July 2026

Geneva Telegram

Multilateral Dialogue Geneva

KONRAD ADENAUER STIFTUNG

PABS Annex to the WHO Pandemic Agreement: IGWG7 brings competing System Models on the Table

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On 22 May 2026, the Seventy-ninth World Health Assembly (WHA) decided to extend the negotiations on the PABS[1] Annex to the WHO Pandemic Agreement by one year. The decision followed a long series of intensive negotiating rounds in which persistent disagreements over central elements of the system had allowed only cautious progress. The Intergovernmental Working Group (IGWG) tasked with developing the PABS Annex now has until the Eightieth World Health Assembly in May 2027 to bridge the remaining differences and bring the Annex to a conclusion acceptable to all parties.

The seventh formal session of the IGWG, held in Geneva from 6 to 17 July, marked the beginning of this extended phase of negotiations. Discussions were based on an overview of the current state of discussions[2] previously presented by the World Health Organization (WHO), which also consolidated the outcomes of the hybrid informal consultations held from 22 to 26 June and on 29 June and 3 July. In addition, two concrete proposals were on the table for structuring access to pathogen materials and sequence information and the associated sharing of benefits: a so-called Federated Model submitted by the Africa Group and a Hybrid Model proposed by the European Union. Both envisage a WHO-coordinated laboratory network, the inclusion of existing recognized sequence databases and legally binding PABS contracts. They differ fundamentally, however, in how existing and newly generated sequence information would be integrated into the PABS architecture, where pathogen materials and data should be held, under what conditions they may be shared, and at what point benefit-sharing obligations should arise. Although the IGWG did not agree on either model during its seventh session, the presentation of the two proposals marked an important step towards more concrete negotiating texts and created a basis for further operational convergence.

One more year – and a more precise mandate

On 22 May 2026, the WHA agreed to extend the negotiations on the PABS Annex to the WHO Pandemic Agreement by a further year. Should agreement be reached sooner, a special session of the World Health Assembly could be convened as early as the end of 2026. Given the questions that remain unresolved regarding the access architecture, contractual obligations, data governance and benefit-sharing – in other words the core parameters of the PABS System – this scenario is regarded as unlikely in negotiating circles.

It is worth noting that the decision adopted by the Seventy-ninth WHA[3] expressly extends the IGWG's mandate to the development of "legally binding contracts to be negotiated and signed with WHO". The

[1] PABS stands for Pathogen Access and Benefit-Sharing. Access and Benefit-Sharing (ABS) refer to the principle that access to genetic resources, and associated data is granted only under pre-agreed conditions, and that the benefits arising from their use are shared in a fair and equitable manner with the providers.

[2] The following links leads you to the overview: IGWG Informal informals

[3] You can find the decision through the following link: Report of the meeting

question of legal enforceability remains one of the central points of contention. The debate concerns whether fully developed standard contracts should form an integral part of the Annex, or whether the Annex should establish only binding minimum requirements, on the basis of which WHO would subsequently negotiate individual agreements with manufacturers. As early as December 2025, more than 80 states, particularly members of the Africa Group and the Group for Equity[4], had submitted concrete draft standard contracts designed to link access to pathogens from the outset to enforceable benefit-sharing obligations. The EU and other industrialized countries cautioned against blanket contractual requirements that would apply in full from the earliest stages of research, irrespective of the type of user, the purpose of access or any subsequent commercial use. They argued that an overly rigid system could slow research and development, place disproportionate burdens on smaller companies, and encourage both commercial and scientific actors to circumvent the multilateral system.

The explicit inclusion of contract development as a required outcome of the IGWG's extended mandate limits the scope for basing benefit-sharing on voluntary commitments or on benefits to be negotiated only at a later stage. Unsurprisingly, the substantive content and legal form of these contracts therefore remain unresolved points of contention beyond the IGWG's seventh session.

One system, two models

The presentation of two models was among the most significant developments of the meeting. Both seek to translate the objectives enshrined in Article 12 of the WHO Pandemic Agreement into a functioning system[5]. The Article requires the rapid sharing of pathogen materials and sequence information and the rapid, fair and equitable sharing of the benefits arising from their use to take place "on an equal footing". The system is also intended to ensure traceability regarding the origin, transfer and use of pathogen materials and sequence information, without relinquishing open data access or the speed required for research and development.

The two models take different approaches to implementing these requirements in practice. The Africa Group's Federated Model is based on the principle that provider countries should retain control over pathogen materials and raw data[6]. Access would be channelled through a WHO-coordinated network of decentralized national and regional institutions, without requiring data to be transferred to a central repository. The European Union's Hybrid Model, by contrast, starts from the coexistence of existing laboratories, databases and access pathways and seeks to integrate them into a common architecture through shared rules and differentiated access options. The difference lies in how the two models seek to balance control over access with ease of participation. The Federated Model prioritizes state control and the early imposition of legally binding obligations on users, whereas the Hybrid Model emphasizes compatibility with existing structures, flexibility and the broadest possible participation.

Common ground between the two models

Despite their different approaches to governance, the Africa Group's Federated Model and the EU's Hybrid Model share a similar institutional structure. Both seek to bring the sharing of physical pathogen samples and genetic sequence information within a WHO-coordinated system. Access should remain rapid, while also being legally linked to fair benefit-sharing. The benefits envisaged include financial contributions, the provision of vaccines, therapeutics and diagnostics, as well as measures such as research partnerships and capacity-building.

For physical pathogen materials, both proposals envisage a WHO Coordinated Laboratory Network (WCLN). The WCLN would consist of existing national laboratories, reference laboratories and specialized international institutions. WHO would establish common terms of participation and define the respective roles of participating laboratories, recog-

[4] The Group for Equity is a cross-regional grouping, composed primarily of developing countries and emerging economies, that advocates for equity to be more firmly embedded in the negotiations on the WHO Pandemic Agreement. It comprises 33 WHO Member States, including Bangladesh, Brazil, China, India, Indonesia, Colombia, Malaysia, Mexico, Pakistan, South Africa and Thailand.

[5] The Pandemic Agreement can be accessed at the following link: https://apps.who.int/gb/ebwha/pdf_files/WHA78/A78_R1-en.pdf

[6] In this context, "provider countries" refers to countries that contribute pathogen materials or related sequence information to the PABS System through their competent institutions.

nize eligible institutions and coordinate their cooperation. A national laboratory might, for example, analyse a novel virus sample and, where necessary, transfer it to a specialized reference laboratory. Before such a transfer could take place, a legally binding agreement would be required. This agreement would regulate, among other matters, the intended use of the material, biosafety requirements, permissible onward transfers and the identification of the sample.

Both models assume that the WCLN would include national laboratories as well as reference laboratories. These databases would be required to meet common standards on metadata, provenance, transparency and onward sharing. Users would accept legally binding terms, for example through electronic data access agreements. The two models differ, however, over whether access should be open or registration-based and whether raw data should be downloadable. Their shared starting point is nevertheless a landscape of WHO-recognized databases subject to certain binding minimum standards.
Both models also provide for the use of unique persistent identifiers[7]. A pathogen sample would receive a unique identifier that would remain linked to any sequence information generated from it. This would make it possible to trace the country and laboratory of origin and to follow how the material or data were subsequently shared. The identifier would not in itself create a legal obligation. Its purpose would be to provide the technical basis for linking later scientific or commercial use to the relevant PABS rules.

Finally, both models envisage legally binding PABS contracts with WHO, particularly for manufacturers of medical countermeasures. These contracts would specify monetary and non-monetary obligations.

If the elements on which the two models overlap were translated into an operational process, the PABS System would broadly function as follows. A country identifies a pathogen with pandemic potential. The responsible laboratory shares the sample through the WCLN and the corresponding sequence information through a recognized database. Both the material and the data receive unique identifiers. Users accept binding access conditions, while manufacturers enter into PABS contracts with WHO. WHO coordinates the system, records the relevant transactions and administers the resulting benefit-sharing obligations. The two models begin to diverge over how tightly access should be controlled and at what stage contractual obligations should take effect.

Trust is good, control is better: The Federated Model

The Federated Model[8] proposed by the Africa Group is based on the premise that equitable benefit-sharing requires reliable control over access. Once raw data have been made freely available, provider countries lose a substantial degree of influence over how those data are subsequently used. Unlike the Hybrid Model, the Federated Model therefore treats controlled access not as one option among several, but as the organizing principle of the system as a whole. Its aim is to enable rapid international access without requiring providers to relinquish full control over their samples and raw data.

Provider countries would determine where their samples and sequence information are held. These could be stored by national or regional institutions, as well as by recognized international platforms. WHO would operate a central access service that catalogues available resources, verifies users' eligibility, routes requests and records their use. WHO itself, however, would hold neither the samples nor the raw data.

As a general rule, sequence information would not be made available as freely downloadable raw data. Instead, a manufacturer or research institution would submit a query or analytical procedure to the institution holding the data, which would perform the computation locally. The user would receive only the resulting outputs, such as sequence comparisons, phylogenetic analyses, variant identification or model-based calculations. Even during a health emergency, the raw data would remain with the institution responsible for holding them. The model thus follows the principle that the analysis should move to the data, rather than the data to the user.

[7] Persistent identifiers are permanently assigned, unique identifiers that make it possible to reliably identify and track datasets or other digital objects, even if their storage location or technical environment changes. The ISBN of a book is an example of this.

[8] *Health Policy Watch* has shared a draft of the model: The Federated Model

Under the Federated Model, all users would be required to register and accept a data access agreement. Manufacturers would additionally be required to conclude a PABS contract with WHO. A standardized material transfer agreement would be required before any physical sample could be shipped. Each sample would be assigned a unique persistent identifier, which would remain linked to any sequence information subsequently generated from it. This would make it possible to trace the sample from its initial collection, through its scientific use, to any eventual product development.

The model reflects key demands advanced by the Africa Group and the Group for Equity. Both groups argue that benefit-sharing obligations should arise at the point of access to pathogen materials or sequence information and that manufacturers should therefore enter into a standardized, legally binding PABS contract with WHO at that stage. The model also provides for mandatory user registration and binding data access agreements. Benefit-sharing would include both monetary and non-monetary contributions, with financial payments extending beyond the costs of operating the system itself. Additional measures would include non-exclusive licences, technology transfer and support for expanding laboratory and manufacturing capacity in developing countries. During a health emergency, manufacturers would also be required to make a defined share of their vaccines, therapeutics or diagnostics available through WHO.

The practical challenge of the Federated Model may lie in its implementation at the global level. Federated data analysis is familiar from the field of sensitive human genomic data, but the current infrastructure for pathogen sequences is based predominantly on openly accessible datasets that can be combined freely. A federated system would require robust computing infrastructure across all participating institutions, common technical standards, interoperable identifiers, and reliable procedures for authentication and access control. Institutions in countries with limited digital and financial capacity might require substantial support to meet these requirements. It would also be necessary to ensure that analyses can be performed quickly, that results can be independently verified, and that research involving multiple datasets remains reproducible. Without long-term financing and binding technical standards, the system could create new bottlenecks and dependencies.

One objection to an architecture centred strongly on the origin of samples and sequence information is that the value of a medical countermeasure can rarely be attributed to any single sample or sequence[9]. Research and product development typically draw on a large number of data points generated at different times and in different institutional settings. An early sequence may provide the starting point for further investigation, but it is generally insufficient on its own to support the development of a reliable diagnostic test, vaccine or therapeutic. Only comparisons with additional samples can show which characteristics of a pathogen remain stable, how it changes and whether a medical product will perform reliably under different epidemiological conditions. Older sequences, reference data and existing platform technologies also contribute to this process. The origin of the first available material therefore remains relevant, but does not automatically establish an exclusive claim to the value of the eventual product. The contribution of a provider country forms part of a broader research process whose individual scientific and economic inputs are difficult to separate[10].

The EU Hybrid Model

Unlike the Federated Model, the Hybrid Model[11] does not prescribe a single access procedure for all pathogen materials, sequence information and users. Instead, it allows several access pathways to operate in parallel, with provider countries retaining discretion over how tightly access is controlled and at what stage a user must conclude a PABS contract with WHO. Controlled access is treated as one possible form of participation rather than as the organizing principle of the system as a whole.

The model rests on the assumption that the PABS System can be effective only if research institutions, databases and companies actually use it. High barriers to access could encourage users to turn instead to openly accessible platforms outside the system. The EU therefore proposes differentiated obligations and a degree of choice for provider countries.

[9] Lawrence Kerr writes about this: https://ldkerr1964.substack.com/p/beyond-the-first-sequence-why-pathogen
[10] According to Kerr.
[11] *Health Policy Watch* has shared a draft of the model: The Hybrid Model

The legal requirements applicable in a given case would depend on the type of user, the purpose of access and the stage at which the material or data are being used.

For physical materials, the model provides for three access pathways with different levels of contractual obligation. Under the first, a provider country could release a sample on the basis of a binding shipping or material transfer agreement. This would regulate matters such as the intended use, biosafety requirements, permissible onward transfers and the identification of the material. A full PABS contract would not yet be required. A second option would make access conditional on a binding commitment by the user to conclude such a contract with WHO at a later stage. The strictest option would require the PABS contract to be in place before the material is released.

The Hybrid Model likewise allows different forms of access to sequence information. Open databases could continue to operate alongside platforms requiring registration or imposing tighter access controls. Users would accept electronic access terms governing metadata, unique persistent identifiers and onward sharing. There would be no general registration requirement, although individual countries or databases could impose one. In this way, the model would bring existing scientific infrastructures into the PABS System without subjecting every database and platform to identical access conditions.

The Hybrid Model is specifically designed as a non-exclusive system. National access and benefit-sharing rules, bilateral agreements, and procedures based on *Prior Informed Consent* and *Mutually Agreed Terms* could continue to operate alongside the WHO-coordinated architecture. Provider countries could therefore share pathogen materials and sequence information outside the WLCN or through databases not recognized by WHO. The WHO architecture would provide an additional multilateral access pathway rather than replacing existing national and bilateral arrangements.

The main advantage of the model lies in its adaptability. It could make participation easier for research institutions and companies that are unwilling to assume the full obligations of a PABS contract before every use. From the perspective of many developing countries, however, this flexibility is also its central weakness. Different access pathways may entail obligations of different scope. Where users can choose between open databases, restricted-access platforms and external bilateral arrangements, they may be drawn to the option carrying the least demanding legal requirements. Some countries of the Global South hence argue that the model does not ensure that access to pathogen materials and sequence information is immediately and legally tied to benefit-sharing.

The remaining scope for compromise?

The two models reflect different political priorities and essentially different views of how much trust a multilateral system can be expected to depend on and how firmly access must be secured through legal obligations. For many developing countries, this question is shaped by the experience of the COVID-19 pandemic. While the rapid sharing of pathogen data was treated as an immediate prerequisite for global research and response, subsequent access to vaccines and other medical countermeasures remained heavily dependent on manufacturing capacity, supply contracts and the distributional power of individual states and companies. This created an asymmetry between the early expectation to share pathogens and the less reliably secured sharing of resulting benefits. The conflict over the PABS System is therefore also a conflict over whether another advance of trust should be granted, or whether reciprocity must be legally guaranteed from the outset. This divide cannot be bridged simply by combining selected elements of the two approaches. The limits of the current scope for compromise became apparent when the WHO Secretariat attempted to bring both proposals together in a single model. According to sources close to the negotiations, the resulting proposal failed to secure sufficient support either among proponents of the Federated Model or among supporters of the Hybrid approach[12].

The IGWG will reconvene for its eighth session from 14 to 18 September, providing a further opportunity to move towards a common compromise.

[12] This was reported by the Third World Network: WHO: Working group considers conceptual design of PABS system

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