by WHO CA+. The governments must implement the decisions if necessary through force (military, police, etc.)
- There are no national borders to protect a nation as the decisions of the WHO governing body affect all populations across the world. National borders are eliminated while at the same time used as a means of population control (travel restrictions, people not be able to leave their country, etc.)
- The national security of every government is compromised
- The sovereignty of nations and its peoples is undermined

The undermining of self-determination of nations and its peoples, the bypassing of traditional legislative, judiciary and executive branches of governments, and the usurpation of power with the goal of total world population control crassly threaten and disavow the provisions of the United Nations Charta, and therefore it must be stopped.

Pharma companies and private contractors are the main beneficiaries of the WHO CA+ via secretive public-private partnerships financed by public money

Under the legally binding provisions of WHO CA+ signatory governments must:

- Purchase, enhance capacities to establish and maintain strategic stockpiles of pandemic response products (vaccines, biomaterials, diagnostics, test kits, etc.), which they will have to buy from the pharma companies defined by the WHO governing body
- Allocate supplies, raw materials and other necessary inputs for sustainable production of pandemic response products (especially active pharmaceutical ingredients) including for stockpiling purposes
- Strengthen local capacity to manufacture pandemic response products and incentives to promote transfer of technology and know-how
- Incentivize the timely, i.e. fast authorization of pandemic response products
- Encourage, incentivize, and facilitate participation of private-sector entities in voluntary transfer of technology and know-how
- Support time-bound waivers of protection of intellectual property rights that are a barrier to manufacturing of pandemic response products during pandemics. This provision helps pharma companies protect their intellectual property rights, e.g. for vaccines and drugs that have been developed with public money, directly or indirectly.

These provisions will force governments to purchase products (vaccines, biomaterials, diagnostics, test kits, etc.) from pharma companies dictated by the WHO governing body, whether the products are effective, needed or not. Similar as in the SARS-CoV-2 virus crisis, billions of vaccine doses have been paid for with taxpayers' money to benefit pharma companies and without being used. Specific WHO CA+ provisions sponsored by the pharma lobby primarily benefit pharma companies to the detriment of governments and tax paying citizens. Therefore, it must be stopped.

WHO CA+ provisions enshrine a totalitarian control of the communication policies and power over deciding what is “information” to be promoted and what is “mis- and disinformation” to be actively suppressed

In partnership with global and local media corporations and outlets, WHO CA+ enacts the “Gleichschaltung” (eng. synchronization) of all communications and messaging to populations to educate about “science” and ensure compliance with health measures, lockdowns, protective measures (masks), testing, quarantine, vaccination mandates, etc. In particular:

- Governments must establish and strengthen cooperation with media companies to inform the public, communicate risks and manage infodemics through all media channels including social media according to the WHO guidelines
- Governments must “conduct social media analysis” to “identify misinformation” and “design communications and messaging to the public” to “counteract misinformation, disinformation and false news” according to the WHO guidelines
- Governments must provide effective global and national “communications based on evidence” and “ethical professional journalism” according to the WHO guidelines
- Governments must research into behavioral barriers and drivers of adherence to public health measures, confidence and uptake of vaccines, use of therapeutics and trust in science and government institutions according the WHO guidelines

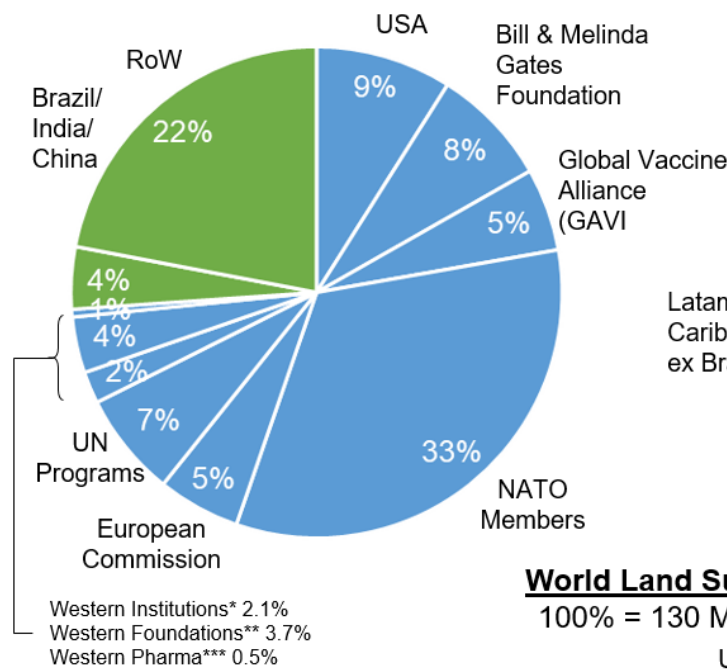
With WHO CA+ and the WHO as the “supreme health authority”, there will be only one communication, one science, one evidence, one voice, one opinion, namely the one decided by the “supreme policy setting body” of the WHO CA+. Everything and everyone else will be actively suppressed. This is highly dangerous and therefore it must be stopped.

The WHO is financed and dominated by the US/NATO and Western-led institutions aiming to establish total control over the world's population and the world's land masses

WHO is Financed and Dominated by USA/NATO and Western Institutions Aiming to Establish Total Control Over the World's Population and Land Mass

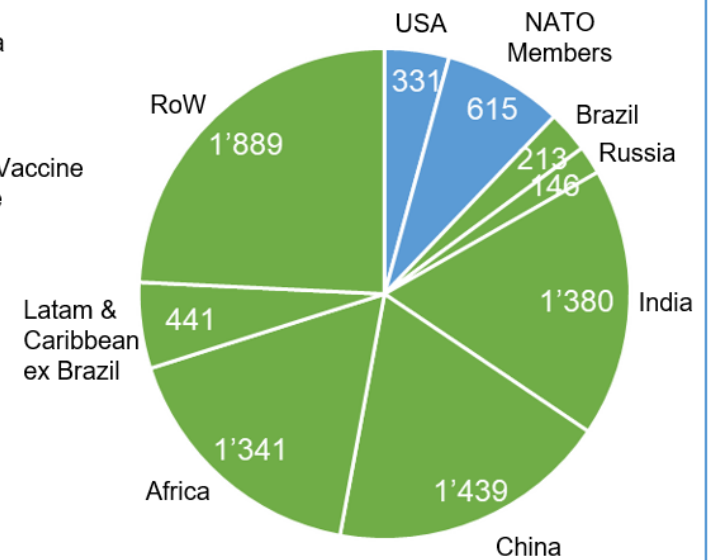
WHO Funding 12020-2021

100% = USD 7'583 M



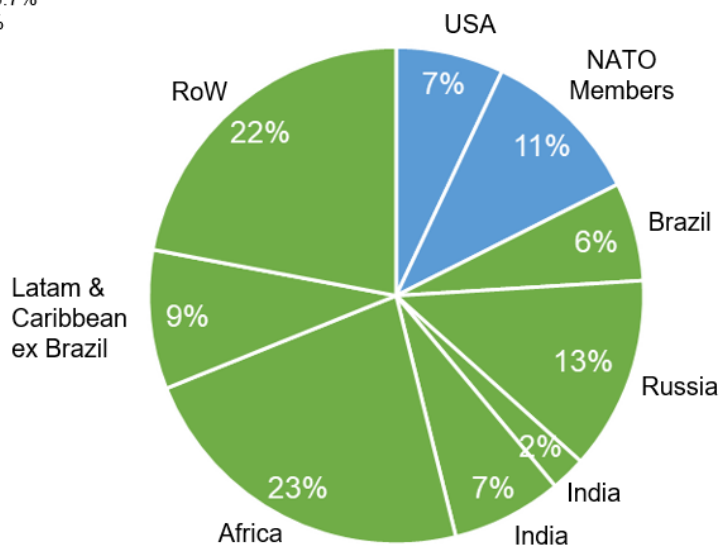
Population 2022

100% = 7'795 M



World Land Surface

100% = 130 M km2



* E.g. World Bank, European Investment Bank, and others

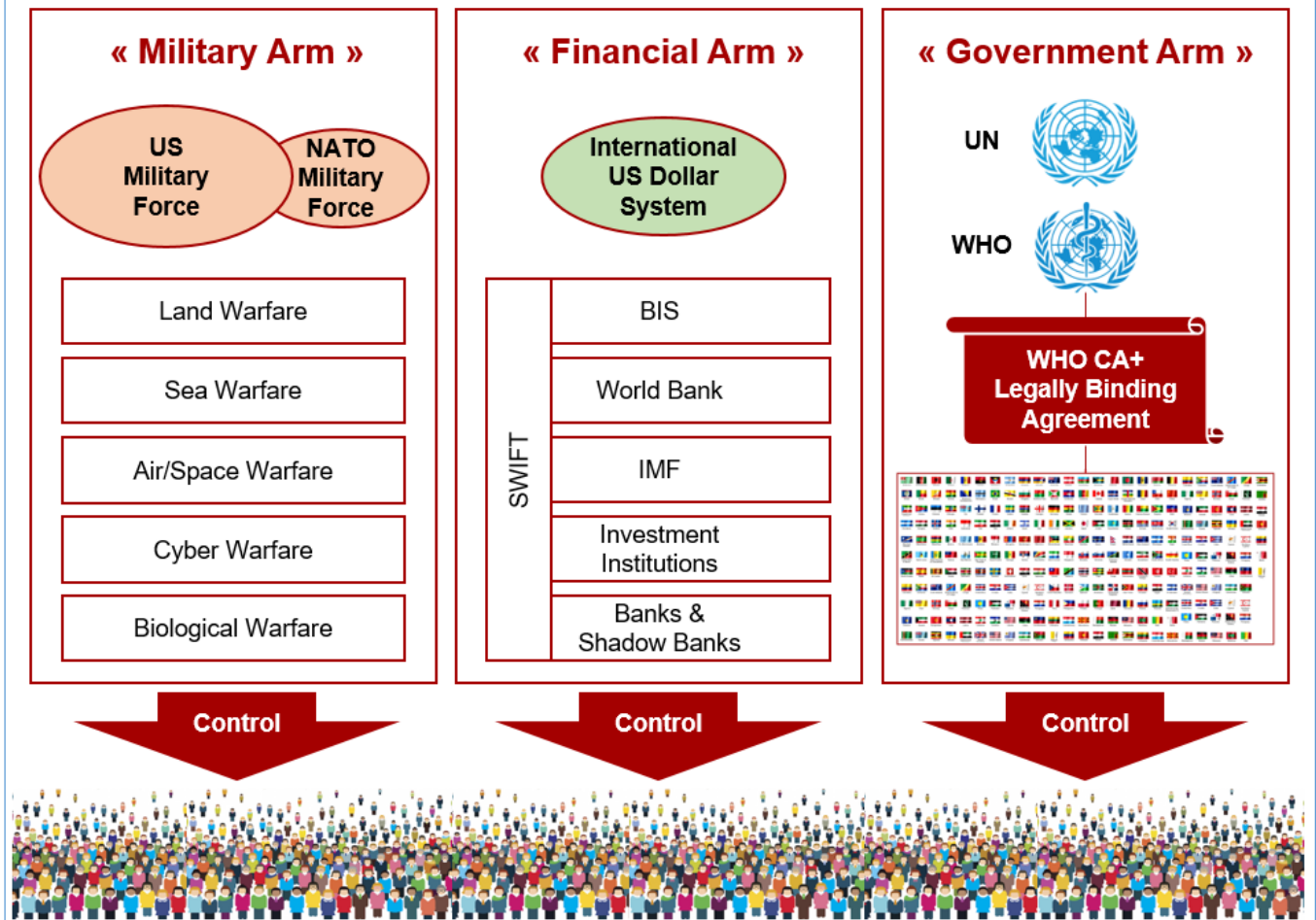
** E.g. Rotary International, Rockefeller Foundation, Bloomberg Family Foundation, Open Society Foundations (Soros), CDC Foundation, Clinton Health Access Initiative, Christian Hansen Holding, Ikea Foundation, and others

*** E.g. Glaxo Smith Kline, Sanofi-Aventis, Hoffman La Roche, Bayer, Novartis, Medimmune, Merck, Bristol Meyers Squibb, and others

Source: WHO website, worldometers.info

WHO CA+ establishes the government arm and last pillar of USA/NATO's power architecture for full-spectrum world domination

WHO CA+ Establishes the Government Arm and Last Pillar of USA/NATO's Full-Spectrum World Domination Architecture



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In the name of all human beings on earth,
in the name of human rights,
in the name of human dignity and worth of the human person,
in the name of god and all faiths of all believers,
in the name of peaceful co-existence among peoples of all races and cultures,
the USA/NATO and UN/WHO plan to establish a global health dictatorship for
world population control
is dangerous and must to be stopped.

If you are listening to this, you are the resistance.

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

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

Reader's guide

Brackets [] indicate options for similar text

1. The Parties [shall]/[should] adopt a whole-of-government approach for pandemic prevention, preparedness, response and recovery of health systems.
2. Towards this end, each Party [shall]/[should] endeavour to:
 - (a) Collaborate, including with nongovernmental organizations, the private sector and civil society, through an ***all-encompassing whole-of-government, multistakeholder, multidisciplinary approach***.
 - (i) Measures to develop, through a whole-of-government and multisectoral collaboration, plans that facilitate rapid and equitable restoration of public health capacities following a pandemic;

Bold italics indicates the focus of the provision.

Underlined text indicates the focus of the measure.

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

BACKGROUND, METHODOLOGY AND APPROACH

Background

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

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

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

Methodology and approach

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

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

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

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

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

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

Preamble¹

1. *Reaffirming* the principle of sovereignty of States Parties in addressing public health matters, notably pandemic prevention, preparedness, response and health systems recovery;
2. *Recognizing* the critical role of international cooperation and obligations for States to act in accordance with international law, including to respect, protect and promote human rights;
3. *Recognizing* that all lives have equal value, and that therefore equity should be a principle, an indicator and an outcome of pandemic prevention, preparedness and response;
4. *Recalling* the preamble to the Constitution of the World Health Organization, which states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition, and that unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger;
5. *Noting* that a pandemic situation is extraordinary in nature, requiring States Parties to prioritize effective and enhanced cooperation with development partners and other relevant stakeholders to address extraordinary challenges;
6. *Recognizing* that the international spread of disease is a global threat with serious consequences for public health, human lives, livelihoods, societies and economies that calls for the widest possible international cooperation and participation of all countries and relevant stakeholders in an effective, coordinated, appropriate and comprehensive international response;
7. *Recalling* the International Health Regulations (2005) of the World Health Organization and the role of States Parties and other stakeholders in preventing, protecting against, controlling and providing a public health response to the international spread of disease in ways that are commensurate with, and restricted to, public health risks, and which avoid unnecessary interference with international traffic and trade;
8. *Recognizing* that national action plans for pandemic prevention, preparedness, response and recovery of health systems should take into account all people, including communities and persons in vulnerable situations, places and ecosystems;
9. *Recognizing* that the threat of pandemics is a reality and that pandemics have catastrophic health, social, economic and political consequences, especially for persons in vulnerable situations, pandemic prevention, preparedness, response and recovery of the health system must be systemically integrated into whole-of-government and whole-of-society approaches, to ensure adequate political commitment, resourcing and attention across sectors, and thereby break the cycle of “panic and neglect”;
10. *Reflecting* on the lessons learned from coronavirus disease (COVID-19) and other outbreaks with global and regional impact, including, inter alia, HIV, Ebola virus disease, Zika virus disease, Middle

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

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

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

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

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

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

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

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

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

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

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

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

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

22. *Understanding* that most emerging infectious diseases originate in animals, including wildlife and domestic animals, then spill over to people;
23. *Recognizing* the importance of working synergistically with other relevant areas, under a One Health Approach, as well as the importance and public health impact of growing possible drivers of pandemics, which need to be addressed as a means of preventing future pandemics and protecting public health;
24. *Noting* that antimicrobial resistance is often described as a silent pandemic and that it could be an aggravating factor during a pandemic;
25. *Reaffirming* the importance of a One Health approach and the need for synergies between multisectoral and cross-sectoral collaboration at national, regional and international levels to safeguard human health, detect and prevent health threats at the animal and human interface, in particular zoonotic spill-over and mutations, and sustainably balance and optimize the health of people, animals and ecosystems, and, in this respect, acknowledging the creation of the Quadripartite, (WHO, the Food and Agriculture Organization (FAO), the World Organisation for Animal Health (WOAH) and the United Nations Environment Programme (UNEP)) to better address any One Health-related issue;
26. *Reiterating* the need to work towards building and strengthening resilient health systems to advance universal health coverage, as an essential foundation for effective pandemic prevention, preparedness, response and recovery of health systems, and to adopt an equitable approach to prevention, preparedness, response and recovery activities, including to mitigate the risk that pandemics exacerbate existing inequities in access to services;
27. *Recognizing* that health is a precondition for, and an outcome and indicator of, the social, economic and environmental dimensions of sustainable development and the implementation of the 2030 Agenda for Sustainable Development;
28. *Recognizing* that pandemics have a disproportionately heavy impact on frontline workers, notably health workers, the poor and persons in vulnerable situations, with repercussions on health and development gains, in particular in developing countries, thus hampering the achievement of universal health coverage and the Sustainable Development Goals, with their shared commitment to leave no one behind;
29. *Recognizing* the need to enhance global solidarity and effective global coordination, as well as accountability and transparency, to avoid serious negative impacts of public health threats with pandemic potential, especially on countries with limited capacities and resources;
30. *Acknowledging* that there are significant differences in countries' capacities to prevent, prepare for, respond to, and recover from pandemics;
31. *Deeply concerned* by the gross inequities that hindered timely access to medical and other COVID-19 pandemic response products, notably vaccines, oxygen supplies, personal protective equipment, diagnostics and therapeutics;
32. *Reiterating* the determination to achieve health equity through resolute action on social, environmental, cultural, political and economic determinants of health, such as eradicating hunger and poverty, ensuring access to health and proper food, safe drinking water and sanitation, employment and decent work and social protection in a comprehensive intersectoral approach;

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

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

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

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

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

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

[38. Proposal: *Recognizing* that protection of intellectual property rights is important for the development of new medicines, and also recognizing concerns about the negative effect on prices and on the production of, timely and equitable access to, and distribution of vaccines, treatments, diagnostics and health technologies and know-how;]

[38. Proposal: *Recognizing* that intellectual property protection is important for the development of new medicines, and also recognizing concerns about its effect on prices, as well as noting discussions on enhancing global efforts towards the production of, timely and equitable access to, and distribution of health technologies and products;]

[38. Proposal: *Recognizing* the concerns that intellectual property on life-saving medical technologies continue to pose threat and barriers to the full realization of the right to health and to scientific progress for all, particularly the effect on prices, which limits access options and impedes independent local production and supplies, as well as noting structural flaws in the institutional and operational arrangements in the global response to the COVID 19 pandemic, and the need to establish a future pandemic prevention, preparedness and response mechanism that is not based on a charity model;]

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

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

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

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

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

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

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

Vision

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

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

Chapter I. Introduction

Article 1. Definitions and use of terms

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

Article 2. Relationship with international agreements and instruments

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

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

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

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

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

Chapter II. Objective(s), principles and scope

Article 3. Objective(s)

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

Article 4. Principles

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

1. **Respect for human rights** – The implementation of the WHO CA+ shall be with full respect for the dignity, human rights and fundamental freedoms of persons, and each Party shall protect and promote such freedoms.
2. **The right to health** – The enjoyment of the highest attainable standard of health, defined as a state of complete physical, mental and social well-being, is one of the fundamental rights of every human being without distinction of age, race, religion, political belief, economic or social condition.
3. **Sovereignty** – States have, in accordance with the Charter of the United Nations and the principles of international law, the sovereign right to determine and manage their approach to public health, notably pandemic prevention, preparedness, response and recovery of health systems pursuant to their own policies and legislation provided that activities within their jurisdiction or control do not cause damage to other States and their peoples. Sovereignty also covers the rights of States over their biological resources.
4. **Equity** – An effective response to pandemics requires ensuring fair, equitable and timely access to affordable, safe and efficacious pandemic response products, among and within countries, including between groups of people irrespective of their social or economic status.
5. **Solidarity** – The effective prevention of, preparedness for, and response to, pandemics require national, international, multilateral, bilateral, and multisectoral collaboration, coordination and cooperation in order to achieve a fairer, more equitable and better prepared world.
6. **Transparency** – The effective prevention of, preparedness for, and response to, pandemics depends on transparent and timely sharing of information, data and other elements at all levels, notably through a whole-of-government and whole-of-society approach, based on, and guided by, the best-available scientific evidence, consistent with national, regional and international privacy and data protection rules, regulations and laws.
7. **Accountability** – Countries are responsible and accountable for strengthening and sustaining their health systems' capacities and public health functions to provide adequate health and social measures by adopting and implementing legislative, executive, administrative and other measures for fair, equitable, effective and timely pandemic prevention, preparedness, response and recovery of health systems. All Parties [shall] / [should] cooperate with other States and relevant international organizations, with particular reference to entities at the frontline of humanitarian settings and fragile and conflict-affected areas, in order to collectively strengthen, support and sustain capacities for global prevention, preparedness, response and recovery of health systems.
8. **Common but differentiated responsibilities and capabilities in pandemic prevention, preparedness, response and recovery of health systems** – Full consideration and prioritization are required of the specific needs and special circumstances of developing country Parties, especially those that (i) are particularly vulnerable to adverse effects of pandemics; (ii) do not have adequate capacities to respond to pandemics; and (iii) would have to bear a disproportionate or abnormal burden.
9. **Inclusiveness** – The active engagement with, and participation of, all relevant stakeholders and partners across all levels, consistent with relevant and applicable international and national guidelines,

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

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

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

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

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

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

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

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

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

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

Article 5. Scope

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

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

Article 6. Global supply chain and logistics network

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (i) measures to build and strengthen the capacity of regulatory authorities and increase the harmonization of regulatory requirements at the international and regional level, including through mutual recognition agreements
- (ii) measures to build and strengthen country regulatory capacities for timely approval of products for pandemic prevention, preparedness, response and recovery of health systems
- (iii) measures to accelerate the process of licensing and approving pandemic response products for emergency use in a timely manner, including the sharing of regulatory dossiers
- (iv) measures to monitor and regulate against sub-standard and falsified pandemic response products, through existing Member State mechanisms.

Article 8. Increase research and development capacities

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

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

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

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

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

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

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

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

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- (c) measures to ensure that promoters of research for pandemic response products assume part of the risk (liability) when the products or supplies are in the research phase, and that making access to such pandemic response products or supplies conditional on a waiver of such liability is discouraged
- (iv) measures to promote and incentivize technology co-creation and joint venture initiatives aimed at strengthening research and development capacities, particularly in developing countries, including through regional hubs or centres of excellence
- (v) measures to provide international standards for, and oversight of, as well as reporting on, laboratories and research facilities that carry out work to genetically alter organisms to increase their pathogenicity and transmissibility, in order to prevent accidental release of these pathogens, while ensuring that these measures do not create any unnecessary administrative hurdles for research
- (b) Foster ***information sharing*** through open science approaches for rapid sharing of scientific findings and research results, irrespective of the outcome, by means that include:
- (i) measures to promote the dissemination of the results of publicly and government-funded-research for the development of pandemic response products
- (ii) measures to promote and strengthen knowledge translation and evidence communication tools and strategies at local, national, regional and international levels
- (c) Develop strong, resilient national, regional and international ***clinical research ecosystems***, by means that include:
- (i) measures to foster and coordinate national, regional and international high quality clinical research/trials
- (ii) measures to ensure equitable access to investment in clinical trials, so that resources are deployed optimally and efficiently
- (iii) measures to support the transparent and rapid reporting of clinical research/trial results, to ensure evidence is available in a timely manner to inform national, regional and international decision-making
- (iv) measures related to disclosure of disaggregated information on research and development and clinical trials of vaccines, diagnostics, pharmaceuticals and other products relevant to pandemic preparedness and response
- (d) Increase the ***transparency of information about funding*** for research and development for pandemic response products, by means that include:
- (i) measures related to the disclosure of information on public funding for research and development of potential pandemic response products and provisions to enhance the availability and accessibility of the resulting work, including freely available and publicly accessible publications and public reporting of the relevant patents

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (i) measures to strengthen post-emergency health system recovery strategies in order to share the lessons learned and to improve countries' capacity in prevention, preparation, surveillance and response
- (ii) measures related to resources and training at national level in order to care for patients with long-term effects from the disease
- (d) Strengthen ***public health laboratory and diagnostic capacities, and national, regional and global networks***, including standards and protocols for public health laboratory biosafety and biosecurity;
- (e) Enhance ***financial, technical and technological support, assistance and cooperation*** among Member States to strengthen health systems consistent with the goal of universal health coverage;
- (f) Develop and ***sustain up-to-date, universal platforms and technologies*** for forecasting and timely information sharing, through appropriate capacities, including building ***digital health and data science capacities***.

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

1. The Parties [shall]/[should] strengthen and sustain an adequate, skilled, trained, competent and committed health workforce, with due protection of their employment, civil and human rights and well-being, consistent with relevant codes of practice, including at the frontline of pandemic prevention, preparedness, response and recovery of the health system.
2. Towards this end, each Party [shall]/[should]:
 - (a) Mobilize and coordinate ***adequate human, financial and other necessary resources*** for affected countries, based on public health need, in order to contain outbreaks and prevent an escalation of small-scale spread to global proportions;
 - (b) Strengthen in- and post-service training of adequate numbers of ***health workers***, including community health workers equipped with public health core competencies, and ensure adequate laboratory capacity, including for conducting genomic sequencing, through sustainable funding support, and deployment and retention of a health workforce that can be mobilized for pandemic response in all settings;
 - (c) Establish an available, skilled and trained ***global public health emergency workforce*** that is deployable to support affected countries upon request, through scaling up of training and capacity of training institutions, by means that include:
 - (i) measures to support the development of a network of training institutions, national and regional facilities and centres of expertise in order to establish common protocols to enable more predictable, standardized and systematic response missions and deployment of surge staff
 - (d) Provide ***better opportunities and working environments for health workers***, notably women, to ensure their role and leadership in the health sector, with a view to increasing the meaningful representation, engagement, participation and empowerment of all health workers, while addressing discrimination, stigma and inequality and eliminating bias, including unequal

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

Article 12. Preparedness monitoring, simulation exercises and peer reviews

1. The Parties [shall]/[should] develop and implement effective and efficient monitoring of pandemic prevention and preparedness, through regular simulation exercises and peer review.
2. Towards this end, each Party [shall]/[should]:
 - (a) Develop and implement *comprehensive, inclusive, multisectoral national pandemic prevention, preparedness, response and health system recovery strategies*;
 - (b) Map and develop *monitoring and evaluation plans* for health interventions related to outbreaks and public health emergencies
 - (i) measures to ensure dynamic preparedness capacity assessment is undertaken and national action plans are developed
 - (ii) measures to develop, incorporate from, or build on, existing global and national indicators for monitoring prevention and preparedness
 - (c) Periodically *drill the national action plans*, through global, regional and national simulation and tabletop exercises, which include risk and vulnerability mapping;
 - (i) measures to support Parties, particularly in developing countries, to regularly conduct simulation exercises to assess readiness and gaps, including logistics and supply chain management, as well as to plan and implement measures for strengthening and sustaining preparedness capacity
 - (ii) measures to support countries to conduct after action reviews of any public health emergency event in order to identify gaps, share lessons learned, and improve national pandemic prevention and preparedness
 - (d) Establish, regularly update and broaden implementation of a *global peer review mechanism* to assess national, regional and global preparedness capacities and gaps, by bringing nations together to support a whole-of-government and whole-of-society approach to strengthening national capacities for pandemic prevention, preparedness, response and health systems recovery, through technical and financial cooperation, mindful of the need to integrate available data, and to engage national leadership at the highest level;
 - (e) Implement the *recommendations generated from review mechanisms*, including prioritization of activities for immediate action;
 - (f) Provide *regular reporting*, building on existing relevant reporting where possible, on pandemic prevention, preparedness, response and health systems recovery capacities.

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

Article 13. Coordination, collaboration and cooperation

1. The Parties [shall]/[should] coordinate, collaborate and cooperate, in the spirit of international solidarity, with other Parties and competent international and regional intergovernmental organizations and other bodies in the formulation of cost-effective measures, procedures and guidelines for pandemic prevention, preparedness, response and recovery of health systems.
2. Towards this end, each Party [shall]/[should]:
 - (a) Promote global, regional and national ***political commitment, coordination and leadership*** for pandemic prevention, preparedness, response and recovery of the health system, by means that include establishing appropriate governance arrangements/[good governance principles] rooted in the Constitution of the World Health Organization;
 - (b) Support mechanisms that ensure global, regional and national ***policy decisions are science and evidence-based***, through enhanced coordination, collaboration and sharing of information among experts, scientific bodies, academic institutions and networks;
 - (c) Develop ***policies that are inclusive***;
 - (i) measures to recognize the specific needs of persons in vulnerable situations, indigenous peoples, and those living in fragile areas, such as small island developing States facing multiple threats simultaneously
 - (ii) measures to promote equitable gender, geographical and socioeconomic status, representation and participation in global and regional decision-making processes, global networks and technical advisory groups, as well as the participation of youth
 - (a) measures to gather and analyse data, including data disaggregated by gender, on the impact of policies on different groups
 - (d) Promote ***solidarity with countries that report public health emergencies*** as an incentive to facilitate transparency and timely reporting of public health events;
 - (e) Enhance ***WHO's central role as the directing and coordinating authority*** on international health work, mindful of the need for coordination with entities in the United Nations system and other intergovernmental organizations;
 - (i) facilitate WHO rapid access to outbreak areas, including through the deployment of expert teams to evaluate and support the response to emerging outbreaks.

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

1. The Parties [shall]/[should] adopt a whole-of-government approach to pandemic prevention, preparedness, response and recovery of health systems.
2. Towards this end, each Party [shall]/[should]:

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- (a) Collaborate, including with non-State actors, the private sector and civil society, through an ***all-encompassing whole-of-government, multistakeholder, multi-disciplinary and multi-level approach***, by means that include:
- (i) measures to develop, through whole-of-government and multisectoral collaboration, plans that strengthen pandemic preparedness, prevention, response capacities and which facilitate rapid and equitable restoration of public health capacities following a pandemic
- (b) Tackle the ***social, environmental and economic determinants of health*** that contribute to the emergence and spread of pandemics, and prevent or mitigate the socioeconomic impacts of pandemics, including but not limited to, those affecting economic growth, the environment, employment, trade, transport, gender equality, education, social assistance, housing, food insecurity, nutrition and culture, and especially for persons in vulnerable situations;
- (c) Support timely and scalable ***mobilization of multi-disciplinary surge capacity*** of human and financial resources and facilitate timely allocation of resources to the frontline pandemic response;
- (d) Strengthen ***national public health and social policies to facilitate a rapid, resilient response***, especially for persons in vulnerable situations.

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

1. Recognizing that pandemics begin and end in communities, for effective pandemic prevention, preparedness, response and recovery of health systems, the Parties [shall]/[should] promote, empower and strengthen the engagement/participation of communities to ensure their ownership of, and contribution to, community readiness and resilience, including public health and social measures.
2. Towards this end, each Party [shall]/[should]:
- (a) Engage with ***communities, civil society, academia and non-State actors, including the private sector***, as part of a whole-of-society approach to pandemic prevention, preparedness, response and recovery of health systems;
- (b) Promote ***science and evidence-based/informed effective and timely risk assessment***, including the uncertainty of data when communicating such risk to the public;
- (c) Mobilize ***social capital in communities for mutual support***, especially to persons in vulnerable situations;
- (d) Promote two-way ***engagement of civil society, communities and non-State actors, including the private sector***, as part of a whole-of-society response that involves communities in decision making and uses feedback mechanisms;
- (e) Establish or reinforce and adequately finance ***an effective national coordinating multisectoral mechanism*** with meaningful representation, engagement, participation and empowerment of communities, for pandemic prevention, preparedness, response and recovery of health systems.

Article 16. Strengthening pandemic and public health literacy

1. The Parties [shall]/[should] increase science, public health and pandemic literacy, as well as access to information on pandemics and their effects, and tackle false, misleading, misinformation or disinformation, including through promotion of international cooperation.
2. Towards this end, each Party [shall]/[should]:
 - (a) **Inform the public, communicate risk and manage infodemics** through effective channels, including social media;
 - (b) Conduct regular social media analysis to identify and **understand misinformation, and design communications and messaging** to the public to counteract misinformation, disinformation and false news;
 - (c) Foster **health, science and media literacy, and promote communications on scientific, engineering and technological advances** relevant to the development and implementation of international rules and guidelines for pandemic prevention, preparedness, response and recovery of health systems;
 - (d) Promote and facilitate, at all appropriate levels, in accordance with national laws and regulations, **development and implementation of educational and public awareness programmes** on pandemics and their effects;
 - (e) Strengthen **public trust and counter misinformation and disinformation**, including through providing timely, simple, clear, coherent, accurate, transparent and effective global and national communications, based on science and evidence, promoting media literacy and ethical professional journalism, and strengthening research on misinformation and disinformation and its relationship to public trust in order to inform policies;
 - (f) Strengthen **research into the behavioural barriers and drivers** of adherence to public health measures, confidence and uptake of vaccines, use of therapeutics and trust in science and government institutions.

Article 17. One Health

1. In the context of pandemic prevention, preparedness, response and recovery of health systems, the Parties [shall]/[should] promote and enhance synergies between multisectoral collaboration at national level and cooperation at the international level, in order to safeguard human health and detect and prevent health threats at the interface between animal, human and environment ecosystems, while recognizing their interdependence.
2. Towards this end, each Party [shall]/[should]:
 - (a) Promote and implement a **One Health approach that is coherent, coordinated and collaborative** among all relevant actors, existing instruments and initiatives, by means that include:
 - (i) measures to identify and integrate into relevant pandemic prevention and preparedness plans, drivers for the emergence of disease at the human–animal–

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

- (b) Implement actions to ***prevent pandemics from pathogens resistant to antimicrobial agents***, taking into account relevant tools and guidelines, through a One Health approach, and collaborate with relevant partners, including the Quadripartite;
- (c) Strengthen ***multisectoral, coordinated, interoperable, integrated One Health surveillance systems*** to minimize spill-over events and mutations and prevent small scale outbreaks in wildlife or domesticated livestock from becoming a pandemic, by means that include:
 - (i) measures to ensure that actions at national and community levels encompass whole-of-government and whole-of-society perspectives, including engagement of communities in surveillance that identifies zoonotic outbreaks and antimicrobial resistance
- (d) Develop and implement a ***national One Health Action Plan on antimicrobial resistance*** which improves antimicrobial stewardship in the human and animal sectors; optimizes consumption; increases investment in, and promotes equitable and affordable access to, new medicines, diagnostic tools, vaccines and other interventions; strengthens infection prevention and control in health care settings; and provides technical support to developing countries;
- (e) Enhance the ***surveillance and reporting of antimicrobial resistance*** in human, livestock and aquaculture of pathogens which have pandemic potential, building on the existing global reporting systems;
- (f) Regularly ***assess One Health capacities***, insofar as they relate to pandemic prevention, preparedness, response and recovery of health systems, to identify gaps, policies and the funding needed to strengthen those capacities;
- (g) Strengthen ***synergies with other existing relevant instruments*** which address the drivers of pandemics, such as climate change, biodiversity loss, ecosystem degradation and increased risks at the animal–human–environment interface due to human activities;
- (h) Take the One Health approach into account at national, subnational and facility levels in order to produce science-based evidence, and support, facilitate and/or oversee the correct, ***evidence-based and risk-informed implementation of infection prevention and control***.

Chapter VI. Financing

Article 18. Sustainable and predictable financing

1. The Parties [shall]/[should] ensure, through existing and/or new mechanisms, sustainable and predictable financing, while enhancing transparency and accountability, to achieve the objective of the WHO CA+.
2. Towards this end, each Party [shall]/[should]:
 - (a) Strengthen and prioritize ***domestic financing*** for pandemic prevention, preparedness, response and health systems recovery, including through greater collaboration between the health, finance and private sectors, in support of primary health care and universal health coverage;

- (b) Finance, through *new or established international mechanisms*, regional and global capacity-building for pandemic prevention, preparedness, response and recovery of health systems;
- (c) Measures to ensure/enhance *sustainable, [equitable, fair,] and predictable financing* of global, regional and national systems and tools and global public goods for pandemic prevention, preparedness, response and recovery of health systems, through existing or new mechanisms, while avoiding duplication and ensuring synergies, in order to guarantee equitable access to preparedness financing;
- (d) Facilitate rapid and effective mobilization of *adequate financial resources*, including from international financing facilities, to affected countries, based on public health need, to maintain and restore routine public health functions during and in the aftermath of a pandemic response.

Chapter VII. Institutional arrangements

Article 19. Governing body for the WHO CA+¹

1. A governing body for the WHO CA+ is established to promote the effective implementation of the WHO CA+ (hereinafter, the “Governing Body”).
2. The Governing Body shall be composed of:
 - (a) The Conference of the Parties (COP), which shall be the supreme organ of the Governing Body;
 - (b) The Officers of the Parties (OP), which shall be the administrative organ of the Governing Body; and
 - (c) The Enlarged Conference of the Parties (E-COP), which will include relevant stakeholders and will provide broad input for the decision-making processes of the COP.
3. The COP, as the supreme policy setting organ of the WHO CA+, shall keep under regular review the implementation of the WHO CA+ and any related legal instruments that the COP may adopt, and shall make the decisions necessary to promote the effective implementation of the Convention. The COP shall:
 - (a) Be composed of delegates representing Parties;
 - (b) Convene ordinary sessions of the Governing Body; the first of which shall take place not later than one year after the date of entry into force of the Convention, at a time and place to be determined by the WHO Secretariat, with the time and place of subsequent ordinary sessions to be determined by the COP upon a proposal of the Officers of the Parties;
 - (c) Convene extraordinary sessions of the Governing Body at such other times as may be deemed necessary by the COP, or at the written request of any Party, provided that, within 30

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

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

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

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

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

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

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

(a) Be composed of delegates representing Parties;

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

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

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

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

Article 20. Oversight mechanisms for the WHO CA+¹

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

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

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

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

Article 21. Assessment and review

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

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

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

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

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

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

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

Chapter VIII. Final provisions

Article 23. Reservations

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

Article 24. Withdrawal

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

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

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

Article 25. Right to vote

1. Each Party to the WHO CA+ shall have one vote, except as provided for in paragraph 2 of this Article.
2. Regional economic integration organizations, in matters within their competence, shall exercise their right to vote with a number of votes equal to the number of their Member States that are Parties to the WHO CA+. Such an organization shall not exercise its right to vote if any of its Member States exercises its right, and vice versa.

Article 26. Amendments to the WHO CA+

1. Any Party may propose amendments to the WHO CA+. Such amendments will be considered by the Governing Body.
2. Amendments to the WHO CA+ shall be adopted by the Governing Body. The text of any proposed amendment to the WHO CA+ shall be communicated to the Parties by the Secretariat at least six months before the session at which it is proposed for adoption. The Secretariat shall also communicate proposed amendments to the signatories of the WHO CA+ and, for information, to the Depository.
3. The Parties shall make every effort to reach agreement by consensus on any proposed amendment to the WHO CA+. If all efforts at consensus have been exhausted, and no agreement reached, the amendment shall as a last resort be adopted by a two-thirds majority vote of the Parties present and voting at the session. For purposes of this Article, Parties present and voting means Parties present and casting an affirmative or negative vote. Any adopted amendments shall be communicated by the Secretariat to the Depository, who shall circulate it to all Parties for acceptance.
4. Instruments of acceptance in respect of an amendment shall be deposited with the Depository. An amendment adopted in accordance with paragraph 3 of this Article shall enter into force for all Parties when adopted by a two-thirds vote and accepted by two-thirds of the Parties in accordance with their respective constitutional processes.
5. The amendment shall enter into force for any other Party on the ninetieth day after the date on which that Party deposits with the Depository its instrument of acceptance of the said amendment.

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

1. Annexes to the WHO CA+ and amendments thereto shall be proposed, adopted and shall enter into force in accordance with the procedure set forth in the WHO CA+.
2. Annexes to the WHO CA+ shall form an integral part thereof and, unless otherwise expressly provided, a reference to the WHO CA+ constitutes at the same time a reference to any annexes thereto.
3. Annexes shall be restricted to lists, forms and any other descriptive material relating to procedural, scientific, technical or administrative matters.

Article 28. Protocols to the WHO CA+¹

1. Any Party may propose protocols to the WHO CA+. Such proposals will be considered by the Governing Body.
2. The Governing Body may adopt protocols to the WHO CA+. In adopting these protocols every effort shall be made to reach consensus. If all efforts at consensus have been exhausted and no agreement reached, the protocol shall as a last resort be adopted by a two-thirds majority vote of the Parties present and voting at the session. For the purposes of this Article, Parties present and voting means Parties present and casting an affirmative or negative vote.
3. The text of any proposed protocol shall be communicated to the Parties by the Secretariat at least six months before the session at which it is proposed for adoption.
4. States that are not Parties to the WHO CA+ may be Parties to a protocol thereof, provided the protocol so provides.
5. Any protocol to the WHO CA+ shall be binding only on the Parties to the protocol in question. Only Parties to a protocol may take decisions on matters exclusively relating to the protocol in question.
6. The requirements for entry into force of any protocol shall be established by that instrument.

Article 29. Signature

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

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

1. The WHO CA+ shall be subject to ratification, acceptance, approval or accession by States, and to formal confirmation or accession by regional economic integration organizations. It shall be open for accession from the day after the date on which the WHO CA+ is closed for signature. Instruments of ratification, acceptance, approval, formal confirmation or accession shall be deposited with the Depository.
2. Any regional economic integration organization which becomes a Party to the WHO CA+ without any of its Member States being a Party shall be bound by all the obligations under the WHO CA+. In the case of those organizations, where one or more of its Member States is a Party to the WHO CA+, the organization and its Member States shall decide on their respective responsibilities for the performance of their obligations under the WHO CA+. In such cases, the organization and the Member States shall not be entitled to exercise rights under the WHO CA+ concurrently.
3. Regional economic integration organizations shall, in their instruments relating to formal confirmation or in their instruments of accession, declare the extent of their competence with respect to

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

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

Article 31. Entry into force

1. The WHO CA+ shall enter into force on the [thirtieth] day following the date of deposit of the [fortieth] instrument of ratification, acceptance, approval, formal confirmation or accession with the Depository.
2. For each State that ratifies, accepts or approves the WHO CA+ or accedes thereto after the conditions set out in paragraph 1 of this Article for entry into force have been fulfilled, the WHO CA+ shall enter into force on the [thirtieth] day following the date of deposit of its instrument of ratification, acceptance, approval or accession.
3. For each regional economic integration organization depositing an instrument of formal confirmation or an instrument of accession after the conditions set out in paragraph 1 of this Article for entry into force have been fulfilled, the WHO CA+ shall enter into force on the thirtieth day following the date of its depositing of the instrument of formal confirmation or of accession.
4. For the purposes of this Article, any instrument deposited by a regional economic integration organization shall not be counted as additional to those deposited by States Members of the Organization.

Article 32. Provisional application

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

Article 33. Settlement of disputes

1. In the event of a dispute between two or more Parties concerning the interpretation or application of the WHO CA+, the Parties concerned shall seek through diplomatic channels a settlement of the dispute through negotiation or any other peaceful means of their own choice, including good offices, mediation or conciliation. Failure to reach agreement by good offices, mediation or conciliation shall not absolve Parties to the dispute from the responsibility of continuing to seek to resolve it.
2. When ratifying, accepting, approving, formally confirming or acceding to the WHO CA+, or at any time thereafter, a Party may declare in writing to the Depository that, for a dispute not resolved in accordance with paragraph 1 of this Article, it accepts, as compulsory, ad hoc arbitration in accordance with procedures to be adopted by consensus by the Governing Body.
3. The provisions of this Article shall apply with respect to any protocol as between the Parties to the protocol, unless otherwise provided therein.

Article 34. Depository

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

Article 35. Authentic texts

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

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