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BRIEFING PAPER FOR PARLIAMENTARIANS AND THE PUBLIC
The IHR Amendments Package and WHO Pandemic Agreement

1. SUMMARY

In the past fortnight, revised drafts of the World Health Organisation's Pandemic Accords (a draft new Pandemic Agreement, and a package of amendments to the existing International Health Regulations) have been made available. Although the new texts, especially as regards the IHRs, mark a significant improvement on the egregious overreach of the previous circulated drafts, significant concerns remain.

This briefing paper explains the key changes and persisting issues. In summary:

★ Many of the most egregious proposals in the original IHR amendments package have been **dropped or significantly scaled back**, including:
- Proposals which would have ordained the WHO with powers to issue binding directives to Member States (dropped)
- Proposals which would have erased reference to "*dignity, human rights and fundamental freedoms*" (dropped)
- Proposals which would have allowed the WHO to intervene on the basis of having identified a mere "*potential*" health emergency (dropped)
- Provisions which had proposed to expand the scope of the IHR's to include "*all risks with a potential to impact public health*" (dropped)
- Provisions expressly favouring the use of digital health passports (dropped)
- Proposals which aimed to construct a global censorship and 'information control' operation led by the WHO (dropped, though the texts still commit States to enhance their abilities to counter 'misinformation and disinformation')
- Plans for the WHO to police compliance with all aspects of the IHRs (scaled back).

★ Significant issues remain across both texts, including:

- **Affirmation of the WHO** as "*the directing and coordinating authority on international health work, including on pandemic prevention, preparedness and response*". Whilst attempts to supercharge the WHO's authority and power have been scaled back from the original proposals, the Pandemic Agreement and the IHRs are still intended by the WHO and its Member States to form a strengthened mandatory global framework agreement for pandemic management as part of a longer-term transfer of public health decision-making away from community and national levels.
- **Covid interventions as a blueprint for future pandemic action**. The proposals start from the premise that the array of Covid interventions actioned during the pandemic are a suitable blueprint to direct future pandemic response behaviour. This is an extremely controversial starting point, which for the UK hugely prejudges the findings of the Covid Inquiry.
- Proposals which envisage a strengthening of national pathogen surveillance **hardwire in a surveillance-first strategy** which seems guaranteed to increase the perception of regular pandemic threats and the likelihood of triggering drastic responses to routine outbreaks.
- Proposals which grant the WHO Director General power to declare a pandemic emergency continue to **vest unacceptably significant discretionary power in just one individual**.
- In promoting the use of behavioural science and 'risk communication' the texts **ordain the use of nudge, propaganda and censorship**. A more appropriate strategy would be to embed legal and practical protections for scientific debate and free speech.
- Taken together the two Accords would **commit the UK to supporting the WHO's global response strategies come what may**, and would seek to commit us to **significant new funding obligations** as part of that. There is no good reason to bind ourselves to the WHO, with its poor pandemic management track record, at least until major reform of that organisation, including its funding model, has been secured.
- The texts assume the need and desirability for an interventionist response to future pandemics, using the Covid response as a starting point. That flawed assumption further relies on an assumption that there are properly functioning and effective national regulatory regimes in place. The **reality across all major jurisdictions is systemic regulatory capture by private industry** which, in the UK, parliamentarians and experts have already called out as a clear threat to patient safety.[1]

[1] https://appgpandemic.org/news/mhra-letter-health-select-committee

★ As of the time of writing, there are only three weeks left until the vote on these proposals is due to be put to the World Health Assembly. Reports suggest that negotiations across many key provisions are still ongoing, and as a result further changes can be expected to these generationally important texts.[2] Any sensible period for scrutiny is over, and the democratic illegitimacy of forcing through a vote on these controversial agreements within the originally planned timeframe will further decimate trust in public health, and the World Health Organisation.

★ Legitimate questions have also been raised about the legality of any adoption vote for the IHR amendments taking place in May 2024 given the impossibility of complying with necessary legal notice periods under Article 55 of the IHR.

★ More broadly, it is inappropriate for the UK now to deepen its integration into a multilateral organisation about which serious governance, ethical, conflict and competency concerns persist: in relation to its senior personnel, its duplicity and mishandling of these negotiations and its private funding arrangements and motivations. Each of these points is discussed more fully below.

2. CONTEXT

This briefing paper explains the twinned proposals, coordinated by the World Health Organization and negotiated by its constituent Member States, for a package of amendments to the existing International Health Regulations (IHRs), and for a new Treaty on pandemic prevention, preparedness and response styled as the 'WHO Pandemic Agreement'. The two documents are intended to operate, and need therefore to be read, alongside each other.

There has been vocal public concern about these documents and the fact that the amendments to the IHRs have been negotiated in near total secrecy.

In April 2024, an interim draft 'Bureau's text' of the proposed IHR amendments was released by the WHO.[3] This was the first interim draft text released since the original package of amendments (dated November 2022) was published in early 2023, after which all of the intervening negotiations took place essentially in private. Many of those

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[2] https://healthpolicy-watch.news/wget-it-done-or-dont-block-consensus-tedros-urges-pandemic-negotiators/

[3] https://apps.who.int/gb/wgihr/pdf_files/wgihr8/WGIHR8_Proposed_Bureau_text-en.pdf

original proposals would, if retained, have resulted in serious transgressions against national decision-making autonomy, free speech and human rights.

A week later, an updated draft of the Pandemic Agreement was published to coincide with the final meeting of the Intergovernmental Negotiating Body (INB) charged with finalising that document.[4] In stark contrast to the IHR negotiations, multiple interim drafts of the Pandemic Agreement have been made available over the course of the negotiation period.

As we explain in this document, the interim draft of the IHRs released in April marks a material improvement on many of the most critical issues raised by the original IHR amendment proposals. That said, many concerns still remain both as regards the intention and legal impact of the two documents when read together, and in respect of the underlying ethos, funding structure and process and timing for these twin proposals.

The commentary which follows is based on the two draft texts identified above. We understand that negotiations have not yet concluded and it is likely that the substance of either document will change before it is finalised.

3. CONTINUING CONCERNS WITH THE LEGAL TEXTS

Role of the WHO: Though as we explain in more detail below the IHRs no longer expressly empower the WHO to give binding directions to Member States, as had originally been tabled, the drafting which remains across the two legal texts both expressly and implicitly regards the WHO as "*the directing and coordinating authority on international health work, including on pandemic prevention, preparedness and response*".[5] While this has always been the stated intention of the documents, there is an overarching question as to why, given its poor performance in both managing and investigating the causes of the Covid pandemic, national governments are contemplating elevating it as a global health authority.

There is an extent to which any international treaty represents an incursion into national sovereignty and autonomy. Although the amended IHRs will no longer include powers for the WHO unilaterally to give binding directions to Member States, the IHRs and the Pandemic Agreement remain binding agreements as a matter of international law, and in many respects seek to strengthen and expand an already mandatory framework not

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[4] https://apps.who.int/gb/inb/pdf_files/inb9/A_inb9_3Rev1-en.pdf

[5] Draft Pandemic Agreement, Recital 3.

only for international cooperation but also for *national*-level approaches and capacities for preventing and responding to health risks.

Covid interventions as a blueprint: Throughout both documents assumptions both explicit and implicit are made across the two documents as to the permanent desirability and effectiveness of a global and interventionist response including "control measures", quarantines, restrictions on movement and societal lockdowns.[6] None of these measures are without controversy, and eminent experts continue to debate their relative and absolute efficacy in relation to Covid. With the UK's Covid Inquiry still yet to complete its evidence gathering, let alone report any conclusions, it would be premature to commit the UK to a public health regime that prioritises these measures and obliges us progressively to strengthen our commitment to using them.[7]

Commitments to a surveillance-led prevention strategy: Public health commentators have questioned the WHO's desire seemingly to prioritise pandemic surveillance and prevention at the expense of competing health priorities, including hygiene and healthcare initiatives in developing countries that have historically saved millions of lives each year. Commentators have also pointed out that creating an industrial complex to identify new pandemic threats will inevitably increase the perception of pandemic threats and the likelihood of triggering drastic responses to routine outbreaks.[8]

The surveillance-related proposals which remain in the interim draft of the IHRs appear to fall far short of the expansive original proposals under which the WHO would have coordinated a global system of local, regional and national surveillance operations (Article 44, Annex 1 and New Annex 10). Yet the apparent presumption that it will be desirable – continuously – to seek out new pathogens and variants evidently has not abated, and remains reflected both in the IHRs text and, particularly, in the draft Pandemic Agreement.

In the new draft IHR text, Member States will commit to develop, strengthen and maintain pathogen surveillance capacity, with supporting obligations to "*progressively strengthen"* surveillance activities also still appearing in the Pandemic Agreement;[9] this

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[6] For example, Interim Draft IHR Amendments, Article 18.

[7] Draft Pandemic Agreement, Article 4.

[8] https://www.telegraph.co.uk/news/2024/04/28/pandemic-treaty-who-power-demand-20pc-uk-vaccines/

[9] Draft Pandemic Agreement, Article 4

reinforces a provision already in the IHRs which obliges all Member States to develop, strengthen and maintain their capacity to assess, notify and report public health emergency events, including pandemics.[10]

Use of behavioural science and information control: Not only does the draft Pandemic Agreement envisage deploying some of the most controversial techniques used during the Covid pandemic, it commits each Member State to develop and strengthen plans for promoting "*social and behavioural sciences"* and "*risk communications … for pandemic prevention, preparedness and response"*.[11]

These are euphemistic terms for what became in the Covid context the use of fear, psychological techniques, social stigmatisation and propaganda. Similarly controversial are provisions relating to information control. As we discuss more fully below, although ambitious plans to anoint the WHO as a turbo-charged global censorship agency appear to have been dropped from the new draft IHR text, amendments aimed at strengthening each Member State's "*risk communications"* operations nevertheless remain by way of updates to Annex 1 of the draft IHRs, which oblige Member States to develop, strengthen and maintain their capacity to counter "*misinformation and disinformation"*.[12]

Though this seems benign, given what has been learned – since the Pandemic Agreement was first proposed – about the extent and effect of State-led censorship and propaganda during the pandemic, a more appropriate strategy would be to embed legal and practical protections for scientific debate, and for free speech more generally.

Concrete obligations to commit funding: The original (CA+) draft of the Pandemic Agreement proposed to commit all Member States to substantial public spending commitments including a requirement to allocate at least 5% of national health budgets and an unspecified additional percentage of GDP to pandemic prevention, preparation and response initiatives. Additional provisions across the two draft documents anticipated Member States participating in pandemic funding arrangements designed primarily to support Member States whose infrastructure and health systems needed to be upgraded to meet presumed IHR standards.

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[10] Current ('in force') IHRs, Article 5.1.

[11] Draft Pandemic Agreement, Article 6.2(d).

[12] Interim Draft IHR Amendments, Article 44 and Annex 1, paras A.2 and A.3.

Though these granular and significant commitments have disappeared from the new draft IHRs text, and had earlier been removed from the draft Pandemic Agreement, the draft Pandemic Agreement nevertheless still requires Member States both to strengthen domestic funding for pandemic-related activities, and to mobilise additional financial resource to assist other Member States.[13] Member States will also commit via the Pandemic Agreement to participate in a 'Coordinating Financial Mechanism' to support pandemic-related activities in developing countries.[14] These provisions are clearly intended to imply some level of new and additional financial commitment, but leave the quantification of those commitments for another day and, presumably, another negotiation among national governments.

As has been reported in UK press, the Pandemic Agreement in its current draft form also envisages a new mechanism (similarly yet to be designed or agreed) through which the WHO would acquire a right to demand zero- or low-cost access to up to 20% of global production of "*safe, efficacious and effective pandemic-related health products"*.[15] It is not immediately clear how this would be funded, but as the pharmaceutical industry is not party to the Pandemic Agreement it must be presumed that the costs of funding this transfer of resources at the WHO's request are to be underwritten by Member States.

One Health: The Pandemic Agreement advocates for, and requires Member States to commit to promote, a 'One Health' approach to public health management, defined as "*an integrated, unifying approach that aims to sustainably balance and optimize the health of people, animals and ecosystems*".[16] Recital 17 to the Agreement calls out a number of growing perceived threats to public health, including "climate change", "*poverty and hunger*", and "*fragile and vulnerable settings*" (an unexplained concept). Although, as we explain below, earlier proposals which would have expanded the scope of the WHOs areas of interest under the IHRs to include all risks with a potential to impact public health have been scaled back, these 'One Health' elements of the Pandemic Agreement continue to echo the expansionist ambitions of the WHO. In particular they require Member States to "*protect animal and plant health",* as well as human health, by *"…implementing policies that reflect a One Health approach as it*

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[13] Draft Pandemic Agreement, Article 20.1.

[14] Draft Pandemic Agreement, Article 20.2.

[15] Draft Pandemic Agreement, Article 12.

[16] Draft Pandemic Agreement, Article 1(b).

relates to pandemic prevention, preparedness and response".[17] It is hard to see how this reconciles with, for example, advice that triggers the production and disposal of billions of non-compostable single use face masks and testing kits.

Recognising, perhaps, that the One Health framework as drafted is a vague and nebulous concept, the Pandemic Agreement provides in a seemingly open-ended clause that the "*modalities, terms and conditions and operational dimensions of a One Health Approach shall be further defined in an instrument that…will be operational by 31 May 2026"*. In other words, the details are shelved for a future date.

Regulatory strengthening: Article 14 of the Pandemic Agreement requires Member States to strengthen national and regional regulatory authorities and to ensure that emergency regulatory authorisations for pandemic-related health products can be processed during a pandemic. This assumes, of course, that national and regional regulatory authorities can already be relied upon to conduct approval processes and post-authorisation product safety monitoring competently and comprehensively; and that emergency authorisations function properly as accelerated safety approval processes. As volumes of critical academic, clinical and also now legal documentation in the US, UK, Germany, Australia and elsewhere is revealing, this has apparently not always proven to be the case in relation to products granted emergency use authorisations during the Covid pandemic.[18] Certainly there have been serious doubts raised by parliamentarians in relation to the competence and capabilities of the UK medicines regulator.[19]

Whatever one's view on the emerging evidence of procedural failings and inadequacies, conflicts of interest in medicine approval processes, and whatever one's view on the reliability, independence and objectivity of the major medicines regulators, if only because of the documented close financial and organisational ties between key actors in the pharmaceutical industry and the WHO and senior public health officials, Article 14 of the Pandemic Agreement must be read with a degree of healthy scepticism.

Ethics and human rights: As discussed more fully below, one of the most egregious provisions contemplated in either document was a proposal in the original IHRs text to delete reference to the primacy of "*dignity, human rights and fundamental freedoms"* as

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[17] Draft Pandemic Agreement, Article 5.

[18] https://blogs.bmj.com/bmj/2021/05/07/covid-vaccines-for-children-should-not-get-emergency-use-authorization/

[19] https://appgpandemic.org/news/mhra-letter-health-select-committee

a guiding principle of the IHRs. Although that proposal has been dropped, many of the pandemic management measures contemplated in these two documents (lockdowns, the use of behavioural science nudges, mandatory restrictions of personal and community freedoms) are nevertheless controversial from an ethical perspective.

Particularly controversial is a provision in the IHR text which contemplates that the legal requirement for an individual to give informed consent to medical interventions may be overridden by providing that Member States may, including expressly in the absence of consent, "*compel"* travellers to "*undergo … vaccination or other prophylaxis"*.[20]

4. MISSION AND FUNDING STRUCTURE OF THE WHO

It is legitimate to say that the Pandemic Agreement and the IHRs are still intended by the WHO and its Member States to form a strengthened global framework agreement for pandemic management as part of a longer-term transfer of public health decision-making away from community and national levels; and it seems self-evident that the WHO aspires to play a more-than-advisory role in that global framework.

It would equally be legitimate to say that the expansionist ambitions implicit in the WHO's One Health concept, and the presumption that a 'whole-of-society' approach to managing health emergencies including pandemics is always desirable, pose a threat for those who believe the role of the WHO should be still to promote 'the highest attainable standard of health' for the many by supporting and empowering rather than directing national and community-level healthcare.

There are also serious problems with the funding arrangements for the WHO:[21]

Less than 20% of the WHO's financing originates from core contributions by Member States, the majority of its funding being for specified purposes. Much of that 'specified purpose' funding comes from private donors with direct and indirect financial interests in the pharmaceutical industry, which evidently stands to profit from a medicalised approach to pandemic prevention and response. Despite vocal public concern about the conflicts and incentives inherent in this funding model, in 2022 the WHO established the WHO Foundation explicitly to attract 'philanthropic' donations from the commercial sector. The Foundation was established explicitly to insulate the WHO from potential

[20] Interim Draft IHR Amendments, Article 31.2(a).

[21] See e.g. T. Fazi, *How the Who was captured*: https://unherd.com/2023/03/how-the-who-was-captured/

conflicts of interest and reputational risk, yet in its short life the Foundation has already been accused of a lack of transparency and behaviours which undermine good governance.[22]

Central to the WHO's continuing relevance, and arguably its reason for being, is the notion that a more globalised system of public health management will provide better health outcomes for all. Yet when viewed in the context of the increasing dominance of private-interest funding referenced above, it becomes more obviously apparent why an unelected and democratically unaccountable multilateral organisation with a globalist and pro-corporate outlook may no longer be well placed to serve the needs of (possibly any) countries, communities or individuals.

5. PROCESS AND TIMING

It remains the WHO's intent to finalise the two documents so that a final draft of each text can be presented at the World Health Assembly meeting taking place at the end of May 2024. The IHR amendments could be adopted by a simple majority of Member States at that meeting and would come into force 12 months later (following expiry of a 10 month opt-out period); the Pandemic Agreement requires a two-third majority approval and would then come into force once it has been ratified or otherwise approved by at least 60 Member States.

A legitimate question mark has been raised as to the legality of any adoption vote for the IHR amendments taking place in May 2024, which turns on the interpretation and application of Article 55 of the existing in force version of the IHRs. That question is not addressed in this briefing but we have commented on it elsewhere.[23]

6. COMMENTARY ON THE 17 APRIL 2024 DRAFT IHR AMENDMENTS

By any measure, the April 2024 interim draft version of the IHR amendments reflects a material change of tone and position relative to the original package of proposed amendments. Whilst questions remain about the significant overreach and expansionist ambitions evident in the original draft IHR proposals and the most recent version of the Pandemic Agreement, in our view the new draft reflects a material and meaningful retreat from the original ambitious proposals for revising the IHRs.

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[22] https://pubmed.ncbi.nlm.nih.gov/38412806/

[23] https://twitter.com/UsforThemUK/status/1767230334238708030

It must also be recognised that the purpose of the IHR amendment exercise has only ever been to *expand* the scope of the IHRs and *strengthen* existing positions and powers; it has never been on the table to narrow the scope or powers that have been in force in various forms for decades, and most recently updated in 2005.

We summarise in the following section the key changes between the January 2022 draft proposals for the IHR amendments and the April 2024 version.

A. The WHO's recommendations remain non-binding. Article 13A.1 which would have required Member States to follow directives of the WHO as the guiding and coordinating authority for international public health has been dropped entirely.

One of the most controversial proposals in the original package of amendments was to amend the definitions of WHO temporary and standing recommendations to explicitly delete reference to those recommendations being "non-binding".

This, together with a new Article 13A.1 requiring Member States to "*recognize [the] WHO as the guid[ing] and coordinating authority of international public health response"* and to "*undertake to follow"* its recommendations, would if carried forward have transformed the WHO from a purely advisory body to a supra-national public health executive authority with power to issue legally-binding advice and directions to Member States.

Though the Pandemic Agreement now includes a recital referencing the WHO's role as a "directing authority" for public health, crucially, those key amendments to the IHRs have been dropped in their entirety in this interim text. This is a significant change of position because while it does not affect the binding nature of the obligations to which Member States will commit by adopting the updated IHRs, it *does* affect the force with which the WHO can issue any future statements or advisory communications while exercising its coordinating functions under the IHRs. According to this interim draft, all such WHO communications will remain advisory only.

The fact that this material amendment had been contemplated but is now seemingly rejected in the latest draft is helpful insofar as it should carry jurisprudential weight were any question to arise in the future as to whether a WHO advisory or recommendation issued pursuant to the IHRs should – in a domestic legal context – be considered binding.

That said, the latest draft has retained a provision which requires Member States "*when requested by WHO"* to provide "*to the fullest extent possible within the means and resources at their disposal, support to WHO-coordinated response activities"*. Concerns have rightly been raised that this could be read as a means of getting to a similar practical outcome where Member States consider themselves bound to do what they can to implement WHO advisories and recommendations. This may be particularly the case for those countries which rely materially on WHO support, and World Bank or IMF funding, for their domestic healthcare activities.

B. An egregious proposal which would have erased reference to the primacy of "dignity, human rights and fundamental freedoms" has been dropped. This proposal marked a particularly low watermark, and should never have been suggested.

The original draft of the IHR amendments had proposed to delete from Article 3.1 of the IHRs the words "*The implementation of these Regulations shall be with full respect for the dignity, human rights and fundamental freedoms of persons"* and to replace them with "*The implementation of these Regulations shall be based on the principles of equity, inclusivity, coherence and in accordance with their common but differentiated responsibilities of the States Parties"*.

This was an egregious change which would have cut across seven decades of international human rights norms and jurisprudence. The new interim draft now reads:

"*1. The implementation of these Regulations shall be with full respect for the dignity, human rights and fundamental freedoms of persons, and shall promote equity and solidarity among States Parties."*

The additional recognition of equity and solidarity between nation states seems inoffensive, and unsurprising given what we understand to have been the equity-focussed nature of much of the recent negotiations.

C. Proposals to construct a global censorship and 'information control' operation led by the WHO have been scaled back.

The original draft IHRs text had proposed, in an extensively amended Article 44 and expanded Annex 1, to mandate that Member States collaborate with each other, and with the WHO, and that the WHO itself "*at the Global level … strengthen capacities to … counter misinformation and disinformation"*. The latter requirement in particular

provoked controversy because it suggested that the WHO would develop its own information control and censorship operations distinct from the domestic activities of Member State governments and agencies, 'at a global level'.

Those already concerned by the extent of the State-sponsored censorship and information control revealed to have taken place during the Covid pandemic had regarded the implication of any supra-national (and unelected, democratically unaccountable) authority acquiring the means and the legal standing to control lawful scientific and public debate at a national or global level as a profound threat to free speech, national autonomy and democracy, and human rights. This was particularly worrying when read alongside the proposed amendment to Article 3 of the IHRs explained in the previous section.

Those proposals have been scaled back significantly in the interim draft IHRs text, and in particular the ambition to anoint the WHO as a global centralised censorship authority appear to have been dropped. Amendments aimed at strengthening each Member State's "*risk communications"* operations remain by way of updates to Annex 1, which oblige Member States to develop, strengthen and maintain their capacity to counter "misinformation and disinformation".

The Pandemic Agreement too contains obligations for Member States to promote evidence-based information, promote trust in public health and cooperate with each other to prevent mis and disinformation. These commitments seem ironic when viewed against the chronic lack of transparency which has plagued the negotiation process, and the concomitant deterioration of public trust in the process and in the WHO.

D. Provisions that would have allowed the WHO to intervene on the basis of a mere 'potential' health emergency have been dropped: a pandemic must now either be happening or likely to happen, but with the safeguard that to activate its IHR powers the WHO must be able to demonstrate that a series of qualitative tests have been met <u>and</u> that rapid coordinated international action is necessary.

Original proposals to modify Article 12 of the IHRs appeared to contemplate the Director General of the WHO being able to declare a public health emergency in circumstances where a perceived health threat is, in his opinion, either "actual" or merely "potential".

The legal implication of that change, when read alongside other proposals to expand the scope of the IHRs and to give the WHO binding powers of direction over Member

States (new Article 13A.1, described above), were of great concern. The proposal prompted legitimate commentary about the risk of the WHO pre-emptively identifying and declaring 'potential' emergencies in order to engage its more extensive powers, and access to Member State resources, under the modified terms of the IHRs.

In the interim draft, however, those modifications to Article 12 no longer appear and, as noted in the sections above, other relevant proposals including the central proposal to grant the WHO powers of direction, have also been deleted. Instead, the Working Group has modified the legal trigger for the Director General to declare a public health emergency so that it would now explicitly include a "*pandemic"* and a "*pandemic emergency"*, both of which are in effect subset concepts of the existing definition of a public health emergency of international concern (PHEIC).

A pandemic emergency is defined as an infectious health emergency which is already, *or is likely to be*, spreading within multiple Member States, and must additionally be *likely to* overwhelm health systems, and *likely to* cause social, economic or political disruption in Member States. Thus it <u>does</u> involve a pre-emptive element (i.e. a potential rather than actual emergency), but crucially, and contrary to concerns that a small number of commentators have voiced, it is not an unfettered discretionary trigger or a hair trigger.

Specifically, to establish that a pandemic emergency is occurring, the definitional provisions as now drafted would require the Director General to establish that a "*rapid, equitable and enhanced coordinate international"* response is "*required"* (importantly not: 'is likely to be required') to an "*extraordinary event"* which constitutes "*a public health risk … through the international spread of disease"*.

In other words, if he abides by the terms of the IHR, the Director General will need to be able to evidence that an extraordinary international infectious public health risk has emerged in sufficiently clear terms that it already "*requires"* a rapid and coordinated international response. Moreover, he will need to demonstrate not only that the risk is or is likely to be spreading but also that it is likely to exceed the capacity of affected national health systems <u>and</u> cause social, economic and/or political disruption.

These function as cumulative tests rather than independent tests; so – as currently drafted – it should not legally be possible for the Director General to declare a pandemic emergency on the basis simply that, for example, health system capacity in some Member States can be stretched close to capacity in flu season.

While many commentators oppose as a matter of principle the notion that the authority to declare a public health emergency, including a 'pandemic' or a 'pandemic emergency', rests with the Director General of the WHO, concentrating decision-making powers in the hands of a single unelected and largely unaccountable individual, we have to recognise that this has been the case since 2005 and was not realistically a point on the table for negotiation during this current process. It is though yet another reason to support a wholesale review of the architecture and the balance of power and control across global, national and local public health bodies.

E. A dampening of the expansionist ambitions of the WHO: provisions which had proposed to expand the scope of the IHRs to include "all risks with a potential to impact public health" (e.g. climate change, food supply) have been deleted.

The original IHR amendments had, via Article 2, proposed to expand the scope of application of the IHRs so that they would apply to "*all risks with a potential to impact public health"*. This would have been a significant amendment which, allied with the proposal to give the WHO power to issue binding directions to Member States, many feared was intended to enable the WHO to expand its spheres of control and influence firmly into areas such as climate change and food supply management.

In the interim draft, Article 2 is left essentially unchanged from its original form – the proposal seemingly rejected – save for the addition of an unsurprising reference to the purpose of the regulations including preparation for future pandemics.

The Pandemic Agreement nevertheless continues to advocate for the 'One Health' approach, discussed above.

F. Bold plans for the WHO to police compliance with all aspects of the regulations have been scaled back.

Whereas the original IHR amendment proposals had contemplated an Implementation Committee and a separate Compliance Committee being formed to oversee implementation and ongoing compliance with the amended instrument, in the new interim draft Article 54 bis envisages a Member State-led 'IHR Implementation and Compliance Committee' to facilitate and oversee implementation and compliance. Notably, and perhaps with a nod to earlier intense criticism of the potential impact of the original proposals on national sovereignty, that committee will be expressly directed by the IHRs to be "*facilitative in nature"* and to be "*transparent, non-adversarial and non-*

punitive". In other words, it can seek to persuade but shall have no sticks – an advisory rather than a directive body.

Nonetheless, in the interim draft IHRs text a new Article 4.1.bis expressly requires Member States to establish national-level authorities with responsibility for implementing the updated IHRs within their respective countries – i.e. a compliance framework is still envisaged, albeit the new text reflects a scaling back from the original proposals.

G. Many other provisions have been diluted, including provisions which would have encouraged and favoured digital health passports; and provisions requiring forced technology transfers and diversion of national resources.

A swathe of legacy IHR provisions relating to, among other matters, border control measures of questionable efficacy deployed during the Covid pandemic remain untouched in the interim draft (Articles 18 and 23), including quarantines, isolations, testing and requirements for vaccination, but a proposal originally to have been inserted as a new Article 23(6), which controversially would have created a presumption in favour of mandating digital health passports, has been dropped.

Unsurprisingly, it appears that provisions which could have forced transfers and licensing of drug and other medical technology IP rights have been removed from the interim draft, presumably under pressure from global pharmaceutical groups. The Pandemic Agreement contains soft provisions intended to prompt relevant Member States to encourage pharmaceutical groups within their influence to be helpful and benevolent with their patents, particularly for the benefit of developing countries, but these are now couched as barely-enforceable commitments to discuss.

IN CONCLUSION

The unexpected extent of the scaling back in the long-overdue April 2024 draft IHRs text was unquestionably a positive development for those who had been concerned by the overreach of the original proposals.

It is nevertheless also now apparent from the late-April updated draft of the Pandemic Agreement that deletions from the draft IHRs text have, in some respects, been compensated for by new additions to that Pandemic Agreement. Whereas the IHRs had drawn a majority of the dissenting criticisms up to this point, the two texts are now perhaps of equal significance for issues of sovereignty, human rights and free speech.

Broader concerns persist, and in particular as to the globalist and pharma-centric mission of the WHO, its private interest funding relationships, and many related conflicts of interest and risks of bias and corporate influence. These issues alone call into question whether countries such as the UK should be – perhaps hastily – committing to ever greater integration with this multilateral organisation, let alone binding itself to a globalised interventionist public health regime, the effectiveness of the core strategies of which are being examined by an ongoing public inquiry in the UK.

Even a cursory review of the conduct of and public reaction to these post-pandemic negotiations exposes the damage done by the WHO, and particularly its Director General, to trust and confidence. It has been characterised by a lack of transparency, a seemingly duplicitous and defensive communications strategy, and a determination to silence and smear critics rather than engage.

In light of that, and the well-documented mis-steps and overreach of the WHO since 2020, critical thinkers must now question whether the Pandemic Treaty and IHRs remain an appropriate framework, and whether the WHO in its current form, with its current funding arrangements, remains an appropriate organisation to play a central, or indeed any, role in the management of future pandemics.

7 May 2024