Consumers' Association of Penang

Memorandum

On

A Review of The WHO Amendments to the International Health Regulations (2005) and the New Pandemic Agreement: Its impact on Malaysia as a sovereign nation and its ability to determine health policy

To

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I Introduction

The World Health Organisation (WHO) is currently working on two international legal instruments which will expand its powers to declare pandemics and authorise the manner in which governments shall respond to them. These two international agreements are:

- Amendments to the International Health Regulations 2005 (IHR 2005); and
- The WHO Pandemic Agreement*

Both these international agreements will be voted on when the World Health Assembly (WHA) meets in May 2024. Amendments to the IHR (2005) are adopted by a simple majority vote by the 194 member nations in the WHA with no further ratification required by Malaysia's parliament. The Treaty requires a two-third majority to be adopted after which it has to be ratified by Parliament.

These two international agreements will have far reaching consequences for the sovereignty of nations (including Malaysia) and their ability to conduct themselves as independent self-governing states in international affairs. According to legal experts the agreements threaten to fundamentally reshape the relationship between the WHO, national governments and citizens.

They place the WHO as having rights overriding that of individuals erasing the basic principles regarding human rights and the sovereignty of states. In so doing they signal a return to a colonialist and feudalistic approach which is antithetical to democratic values.

Despite their national significance, the proposed documents have not garnered attention or interest in the mainstream media neither have they drawn the notice of Parliament.

This memorandum seeks to highlight the most important IHR amendments and proposals in the 'Pandemic Treaty' which will pose a threat to the health and sovereignty of nations. The focus on pandemics as the major thrust in global health policy denies the health needs and priorities of nations in the Global South.

More importantly, crafting a legal framework that will enable the WHO to have unfettered control usurps the rights and responsibilities of Member States to determine their national health policies and public health responses which should be based on a country's own values, needs and priorities.

Up until now, the WHO has been authorised to issue recommendations to Member States but the proposed amendments to the IHR (2005) and the new 'Pandemic Treaty' which is presently being negotiated would empower the WHO to issue legally-binding instructions which would affect individual states and their citizens, regions and or globally.

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* On 30 October, 2023, the Intergovernmental Negotiating Body (INB) published the latest 'Proposal for Negotiating Text of the WHO Pandemic Agreement'. This draft text is to be considered by the Seventh meeting of the INB for conversion into a formal negotiating text. The Seventh meeting of the INB is to be held at WHO, Geneva from 6 to 10 November, 2023.

If adopted they would 'hardwire into international law a top-down supranational approach to public health' particularly in relation to public health emergencies of international concern including pandemic preparedness and pandemic response policies. The proposals also broaden the scope of emergencies to include potential rather than actual harm.

In effect all decision making will be placed in the hands of the WHO (and the Director General) which is an unaccountable, and unelected body that will have sweeping, unfettered powers to control, direct and interfere in the affairs of its Member States and to override fundamental rights of its citizens.

To complement the IHR amendments and the Treaty process, an international bureaucracy is being built with a funding target of up to USD31 billion per year, including USD10 billion in new funding. (Note that the entire WHO annual budget is around USD3.6 billion). David Bell has noted that: 'This is essentially creating a self-perpetuating pandemic industry, with major internal conflicts of interest, funded by the world's taxpayers but being under a UN Agency having no national legal oversight and little accountability'. David Bell, a former medical officer, and scientist at the WHO now works as a public health physician and consultant in global health.

Its justification for continued funding will rely on declaring and responding to perceived threats, restricting the lives of others whilst accruing profits to its sponsors through pharmaceutical recommendations and mandates'. As Ramesh Thakur, former UN Assistant Secretary General noted, 'the international bureaucracy's defining purpose, existence, powers, and budgets will depend on outbreaks of pandemics, the more the better'.

II. Summary of main proposals of the two international instruments

Some of the main proposals in the draft of the two international agreements are summarised below:

- The IHR amendments provide a legal framework for exclusive centralised power over global public health policy in times of actual and potential crisis. This power would be exercised by a few powerful WHO donors that will exert control over the WHO.

- Change the recommendations of the IHR 2005 from "nonbinding" to mandatory instructions that nation states undertake to follow and implement. This changes the WHO from an advisory body that makes recommendations to nations to a governing body whose 'advice' would be legally binding.

- Solidify the Director General's ability to independently declare public health emergencies.

- Expand the definition of pandemics and health emergencies including the introduction of the term "potential for harm" rather than "actual harm".

- Give WHO control over certain country resources, including requirements for financial contributions and provision of intellectual property and know-how (within the broad definition of health products).

- Enable the WHO to share country data without consent.

- Establish systematic global collaboration to counter dissent from positions held by governments and the WHO, thereby promoting power over information. Member States will be obliged to impose online censorship in the event of future crises under the guise of 'tackling misinformation'.

- Powerful Member States and private stakeholders could further use the revised IHR (2005) to legitimise health colonialism and pressure low-income countries into compliance.

- WHO Member States to set up an extensive surveillance system with global digital health certificates, locator forms, global digital vaccine passport system to ensure mass compliance with centralised directives which the WHO will verify regularly through a country review mechanism.

- Change existing IHR provisions affecting individuals from nonbinding to binding including border closures, travel restrictions, confinement (quarantine), medical examinations and medications of individuals. The latter would include requirements for injection with vaccines or other pharmaceuticals. The WHO will have the authority to mandate medical examinations, proof of prophylaxis, proof of vaccine and to implement contact tracing quarantine and what treatment any individual shall have.

- A number of the amendments if approved would hand power to the WHO over the identification, production and allocation of health products under specific circumstances turning it into a cartel. Under the proposals, the WHO could tell State Parties to increase the production of a certain pharmaceutical thus boosting the profits of the manufacturer and shareholders for the WHO to then distribute as it sees fit, building up a patronage system over recipients.

- The draft Treaty supports gain-of-function research despite its extreme biosafety hazards. Gain-of-function research (GoF research) is medical research that genetically alters an organism in a way that may enhance the biological functions of gene products. This may include an altered pathogenesis, transmissibility, or host range, i.e., the types of hosts that a microorganism can infect. Simply, it refers to genetically altering microbes like viruses and bacteria to increase their ability to be harmful and to be passed on to a human or animal or a microbe to another. Currently, there are almost no national or international laws to control or ban gain of function research.

- Emphasis on a 'One Health' agenda will expand the scope of the Treaty. 'One Health' encompasses a wide range of aspects of life and the biosphere that can impact health and have the 'potential' to spread harm across borders. So public health can be deemed to include climate change, biodiversity loss, urbanisation, food production, and international travel.

Both draft instruments are currently passing through the usual WHO process of open and closed committee meetings and internal and external reviews after submission of proposals by various states. The IHR (2005) amendments process is under the Working Group on Amendments to the International Health Regulations (2005) – (WGIHR) while the Pandemic Agreement is under the International Governmental Negotiating Body (INB).

Scholars have noted that both processes appear rushed and that negotiating a new multilateral treaty in less than three years is highly unusual. Negotiation of multilateral treaties usually takes years and their ratification and entry into force even longer. The revision process of the IHR (2005) took ten years from 1995 to 2005, while the negotiation of the only treaty adopted under Article 19 of the WHOC (WHO Constitution), the *Framework Convention on Tobacco Control* took eight years and another three years to enter into force.

In the case of the IHR (2005) amendments, Member States were given only four months to table amendments to the IHR (2005). This short time frame was also brought up by the International Health Regulations Review Committee (see Part V) which was given less than 100 days to complete their report, posing limitations to their mandate (page 15).

Both the Pandemic Agreement and the IHR (2005) amendments complement each other. The IHR (2005) amendments focus on the specific powers and processes sought by the WHO and its sponsors. The Pandemic Agreement concentrates largely on the governance and funding to support these. While both the texts need to be assessed together, in many respects it is the IHR (2005) amendments which contain the more concerning proposals from the perspective of national sovereignty and individual human rights.

These two documents need to be considered in the context of an evolving and increasingly privatised funding structure for the WHO, which is influencing the ethos and purpose of that organisation. The pandemic agenda must also be seen in the context of the unprecedented profits and wealth transfers, and the suspension of basic human rights that the COVID-19 public health response promoted.

For a better understanding of the current developments regarding the proposed amendments to the IHR (2005), the new 'pandemic Treaty', the role of WHO in international health policy, some background and context is essential.

III. The Transformation of the WHO

The WHO was set up in 1948 as a specialised health agency of the United Nations system to promote 'the attainment by all peoples of the highest possible level of health … one of the fundamental rights of every human being' whereby health was understood as 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity', and that 'governments have a responsibility for the health of their peoples'.

This was enshrined in the WHO constitution (WHOC) in line with the Charter of the United Nations. The WHOC 'was premised on the concept that all peoples were equal and born with basic inviolable rights'.

Global health meant that economic and social development are fundamental determinants of health. It advocated community control, informed-consent and the centrality of patient-centred care. These guiding principles defined the work of the WHO which emphasised the supremacy of individual, and community rights and well-being.

In the aftermath of the post war experience and the emerging struggles of colonised societies to assert their independence and freedom from the yoke of tyranny and oppression, these values and aspirations became even more relevant and important. They found expression and

reaffirmation in the WHO-UNICEF Declaration of Alma Ata in 1978, which emphasised the primacy of community participation and health systems strengthening.

The Alma Ata Declaration was a major milestone of the twentieth century in the field of public-health which identified primary health care as key to the attainment of the goal of Health for All (HFA). This was a manifesto to improve health in the developing world by the year 2000, by raising living standards through clean water, improved sanitation and nutrition – the fundamental contributory elements to good health and well-being.

In the primary health care framework, immunisation against the major infectious diseases was but one of the tools in the box alongside the other determinants of health which include education, food supply, maternal and child health care, prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries and provision of essential drugs.

In the early 80s, WHO HFA reports consistently noted how disease in developing countries was closely related to economic and social conditions notably malnutrition and unsafe water. When vaccination is mentioned, it is as '*a tool*' rather than '*the tool*' for tackling disease.

i. Corporate Funding and Public-Private-Partnerships

However, the emphasis and direction of WHO has changed over the past few decades especially in terms of funding namely:

- A large proportion of WHO's funding comes from private and corporate sources including the drug industry like Glaxo SmithKline and Novartis. In 2018 alone the WHO took over USD70 million from BigPharma. This was not the case initially as its core funding was provided by countries based on GDP.

- Most funding is now focused on specified uses, that is, it is given to the WHO for specific projects in designated areas rather than being used at the WHO's discretion to address the greatest disease burdens. Thus, WHO's priorities have changed moving from community centred care to a more vertical commodity based approach particularly vaccines that generate profits for its private and corporate funders.

In place of the preventive and 'holistic' approach to health initially championed by the WHO, which viewed health as the outcome of a wide range of economic, social and political factors, 'a new paradigm has gradually emerged: a commercialised approach to health, single-mindedly focused on high-tech largely vaccine-based solutions, with a particular interest for genetically engineered biotechnologies – an emerging industry potentially worth billions of dollars' writes Thomas Fazi, columnist and author.

The past two decades have seen an expansion and flourishing of the 'global health industry' with various organisations through the rise of public-private partnerships (PPPs). Notable among them are the GAVI (Global Alliance for Vaccines) which focuses solely on vaccines and the CEPI (Coalition for Epidemic Preparedness) an organisation set up at the World Economic Forum meeting in 2017 specifically to manage pandemics by the Bill and Melinda Gates Foundation (BMGF or Gates Foundation), Wellcome Trust, and the governments of Norway and India. To date, CEPI has secured financial support from some 34 countries including Malaysia.

GAVI and CEPI, along with others like Unitaid and the Global Fund include corporate and private interests directly on their boards which have a narrow health focus that reflects the priorities of private sponsors. They influence the WHO through direct funding and through funding within the WHO Member States.

On December 9, 2009, Wikileaks released a confidential pharmaceutical industry trade association dossier about the WHO Expert Working Group on R & D Financing. The documents show the influence of Big Pharma on the policy making decisions of the WHO. These confidential documents were obtained by the drug industry i.e. the International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) before their public release to the WHO Member States. The document also illustrates that the WHO Expert Group was highly responsive to industry lobbying.

ii. Bill Gates's Influence on the WHO

The makeover of the WHO in international health policy was largely due to the role played by Bill Gates. As the second largest funder of WHO (he gave USD237.8 million to the WHO in 2018 alone), Gates exercises a massive influence over the organisation. He has used that clout to push vaccine-driven responses in matters of global health, both through the WHO and through related public-private-partnerships like GAVI and CEPI.

In 2011, Gates declared at the World Health Assembly (WHA) that all Member States must make vaccines a central focus of their health systems. He added that countries must pledge to meet vaccine coverage targets of 90 per cent at country level and ensure all children have access to vaccines and to new ones as they become available.

The following year the WHA adopted a 'Global Vaccine Action Plan 2012-2020', that the Gates Foundation co-authored. Now over half of the WHO's total budget goes to vaccines.
The Gates Foundation is heavily invested in the pharmaceutical industry. Gates holds stocks and bonds in companies like Merck, GSK, Eli Lilly, Pfizer, Novartis and Sanofi. The foundation's website even candidly, declares a mission to pursue 'mutually' beneficial opportunities' with vaccine manufacturers.

According to Greenstein and Loffredo, strong evidence suggests that the Gates Foundation acts as a trojan horse for western corporations whose primary goal is an increased bottom line. The links between the Gates Foundation and Big Pharma are well entrenched. For example:

- The former director of vaccine development at the Gates Foundation and current CEO of the Bill and Melinda Gates Medical Research Institute, Penny Heaton hails from Merck and Novartis.

- Gates Foundation president of global health, Trevor Mundel served in leadership positions at both Novartis and Pfizer. His predecessor, Tachi Yamada was previously a top executive at GlaxoSmithKline (GSK).

- Kate James, worked at GSK for almost 10 years, then became the chief communications officer at the Gates Foundation.

As well, the corporate revolving door extends to the offices of the WHO.

- Tedros Adhanom Ghebreyesus the WHO Director-General who recently won a second term as DG uncontested was previously on the board of GAVI and was chair of the Global Fund.

- Sir Jeremy Farrar the newly appointed WHO chief scientist had moved from The Wellcome Trust as a Director. He is a co-founder of CEPI (which plans to make a vaccine in 100 days). Farrar was a central figure in the propaganda campaign to debunk the lab origin of SARS COV-2. He was also central in the Oxford Recovery and Solidarity trials that overdose patients with HCQ (hyroxycloroquine) to prevent it being used for the treatment of COVID-19.

The Gates Foundation also funds WHO indirectly through GAVI. GAVI is the largest non-State funder of the WHO (after the Gates Foundation). In 2018 it gave USD158.5 million to the WHO. The Gates Foundation has given GAVI more than USD4.1 billion since the latter's establishment in the 1990s, which accounts for some 20 percent of GAVI funds. The Gates Foundation also occupies a permanent seat on GAVI's board.

GAVI itself discloses that the Gates Foundation 'plays both a technical and financial role in efforts to shape vaccine markets'.

When GAVI and the Gates Foundation's contributions to WHO are combined, Gates is the unofficial top sponsor of the WHO surpassing the US government. In 2020 to 2021 Gates donated some USD1,183 million with the US trailing at USD693 million. This as observers have noted is 'the essence of philanthrocapitalism, a capitalist, market based for-profit approach to solving the world's biggest and most pressing issues'. This kind of corporate driven approach exemplifies the conflicts of interest inherent in the WHO's dependence on unaccountable private donors like the Gates Foundation.

Because most of both the Gates Foundation's contributions to the WHO are earmarked (voluntary) the WHO does not decide how these funds are spent – the Gates Foundation does. For instance, the WHO programme that receives the most money is its polio eradication programme, as the Gates Foundation earmarks most of its contribution for polio.

According to *Foreign Affairs* 'few policy initiatives or normative standards set by the WHO are announced before they have been casually unofficially vetted by Gates Foundation staff' or as other sources told *Politico* in 2017, 'Gates priorities have become the WHO's'; or as Margaret Chan the then Director General declared in 2014 that because the WHO's budget is highly earmarked, it is 'driven by donor interests'.

Today more than 80 percent of the WHO's funding is by non-State donors linked to corporate and private interests. Only 16 percent of WHO's total budget come from Member States.

Clearly this will result in a severely compromised WHO beholden to special interests in particular BigPharma. Some examples are listed below:

iii. Vaccines the weapon of choice in Global Health Policy

As writer-researcher Paula Jardine has noted, for over the last 50 years, the control and elimination of diseases through drugs and pharmaceutical agents have become the sole and

ultimate goal of global public health policy. Clean water, ending malnutrition, improving food production and supply and education have been all but eclipsed in the pursuit of universal vaccination.

GAVI, the public-private partnership created more than 20 years ago was the vehicle used to reverse the stagnation of the vaccine market shaping it so more new and underused vaccines could be sold to the developing countries. Because vaccines as products are targeted at healthy people, virtually every person on earth becomes a potential customer and even better, a repeat customer. Vaccines represent opportunities for continuous growth and profit unrivalled in the pharmaceutical sector even before COVID-19.

In 2011, just before GAVI implemented its 'Decade of the Vaccine', vaccines accounted for only three percent of all pharmaceutical sales. However, their sales were growing at twice the rate of any pharmaceutical product at ten to 15 percent per annum compared with five to seven percent for other products.

A 2013 survey of industry trends prepared by the WHO predicted that the global market for vaccines would become an engine of growth for the industry, increasing in market value to USD100 billion by 2025. In a single year, the COVID-19 vaccines alone have eclipsed those projections, generating USD150 billion revenue for the financial year 2021-22 according to the World Economic Forum (WEF).

The revenue growth that the survey found did not come from developing countries. It came from persuading **all** countries whether industrialised or developing to target 90 percent coverage rates for all vaccines on their national immunisation schedules. In fact, 82 percent of all sales accrued to the 15 percent of the global population in industrialised countries where living standards are highest and where well-nourished populations have the lowest disease burden. The portion of the world GAVI was meant to be targeting remained a largely untapped market.

In April 2023, WHO, UNICEF, GAVI, the Gates Foundation and other partners launched 'The Big Catch-up' campaign to boost child vaccination worldwide. WHO said the campaign would focus in particular on 20 countries where three-quarters of all children who missed vaccines in 2021 live. They are Afghanistan, Angola, Brazil, Cameroon, Chad, North Korea, the DRC, Ethiopia, India, Indonesia, Nigeria, Pakistan, Philippines, Somalia, Madagascar, Mexico, Mozambique, Myanmar, Tanzania and Vietnam.

The flagship of the Gates-WHO African vaccine programme is the diphtheria tetanus pertussis (DTP) vaccine. This three in one immunisation shot is given to virtually every child in Africa. This particular vaccine is not currently administered in the developed countries.

iv. Dangerous and Deadly Vaccines

As far back as 1977, *The Lancet* reported that the risks of the whole-cell pertussis jab used in the DTP vaccine are greater than the risks associated with contracting wild pertussis (whooping cough). After mounting evidence linking the drug to brain damage, seizures and even death, western countries phased it out in the 1990s and replaced it with a safer version (DTaP) that did not contain the whole pertussis cell.

However, African countries are still being financially incentivised to continue using the out-of-date dangerous DTP vaccine with GAVI making DTP a priority for African children.

A 2017 study funded by the Danish government concluded that more African children were dying at the hands of the DTP vaccine than by the diseases it prevented. The researchers examined data from Guinea Bissau and concluded that boys were dying at almost four times (3.93) the rate of those who had not taken the shot, while girls suffered almost **ten** times (9.98) the death rate.

Yet these staggering numbers have not stopped the Gates Foundation from spending millions annually to push the DTP vaccine on African health care systems.

- *Oral Polio Vaccine*

The Gates Foundation's work on polio eradication is well known globally. Once again the polio drugs the West uses and the drugs given to the developing countries are dramatically different. The Gates Foundation has spent more than USD1 billion distributing an oral polio vaccine (OPV) that uses a live polio virus to African and Asian countries. This live virus was found to replicate in a child's intestine and spread in places with poor sanitation and plumbing. That means people can contract the virus from the vaccine.

According to a 2017 study by the Universities of California San Francisco and Tel Aviv, the polio virus used in the OPV has replicated in at least 24 cases the researchers examined and rapidly regained its strength and started spreading on its own. In recent years, more children have been paralysed by the vaccine strain of the virus in OPV than by wild polio.

By 2020 the industrialised countries had stopped the use of OPV. Yet in the Global South the Gates Foundation uses its instruments of influence to ensure governments continue using it.

Polio outbreaks in both the Philippines and the Congo are the result of the OPV. In 2005, Oxford's *Clinical Infectious Diseases Journal* argued that polio outbreaks in China, Egypt, Haiti and Madagascar were also caused by the OPV, declaring that 'the time is coming when the only cause of polio is likely to be the vaccine used to prevent it'.

A few years later the same journal wrote that the OPV is not only giving kids polio, but also 'seems to be ineffective in stopping polio transmission' to begin with. In 2012 the *BMJ* (*British Medical Journal*) reported 'the most recent mass polio vaccination programmes in India fueled by the Gates Foundation resulted in increased cases (of polio)'.

Doctors in India have revealed that the OPV is also causing outbreaks of another disease called non-polio acute flaccid paralysis (NPAFP). After an epidemic of NPAFP paralysed 490,000 children between 2000 and 2017, the doctors published a report suggesting that 'the increase in NPAFP and the later decrease in such cases was indeed an adverse effect of the WHO's polio immunization programme'.

NPAFP is clinically indistinguishable from polio but twice as deadly'. Keith Van Haren, Child Neurologist at the Stanford School of Medicine explains that, 'it actually looks just like polio, but that term really freaks out the public-health people'.

In 2012, the *BMJ* wryly noted that polio eradication in India 'has been achieved by renaming the disease'.

However, the Gates Foundation and the WHO continue to distribute the OPV in countries including Nigeria, Pakistan, and Afghanistan, where the Gates Foundation says the WHO is now providing unprecedented levels of technical assistance' for polio vaccination campaigns.

In Syria, GAVI pledged USD25 million for polio immunisation in 2016. A year later the WHO reported that 58 children had been paralysed by the vaccine-derived form of the virus.

Despite the scientific consensus against the OPV, and the opposition to such programmes in the target countries, OPV remains administered in Africa, the Middle East, and South Asia as part of 'aid' programmes, creating windfall profits for BigPharma who may not have been able to sell their products elsewhere.

- *Vaccines For Depopulation?*

Back in 1989 the WHO sponsored a symposium at its headquarters in Geneva on 'Antifertility Vaccines and Contraceptive Vaccines'. The meeting presented proposals for vaccines that were later discovered to have been laced with sterilising hormones HCG and oestradiol. HCG prevents pregnancy and triggers spontaneous abortions and miscarriages while oestradiol can turn men infertile.

In 2015, the Kenyan Conference of Catholic Bishops reported its discovery of a polio vaccine laced with oestradiol that was manufactured in India and distributed by the WHO. In 2014, Dr. Wahome Ngare from the Kenyan Catholic Doctors Association uncovered a tetanus vaccine specifically being administered to women distributed by the WHO that contained the HCG hormone.

All of the polio vaccine samples tested contained HCG, oestrogen-related compounds, follicle stimulating and luteinising hormones, which will damage sperm formation in the testes. Even more disturbing, this vaccine was going to be administered to children under five years of age.

This was not the first time the WHO vaccination campaigns did not turn out to be what it seemed. In 2004, the WHO, UNICEF and CDC launched a vaccination campaign to immunise 74 million African children during a polio outbreak. The initiative encountered a serious obstacle. In Nigeria, lab tests on the WHO's vaccine sample discovered the presence of oestrogen and other female hormones. In the mid-1990s a tetanus vaccine being used on Nicaraguan and Pilipino girls and women in their childbearing years was found to contain HCG, which accounted for a large number of spontaneous abortions that were reported by Catholic health workers.

- *Global South used as Guinea Pigs*

The Gates Foundation also funded clinical trials of Human Papillomavirus (HPV) vaccines made by GSK and Merck. In 2014, the *Economic Times of India* published a report of a joint venture between WHO and the Gates Foundation to test an experimental Human Papilloma Virus (HPV) vaccine on some 16,000 tribal girls between the ages of nine and 15. Most of the vaccines were given to girls at *ashram pathshalas* (boarding schools for tribal children), side-

stepping the need to seek parental consent for the shots. The experiment was conducted in 2008 using Merck's Gardasil vaccine. Many of the girls became ill and some died.

The following year, the WHO and the Gates Foundation conducted a similar experiment on 14,000 girls with GSK's HPV vaccine Cervarix. Again, scores of teenage girls were hospitalised. Investigations by India's health officials uncovered gross violations of India's laws regarding medical safety. In numerous cases there was no consent and the children had no idea what they were being vaccinated for. India's parliamentary committee charged that the 'sole aim of the Gates-funded project was to promote 'commercial interests of the HPV vaccine manufacturers who would have reaped windfall profits if the HPV vaccine had been included in the universal immunisation programme of the country'.

v. WHO's poor management of international health emergencies

- *The 2009 A/H1N1 (Swine flu) Pandemic scare and conflicts of interest*

In his account of the pandemic, Soren Ventegodt, medical scientist wrote that on 11 June 2009, the DG of WHO declared that the world faced a deadly influenza pandemic with millions of deaths predicted in the worst disaster in modern times. The world over prepared for what could be like the plague or the Spanish Flu which could claim the lives of 40 million people or so as it happened during the Spanish Flu in 1918-19 following World War 1.

In June and July national borders were suddenly closed, thousands of public places like restaurants and libraries in many countries shuttered and millions of travelers were stopped from entering a number of countries in Asia if they had fever or a common cold. Many countries started to buy influenza vaccines, and anti-influenza drugs spending billions of dollars from health budgets already under tight constraints.

As this was happening, a joint investigation by the *BMJ* and the *Bureau of Investigative Journalism* uncovered evidence that raised troubling questions about how the WHO managed conflicts of interest among the scientists who advised its pandemic planning, and about the transparency of the science underlying its advice to governments.

The health scare turned out to be a false alarm and the Swine Flu epidemic did not cause the many deaths as first expected. WHO had caused international panic and disaster by declaring the mildest flu ever, the A/H1N1 'Swine flu' influenza to be a pandemic threatening the world.

Sometime in July 2008 the WHO had made two changes in its definition of a pandemic when it dropped reference to the phrase 'with enormous numbers of deaths and illness'. The second change was to exclude the requirement for a new sub-type with a simple reassortant virus meaning that many seasonal flu viruses could be classified as pandemic influenza. If the WHO definition had not changed when the 2009 H1NI virus was identified, the swine flu pandemic would never have been declared as it was not a new sub-type, was not causing enormous numbers of deaths and illness and a significant number of people had already been exposed to an immunogenically similar virus.

During 2010, the situation erupted into a medical scandal when it was discovered that ineffective and dangerous medicines worth billions of dollars had to be destroyed. Close and secret links between the WHO and the pharmaceutical industry producing the vaccines were exposed. The Danish newspaper *Information* found that five researchers involved in advising

WHO during the ‘pandemic’ had been paid around seven million euros from the vaccine industry.

It soon became clear that thousands of patients suffered from a wide range of serious adverse effects. The media then reported that the adjuvants used in the vaccines were not safe but no warning had been given by the vaccine companies neither by the governments buying and selling them. It was revealed that the contracts the industry made with the countries included a paragraph that the adverse effects were the buyer’s full responsibility.

The Polish Minister decried the contracts where the drug companies helped by the WHO sold vaccines that were not properly tested.

The WHO has never publicly disclosed the conflict of interest between the key scientists and the pharmaceutical firms that stood to gain from the pandemic guidance the former were drafting. Despite repeated requests from the *BMJ*, the WHO has failed to provide any details about whether such conflicts were declared by the relevant experts and what, if anything was done about them.

According to F. William Engdahl, author and strategic risk consultant, the WHO Scientific Advisory Group of Experts (SAGE) is riddled with members who receive ‘financially significant funds from either major vaccine-makers, or the Gates Foundation or Wellcome Trust. In the 2020 posting by WHO of the 15 SAGE members, no fewer than eight had declared interest by law of potential conflicts. In almost every case, the significant funder of these eight members included the Gates Foundation, Merck, GAVI, the Vaccine Alliance (a Gates-funded vaccine outfit), Pfizer, Novovax, GSK, Novartis, Gilead and other pharma vaccine players.

- *The 2014 Ebola epidemic in West Africa*

When Ebola broke out in West Africa, the WHO failed to act in an adequate and timely manner. According to news reports, ‘the WHO at first was dismissive of the scale of the problem in West Africa. Then it deflected responsibility for the crisis to the overwhelmed governments of Guinea, Liberia and Sierra Leone. After eight months, it finally stepped up to take charge of the Ebola response but lacked the staff and funds to do so effectively.

In its absence, other organisations such as *Doctors Without Borders* (*Médecins Sans Frontières*) responded swiftly. Over months the group organised and carried out emergency relief operations with sometimes up to 2,400 staff being deployed. Only after a PHEIC (Public Health Emergency of International Concern) was declared in August 2014, nine months after the initial outbreak, was help forthcoming from the international community to effectively control the situation. *Doctors Without Borders* had in June alerted the world that Ebola was raging out of control but was instead denounced by the WHO and accused of scare mongering.

Over 11,300 people perished during this Ebola epidemic. Had the WHO and the international community responded in a timely manner many more lives could have been saved. *Reuters* reported that: ‘The WHO failure to sound the alarm until months into West Africa’s Ebola outbreak was an egregious failure which added to the enormous suffering and death toll, global health experts said’.

Health researchers noted that 'the delay only looked worse with time as leaked WHO documents revealed the WHO decisions were highly political and lacked transparency'.

Doctors Without Borders explained that Ebola belongs to the group of neglected diseases which have been known for a long time but do not earn the necessary scientific attention as they mostly affect poor people in low-income countries far away from markets that are lucrative to industry. Accordingly, funds for the WHO department responsible for Ebola had been cut in half before the 2014 outbreak.

- *The 2018 Ebola epidemic in the Congo (DRC)*

The WHO failed again in its response to the 2018 Ebola outbreak which hit the people of the DRC (Democratic Republic of Congo). This time it took the WHO 11 months to declare a PHEIC for the epidemic. Despite vaccines, the epidemic had a 66 percent mortality rate, which was more than the 2014 epidemic in West Africa. The slow response, the perceived apathy evoked a backlash from the people: the WHO was so hated that there were over 300 attacks on health workers and health centres.

Referring to the response to the Ebola crisis in the Congo, *Medicines Sans Frontieres* (MSF) lamented that: 'this cannot be labelled as anything other than a systematic and catastrophic failure that left thousands dead. Ultimately, we failed the people of DRC'.

'Following the declaration of the epidemic on 1 August 2018, a massive United Nations and Ministry of Health-led response or 'riposte' was rapidly launched. The response was aided by tools that were either unavailable or severely limited in previous Ebola outbreaks, such as new investigational Ebola vaccines and therapeutic treatments.

'Yet despite this', MSF continued, 'the outbreak lasted more than 18 months, and the mortality rate remained very high, at 60-70 percent throughout. This is higher than the mortality rate in the 2014-2016 West Africa outbreak, when such experimental treatments or vaccines were not, or were rarely available.

'Why did we have mortality rate higher than West Africa, when we had all these new treatments and vaccine available?', MSF queried. 'Why were communities attacking Ebola healthcare workers and Ebola Treatment Centres?

'We know the narrow, siloed, Ebola-centric approach adopted by the intervention early on, along with aggressive coercive measures, were crucial factors in the Ebola's response's failure, as we simply failed from the outset to earn the trust of the community. Too much focus was placed on containing the virus instead of supporting the affected people. And without the trust of the community, we set ourselves up to fail the people of DRC'.

Two thirds of the Ebola victims died. First the WHO ignored the outbreak. Then it behaved more like a police force than a public health organisation. This appears to be the WHO's strategy for 'global public health policy'.

The editor in chief of *The Lancet*, Richard Horton was unreserved in his comments regarding the WHO's handling of the epidemic: 'Money was invested in global surveillance and response systems, but little attention was given to standards of care and the effects of the outbreak on families, communities, and health workers. The Ebola outbreak response was

securitised and politicised. A security-based approach emphasised deterrence, compliance, and punishment, principles contrary to public health'.

He went on to say that 'Security concerns diverted attention from human-rights-based protections and violations. There were pervasive failures to apply best public health practices. Decision making was often slow. There was no continuity of care. Ebola responses were not integrated into existing health systems. Interventions, such as new vaccines, can never be substitutes for building trust and cooperation with local populations. Wider health and humanitarian needs were neglected.

'There was little transparency and almost no accountability regarding the massive financial resources mobilised to address Ebola. Technical solutions were insufficient in the face of communities afflicted by precipitous losses of trust. Community engagement often meant little more than issuing instructions. Existing inequities were elided. And those affected saw that their lives were valued differently from the lives of those living in Western nations'.

As can be seen, the WHO's public health emergency measures had little to do with public health and people centred care. The centralised top down, techno-centric and draconian response are antithetical to the principles of public health previously affirmed and espoused by the WHO. They include among others individual rights and autonomy, community and national control over health, informed opinion and active cooperation on the part of the public.

These guarantees are found in the WHO's constitution and the Alma Ata Declaration, which now have been all but jettisoned under the prevailing concept of unaccountable 'public health'. The only winners are the drug manufacturers (and their shareholders) who get to push their experimental vaccines reaping handsome profits in the process.

- *The SARS-Cov-2 Pandemic 2019*[*]

Since the SARS outbreak in 2002, China had a very tight screening regime for respiratory diseases. As such China was able to identify this novel pathogen promptly. On 3 January, 2020 China officially notified the WHO of a cluster of 44 patients of which eleven were severely ill with pneumonia of unknown aetiology, after the WHO requested for more information. At this point in time, there were no deaths reported and no international cases, as well, the human potential of human-to-human transmission was not assessed.

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* *Details of the China outbreak and WHO's response is sourced from Silvia Berendt's testimony, February 12, 2022.*

Meanwhile the novel virus was identified as the SARS coronavirus. Under the IHR (2005) the WHO and the DG is legally obliged to constitute an Emergency Committee (EC) once such an official notification has been received. The EC advises the DG whether a public health emergency of international concern exists and if so, the official proclamation is then made by the DG as the executive authority.

Interestingly at the same time, Professor Drosten and others were working in Germany to deliver to the WHO a diagnostic test assay via the RT-PCR (reverse transcription polymerised chain reaction) method for this novel virus. Professor Drosten was the lead author in 2003

when the SARS coronavirus was identified and since then has been nominated as a WHO expert.

His first protocol for the diagnostic test was officially delivered to the WHO on 13 January 2020, which means that he had worked on this prior to submission to the WHO. WHO immediately disseminated his first protocol of this assay to Member States. This assay was later revised and published in *Eurosurveillance Journal* on 23 January.

Prof. Drosten also contributed to the WHO interim guidance dated 10 January which was published as part of a comprehensive package of some ten guidance documents for countries covering topics related to the management of an outbreak of the new coronavirus disease. By 10 January, WHO already had a comprehensive package published. By the WHO standards, this was quick considering that bureaucratic clearance for publications was required.

On 13 January the EC agreed that there was no international spread of the novel coronavirus outbreak which recorded only 17 deaths and 557 confirmed cases. They decided to meet in ten days' time to assess the current situation of new cases. In the space of ten days the cases increased 14 times worldwide. This happened after the test kits were put to use by the WHO. The test was needed to identify the new virus and international transmission before a PHEIC could be declared.

More importantly the declaration of a public health emergency is connected to the regulatory pathway for emergency use authorisation and production of vaccines. Without a PHEIC, there cannot be any use of untested drugs like vaccines. When a PHEIC is declared, every country has to comply as per the IHR (2005). The WHO announced a PHEIC on 30 January. Suddenly the virus was everywhere and by mid-March or thereabouts the world went into lockdown.

As can be seen, COVID-19 is the first pandemic in which mass lockdowns, border closures, workplace closures and prolonged school closures have been implemented on a global scale. These new approaches in the COVID-19 response have resulted in crippled economies; wide disruption of supply lines; undermined existing health programmes; breakdown in healthcare access; increases in early marriage; domestic violence; mass loss of education of children; increases in current financial inequality and educational inequality. Many countries have increased debt and undergone recession, which will reduce future life expectancy, while suicides and child deaths have increased. Inequality skyrocketed and further entrenched poverty in low-income countries.

Policing was excessive. Rather than 'the least restrictive alternative', populations experienced extreme levels of coercive control during lockdowns. Taken together, these failures risk undermining public trusts in public health and science; and the unchecked use of public power (or prolonged states of emergency) risks undermining democracy itself.

Scholars have labelled the global response to the COVID-19 pandemic an ethical crisis in public health. The new normal of police-enforced lockdowns, bans on citizens leaving and returning home, restrictive public health policies with large penalties for noncompliance diverges from the 'old normal' of public health pandemic response planning which recommend against widespread, prolonged and/or punitive policies as the harms of such policies would likely outweigh any benefits in terms of reduced infectious disease transmission (and the harms would often be inequitably distributed).

The *WHO 2019 Guidelines* on non-pharmaceutical interventions (NPI) recommended against the following measures 'under *any* circumstances' i.e. use of contact tracing (since this is costly and often futile for a widespread or rapidly spreading infection); mandatory quarantine of exposed individuals (since almost every person will sooner or later be exposed to a pandemic virus); entry and exit screening (this has been shown to be ineffective); and border closures (since this impose large costs, are often discriminatory and involve excessive restriction of citizen rights).

When the public health emergency was declared for COVID-19, WHO essentially ignored its Guidelines and made a number of U turns on masks; on corticosteroids use in advanced COVID-19; and human to human transmission. It warned against lifting lockdowns early then praised Sweden's absence of lockdown approach. It downplayed essential natural immunity and promoted the claim that herd immunity could only be achieved through 'vaccination' and denied the virus lab origins theory.

Until April 2021, it refused to acknowledge that SARS-CoV-2 is airborne despite ample evidence presented. To top it all, it promoted censorship of factually proven claims relating to COVID-19 under the guise of fighting disinformation but actually promoting misinformation and disinformation.

WHO and national health bodies acting on WHO's advice withheld and suppressed early treatment protocols due to a focus on ''vaccination'. Had these off-patent cheaper drugs been allowed for early treatment of COVID-19, the unlicensed and profitable mRNA therapies would not have received emergency use authorisation. They were allowed because WHO's private funders such as the Gates Foundation and some Western governments backing the pharmaceutical lobby were vested in it.

Health experts say that 70-80 percent of global COVID deaths could have been avoided with timely treatment. The ban on these safe and cheap early treatment protocols by WHO, governments, and corporate interests resulted in unprecedented suffering and loss of life.

The global response to the COVID-19 pandemic exposes how global health policy has been captured by private corporations and private interests. Scientists and doctors have drawn attention to the fact that the measures recommended by the WHO to national governments are contrary to medical science and epidemiology.

The use of the PCR test has been shown to be faulty and fraudulent. According to Kary Mullis its inventor, the PCR test is capable of manufacturing false positives for almost anything, simply by increasing the cycle threshold to overly high levels. The huge percentage of false positives are a waste of resources on asymptomatic people who are actually healthy. Generating massive numbers of improperly diagnosed fake 'cases' only leads to fear mongering exacerbating panic and hysteria. This feeds into opportunities for BigPharma to promote the use of 'vaccines'.

Dr Silvia Behrendt in her expert testimony to the Grand Jury Proceeding by the Peoples'Court of Public Opinion on Crimes Against Humanity reveals that there was no pandemic until a defective PCR test was introduced that suddenly increased cases multi-fold despite the crucial fact that the infection fatality rate (IFR) of SARS-CoV-2 is low, with a global average IFR at 0.15 per cent and below 0.05 per cent for people under the age of 70

which is comparable to that of seasonal flu (with an IFR of 0.16 percent). In other words, the disease recovery (survival) rate in healthy people is 99.8 per cent. This enabled a PHEIC to be declared and in its wake opened the way for the WHO Emergency Use Authorisation of untested experimental vaccines. And vaccines became the only treatment to be used to control COVID-19.

We have traced some of the major changes that have taken place in the WHO and its role in global public health since its founding; the pervasive influence of major donors on its policies exposing it to conflicts of interest; its involvement in unethical vaccination programmes; and its poor handling of pandemics with severe consequences for public health. In light of the IHR 2005 amendments and Pandemic Treaty proposals currently being negotiated, this background to the WHO serves as a stark reminder of what is at stake.

IV. Key Amendments to the International Health Regulations (2005)

Some of the key amendments that will impact countries, their citizens and their relationship with WHO are discussed below.

i. An authoritarian model

David Bell asserts that the Universal Declaration on Human Rights (UDHR) adopted by the UN after the war is predicated on the concept that all humans are born with equal and inalienable rights, gained by the simple fact that they are born. The UDHR was codified to prevent a return to inequality and totalitarian rule as the world was emerging from the yoke of colonialism and international fascism. This understanding underpins the WHO Constitution (WHOC).

The concept of the nation state being representative of their people and exercising sovereignty over territory and the laws by which their people were governed was tied to this. The proposed IHR (2005) amendments upend these long-held beliefs.

In its current form the IHR (2005) states that: ‘The implementation of these Regulations shall be with full respect for the dignity, human rights and fundamental freedoms of persons’. The amendment proposes this to be deleted from the text to read: ‘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 State Parties, taking into consideration their social and economic development’.

These according to Bell, are vague terms the applications of which are then specifically differentiated in the text according to levels of social and economic development. He adds: ‘The underlying equality of individuals is removed, and rights become subject to a status determined by others based on a set of criteria that they define. It also implies that the wealthy and the poor have different rights, and that there is a hierarchy of development that defines one’s rights’.

Bell further opines that it ‘is a totalitarian approach to society within which individuals may act on the sufferance of others who wield power outside of legal sanction; specifically, a feudal relationship or one of monarch-subject without an intervening constitution’.

ii. WHO authority overrides State authority

The proposed IHR (2005) amendment that the WHO's existing powers to make recommendations should be upgraded from 'nonbinding' to 'binding' recommendations, would mean that States would have to accept the authority of WHO in international public health emergencies. This would elevate the authority of the WHO above their own Ministries of Health.

Powers ceded by national governments to the WHO would include the ordering of border closures, travel restrictions, tracing of contacts, refusal of entry, implementation of exit screening, forced quarantine, medical examinations (including requirements for prove of 'vaccination') and the forced medication of individuals.

If these amendments are accepted, they would enable the WHO to order Member States to require their citizens to disclose their medical status as well as the specific actions mentioned above. These powers could be triggered potentially by the 'determination of a single official' (the Director General of WHO) that a 'potential' public health emergency had arisen following surveillance activities controlled by the WHO.

iii. Censorship

The proposed restrictions on individual rights under the DG's discretion would include freedom of speech. The WHO would have power to designate opinions or information as 'misinformation' or 'disinformation' and require country governments to intervene and stop such expression and dissemination.

The WHO does this currently through its so called 'Infodemic Unit' through which it informs States what in its opinion, amounts to health 'mis or disinformation' concerning international public health emergencies; and tracking social media posts in real time in 30 countries and in nine different languages. While so far this activity is undertaken on a voluntary basis, the amendments would make this practice mandatory.

Critics have commented that this radical change raises concerns about 'the wisdom of ordaining the WHO as the single source of pandemic truth'. This is especially so given that in the early days of the COVID-19 pandemic the WHO itself was already spreading what can only be described as misinformation – such as the WHO's claim that COVID-19 originated from animals (not in a lab) and the denial (against the scientific evidence) that immunity after COVID-19 infection offers effective protection from the disease.

As well, Infodemic management through the WHO has suppressed many important debates like the negative effects of lockdowns, and effective treatment of COVID-19 with repurposed, cheap drugs including as an alternative (or at least complement) to a global vaccination campaign with costly experimental novel products.

According to jurists Behrendt and Muller, 'Infodemic management' through the WHO supposedly to provide authoritative, evidence-based, timely and up-to-date information and advice both to coordinate the global response and to support national pandemic responses raises questions in particular in regard to the right to freedom of expression (Article 19 ICCPR – International Covenant on Civil and Political Rights).

However, ‘in practice during the COVID-19 pandemic, the WHO, the EU and Member States “Infodemic management” led to censorship on platforms like YouTube, Facebook and Twitter’, with for instance YouTube’s policy indicating that it does not ‘allow content that spreads medical misinformation that contradicts local health authorities or the World Health Organisation’s medical information about COVID-19’.

Hence among the censored were highly qualified medical practitioners and scientists, academics and independent journalists. They warned that this ‘entrenches a global practice … that assumes that there is “one medicine”, “one science” and ultimately “one truth” on SARS-CoV-2 and COVID-19, and any future pathogens, held by the WHO’.

This not only undermines the rights to freedom of expression and to receive and impart information, including health related information on evidence basis e.g. of lockdowns, “social” distancing, diagnostics, therapeutics, use of alternative drugs and vaccine approvals. It also ‘misunderstands independent science which thrives on asking questions and thereby contributes to the constructive development of medical science including Covid-19’.

iv. Compulsory provision and sharing of resources

After an emergency is declared, the IHR (2005) amendments would give the WHO DG powers to instruct Member States to provide the WHO and other countries with resources both in terms of funds and other commodities. This could include the WHO giving directions for intervention in manufacturing process to increasing the production of specified health commodities manufactured within their borders.

The amendments suggests that countries would be required to cede power to the WHO over patent law and intellectual property (IP). This would include control of manufacturing know-how, of commodities deemed by the WHO DG to be relevant to the potential or actual health problem. This IP and manufacturing know-how may then be passed to commercial rivals at the DG’s discretion.

However, this may not survive scrutiny by States and vested interests which jealously guard IP rights.

v. Compulsory sharing of data

Presently in sharing data, the WHO is required to take into account the views of the Member State concerned. Under the new amendments the new duty to share data is mandatory: ‘the WHO shall, when justified by the magnitude of the public health risk, immediately share with other states the information available to it’. The WHO no longer needs to consider the views of the Member State affected.

This significantly broadens the scope of data sharing provisions under which Member States would be required to make data available to the WHO at the WHO’s request. States would also have to permit the WHO to make this available not only to other Member States and relevant intergovernmental bodies, but to relevant international and regional organisations.

This includes organisations with private and corporate representation on their boards including those with direct financial conflicts of interest such as CEPI, GAVI and Unitaid.

vi. Fast-track distribution of experimental drugs

The declaration of a PHEIC requires WHO to develop appropriate regulatory guidelines for the rapid approval of health products including vaccines, gene-based therapies, medical devices, and diagnostics.

As legal experts have noted, the 'WHO emergency declarations can trigger the fast-track development and subsequent global distribution and administration of unlicensed investigational diagnostics, therapeutics and vaccines'.

This is done via the WHO Emergency Use Listing Procedure (EULP). The introduction of an 'intermediate public health alert' in particular will further incentivise the pharmaceutical industry to activate domestic fast-track emergency trial protocols, as well as for advance purchase, production and stockpile agreements with governments before the existence of a **concrete** health threat to the world's population has been detected as is already the case under the WHO EULP via the procedures developed for a 'pre-public health emergency phase'.

The WHO EULP through which it 'approves for emergency use' experimental medical products to address a PHEIC including vaccines, enables their global distribution to countries with inadequate regulatory capacities. Compounding this problem is the fact that very limited clinical trial data on efficacy and safety of an unlicensed medical product is required for an Emergency Use Listing (EUL).

The '100 Days' Initiative led by one of the WHO's influential public-private partner, CEPI which aims to develop a 'vaccine' within 100 days ready for distribution and use, to the entire global population once a PHEIC is declared, may also be realised by the proposed amendments, and built upon once they are adopted.

Thus, lowering the bar for declaring a global or regional public health threat triggers a huge opportunity for Western pharmaceutical companies to make money and market experimental (unlicensed) drugs which are often unsafe and of unproven efficacy as the COVID-19 'vaccines' have demonstrated.

vii. DG given unfettered powers

When the IHR was revised in 2005, it included a new provision whereby the DG advised by an Emergency Committee can declare a Public Health Emergency of International Concern (PHEIC).

The amendments will further remove the requirement for there to be a confirmed health emergency in which people are undergoing measurable harm or risk of harm. Instead, the mere 'potential' for a public health emergency allows the DG to assume powers to act in countries and over their citizens. The amendments would give the DG sole authority to declare a potential or perceived PHEIC over the objections of the affected State if the latter does not agree that a potential or perceived public health emergency has been identified.

In a declared emergency, the DG can vary the FENSA (Framework for Engagement of Non-State Actors) rules dealing with private (e.g. for profit) entities, allowing the DG to share a State's information not only with other Member States but with private companies.

Although the DG would seek the views of the Emergency Committee (set up to advise on emergencies), before declaring a PHEIC, the ultimate discretion to declare such an event is the DG's alone. This was clearly demonstrated during the Monkeypox (Mpox) outbreak when the DG declared a PHEIC against the EC's recommendations. This PHEIC is concentrated among men who have sex with men, especially those with multiple partners. The PHEIC for Mpox finally ended on 11 May, 2023.

The threshold to declare a public health emergency is lowered further when the WHO Regional Directors (RDs) are empowered to declare a 'public health event of regional concern' (PHERC). When an event does not fulfil the criteria of a PHEIC, the DG can still issue 'an intermediate public health alert'.

These broad powers also allow the WHO and the DG to consider 'allegations' about a public health event from non-official sources namely sources other than the State concerned and the latter has 24 hours to confirm the allegations and a further 24 hours to accept the WHO offer of 'collaboration'.

'Collaboration as scholars Frijters, Foster and Baker have observed is 'essentially a euphemism for on-site assessment by teams of WHO investigators and concomitant pressure at the whim of WHO personnel to impose potentially far-reaching measures such as lockdowns, movement restrictions, school closures, consumption of medicines, administration of vaccines and any or all of the other social, economic and health paraphernalia that have come to be associated with COVID-19'.

They added that 'these WHO "expert teams" sent in to make on-the-ground assessments, under the banner of "collaboration" with the host country undergoing the health event, will be chock-a-block with operatives from the CDC and who knows what other Western agencies, all poking around potentially sensitive facilities that a host government might justifiably claim a sovereign right to keep to itself'.

Should the country involved refuse to accept WHO's offer of collaboration, the WHO is empowered to disclose the information it has to other Member States – a subtle form of pressure or blackmail on the country to yield to the WHO invitation to 'collaborate'. This gives the affected state no avenue to express its views on the matter even if allegations are unjustified.

The amendments include a new chapter IV (Article 53 bis-quarter) which would establish a Compliance Committee comprising six government-appointed experts from each WHO region who will monitor, promote, and gather information among other functions. In short, it is tasked with permanently snooping around (collecting intelligence) to ensure Member States are complying with the IHR 2005. 'These government appointed members have an open-ended brief enshrined in international law to be busybodies' or even spies.

If the amendments are adopted WHO could unilaterally decide and define health problems and determine the responses and isolate countries that disagree. As observers have noted the WHO would become a 'kind of command-and-control centre for globalist agendas, pushing the products of BigPharma'.

viii. Surveillance capacities expanded

The IHR (2005) amendments and the Treaty would establish a huge surveillance infrastructure and bureaucratic mechanism requiring States to identify new variants of viruses, that constantly arise in nature all of which in theory, could be presumed to pose a potential risk of outbreak and a PHEIC, until proven otherwise. The workforce running this surveillance network will be substantial and global, existing to only identify yet more viruses and variants. Much of the funding for this surveillance network will come from private and corporate interests that stand to gain financially from the vaccine-based responses they envision for real or potential infectious disease outbreaks.

This surveillance mechanism is also discussed in the pandemic preparedness documents of the G20 and the World Bank. The World Bank has created a Financial Intermediary Fund (FIF) to support related pandemic preparedness with the WHO as technical partner, in order to fund the development of a surveillance, identification and response network as envisioned in the two 'pandemic' instruments which was backed by the recent G20 meeting in Bali, Indonesia in November 2022. So far it has managed to raise USD1.6 billion of the hoped for USD 10 billion. The FIF is now called 'The Pandemic Fund'.

As Bell states: 'the surveillance mechanism required of States and expanded within the WHO will ensure that the DG and RDs will have a constant stream of potential public health risks crossing their desks. In each case, they will have power to declare such events a PHEIC or PHERC (International or Regional) concern, issuing orders supposedly binding under international law to restrict movement, detain, inject (arms) on mass scales, yield intellectual property and know-how, and provide resources to the WHO and to other countries the DG deems to require them. Even a DG uninterested in wielding such power will face the reality that they put themselves at risk of being the one who did not 'try to stop' the next pandemic, pressured by corporate interests with hundreds of billions of dollars at stake and huge media sway'.

WHO's focus on pandemics together with one dimensional, mechanistic, technocratic, biomedical approaches which are developed and implemented top down through executive order reflect the biases of the Western elite, international donors and corporate interests not the demands and needs of the Global South.

Member States would have to divert their scarce health resources to pandemic preparedness and response activities at the expense of national and local priorities and other pressing health burdens. This could potentially undermine a country's ability to shape and determine its domestic health policy and health system.

ix. *A looming Digital Tyranny*

Many of the proposed amendments aim to expand the WHO's institutional capacities during a PHEIC and its biosurveillance measures at all times. One important pillar is to develop 'an interoperability mechanism for secure global digital exchange of health information which will include digital health certificates and contact tracing'. The proposals for global digital health certificates are found in six of the articles (A18, A23, A31, A35, A36 and A44) and in Annex 6 of the IHR (2005). Most of the proposals were from the European Union (EU) while Indonesia, the MERCOSUR nations and the Russian Federation submitted proposals as well.

On 5 June, 2023, The European Commission (the executive arm of the EU) and the WHO announced a 'digital health' partnership to establish a new Digital Vaccine Passport system for the world.

This new digital identity scheme is building on the EU Digital Covid Certificate which was implemented in June 2021 during the COVID-19 pandemic. According to the EU more than 2.3 billion certificates were issued. The EU commissioner on Internal Market said that he was 'pleased that the WHO will build on the privacy-preserving principles and cutting-edge technology of the EU certificate to create a global tool against future pandemics'.

Ironically, the EU and the WHO say the EU Vaccine Passport helped 'facilitate safe free movement' but the reality is the passport programme was one of several created by the public-private-partnerships between government and non-governmental organisations and corporations which required individuals to show proof of vaccination to work, travel or eat.

The WHO will now take the EU system and establish a global system that they claim will 'help protect citizens across the world from on-going and future threats, including pandemics'.

This latest partnership is to 'enhance strategic cooperation on global health issues'. Both the EU Commission and the WHO say this new partnership 'bolsters a robust multilateral system with WHO at its core'.

These statements say Derrick Broze, journalist and activist is 'an acknowledgement that these type of programmes begin at the transnational level with globalist organisations like the WHO and the EU before they trickle down to national governments, states, and provinces, and eventually, local councils'.

He added that: 'the push for vaccine passports or digital identities is coming from various organisations such as the Better Identity Coalition (a grouping of banks and Big Tech companies) with ties to cybersecurity spooks (spies) with connections to the national security state, US and Israeli intelligence, banks and corporations'.

However, digitalisation will come with a cost. The United Nations (UN) Secretary-General's High-level Panel on Digital Cooperation 2019 report entitled *Age of Digital Interdependence* warns that: 'A Digital ID can help unlock new opportunities but can also introduce new risks and challenges. They can be used to undermine human rights – for example, by enabling civil society to be targeted, or selected groups to be excluded from social benefits'.

This can later be fused with a social credit system and Central Bank Digital Currency (CBDC) which is now being introduced and tested in many countries across the world. Observers say this will have severe consequences for our freedoms and a repeat of what the world experienced during the pandemic. 'This is truly global in nature put in place not by one or two totalitarian governments, but nearly every country in the world' states James Corbett, writer and public intellectual.

Digitalisation has also led to rising inequality after the pandemic, according to the UN's new Policy Brief *A Global Digital Compact*. 'Digital technologies are accelerating the concentration of economic power in an ever smaller group of elites and companies: the

combined wealth of technology billionaires, USD 2.1 trillion in 2022, is greater than the annual gross domestic product of more than half of the Group of 20 economies'.

The push for vaccine passports is really a push for digital identity schemes which is being sold to the people of the world under the guise of building a more equitable, sustainable and just world, commentators say. The UN (including the WHO) is promoting the idea that digital identity is a human right in an effort to persuade the Global South to participate. The vaccine passport is simply a gateway to a digital identity.

In June 2022, New York University (NYU) School of Law issued a 100-page report detailing the growing dangers of a reliance on digital identity around the world. The report titled '*Paving a Digital Road to Hell*' examines the role of the World Bank and other international networks which have been promoting the use of digital ID in recent years.

The report notes that the World Bank has been 'energetically promoting biometric and other digital systems that are increasingly linked to large scale human rights violations especially in the Global South'. The researchers warn that digital identity schemes 'promoted in the name of development and inclusion, might be achieving neither'. Despite ostensible good intentions on the part of some promoting these systems, they "may well be paving a digital road to hell".

Governments around the world have been investing heavily in digital identification systems, often with biometric components (digital ID). The rapid proliferation of such systems is driven by a new development consensus, packaged and promoted by key global actors like the World Bank, but also by governments, foundations, vendors and consulting firms'.

The fact that the EU and the WHO are announcing a new vision for COVID-19 digital vaccine certificates may yet be a sign that they are not done playing the 'pandemic' card. The US Health and Human Services Secretary speaking to journalists at the recent WHA said: 'I think we'll get an accord in place if everyone realizes that our window before this next pandemic, this next health threat is probably not far away'.

According to Broze the Digital Scheme will also be linked to a digital wallet holding the local Central Bank Digital Currency (CBDC), the digital currency of governments which will be needed for all legal transactions. Eventually, this digital ID and the digital wallet will be connected to, and impacted by, your individual social credit score.

A robust contract tracing system is essential for digital IDs, vaccine passports, CBDCs and implementing a permanent surveillance state, observers say. A full-blown Social Credit Score (SCC) system would be like the one China has where each and every individual is given a score for virtually every action they take. This could be a financial transaction, travel and its carbon footprint, how much energy they use, what they eat, what they buy, what they say, even what they think.

Every aspect is rated, leading to an SCS with real-life consequences if your rating drops below certain thresholds. They could lead to the downgrade of your accommodation, and where one is allowed to live. One's energy supply could be limited or switched off. Access to one's funds or bank account could be controlled or frozen. Travel rights may be restricted or withdrawn. All this can be done at the click of a button.

‘This is the level of control that is available and could be implemented across the world if we don’t firmly say no’ warns Tess Lawrie, founder of the World Council for Health.

Currently most of these programmes are still voluntary just like getting the COVID jabs was initially voluntary. But as can be seen the coercion started very soon and the ‘unvaccinated’ were barred from restaurants, shops, gyms, houses of worship and travelling, and many lost their jobs. Similar penalties or punishments might be in store in the future for citizens who refuse to take part in these social credit schemes or do not want to use a digital ID.

‘We see the push for “contact tracing” apps to track the spread of disease and vaccine passport/health passport apps have begun to acclimate the public to carrying a digital ID card with them everywhere they go’. The public is being primed to accept digital identity as a method of tracking illness (and the population).

Many of the people in the developing countries lack bank accounts and credit cards, and, there exists a thriving informal economy where people trade, buy and sell goods without taxes, regulations or a digital record of any kind. This is the type of behaviour that the Technocrats want to eliminate, says Broze.

Privacy International in challenging the UN SDGs (Sustainable Development Goals) in its report states: ‘If actors fail to consider the risks, ID systems can themselves threaten human rights, particularly the right to privacy. They can become tools for surveillance by the state and the private sector; they can exclude rather than include’.

The UN is not the only supranational body lobbying for digital identity, The WEF (World Economic Forum) was also one of the first organisations to begin promoting the idea of vaccine passports as part of a ‘new normal’. The World Bank has been funding the development of such programmes as part of the identification for Development (iD4D) initiative as well.

Luis Fernando Garcia, the director of the Mexican digital rights organisation R3D, says the programmes are being funded by those interested in exploiting Mexico’s human data: ‘Sophisticated intelligence agencies in rich countries are delighted that poor countries are creating these data bases of people that they can exploit for their benefit. They have offensive capabilities that allow them to attack, obtain, and collect information that less-developed countries create through these databases’, he stated.

As well, an alliance of Microsoft, GAVI, and the Rockefeller Foundation have organised to form the ID2020 project. The ID2020 project launched in 2016, is an attempt to create digital identification for every single person on the planet.

Experts remark that ‘the usual cast of characters, the WEF, the UN, the World Bank, the Gates Foundation have spent the recent years lobbying for the need to create a digital identity for every person on the planet. During the COVID-19 crisis these organisations promoted the use of vaccine passports which is a form of digital identity. They are now poised to use economic crises and fears of pandemic2 to promote the value of digital currency, whether to receive a digital currency in exchange for dollars or to prove vaccination status. One way or another the Technocrats will force their digital identity stranglehold on the masses’.

‘Ultimately the crux of this discussion centers around identity and what is needed for a person to operate in the world today. Digital ID will inevitably be connected to digital currency, and eventually a social credit score. This infrastructure along with widespread facial recognition cameras, will be the invisible enforcement arm of the technocratic surveillance state. Together facial recognition, digital identity, digital currency, and social credit scores ‘represent a giant leap towards digital totalitarianism’ asserts Broze.

Experts warn that vaccine verification technology can easily be adapted to track and score compliance with a vast range of government mandates and priorities above and beyond vaccination status. The rest of functionality of the Chinese social credit system can be integrated into the vaccine passport system in a matter of minutes or hours.

Others have commented that the EU has already begun the implementation of a digital ID wallet to store biometric data like facial recognition and finger prints while acting as the gateway to a wide range of services like opening a bank account, renting a car, checking into a hotel and applying to university.

‘It’s not difficult to see how a powerful centralised digital platform combined with a comprehensive rating system like a personal ESC (Environmental, Social, and Governance) score could create a modern slave class bound to obey the dictates of government and corporate elites’, notes journalist Ashley Sadler.

‘The Canadian government’s militaristic crackdown on the Ottawa Freedom Convoy (who were opposing vaccine mandates) in February 2022 whereby the bank accounts of protesters and supporters were frozen without due process, gives a disturbing glimpse into the ability of governments to easily destroy the lives of dissenters without the costly necessity of arrest or imprisonment’.

In response to the draconian measures taken by Prime Minister Trudeau of Canada, David Solway, Canadian poet and essayist wrote: ‘These are the kinds of measures adopted by a police state. The right to hold ‘unacceptable views’ the freedom to dissent from the government line and its authoritarian agenda and the ability to lead our lives as we see fit, are being efficiently suffocated’.

Solway adds that the proposals on digitalisation in the amendments to the IHR (2005) can be considered as ‘malignant initiatives’.

Roguski, the independent journalist and researcher says the WHO is not waiting for a successful conclusion of the negotiations on the two international instruments in order to implement initiatives such as a global digital vaccine passport. He said: ‘The announcement by the WHO and the EU regarding the launch of their digital health partnership was hardly a surprise. Over a month ago, the WHO quietly published that they were working on “operationalising” the very things that were being “negotiated” ’.

‘This is just one example that clearly shows that the super-secret “negotiations” regarding the IHR are a charade’, he added.

According to Michael Rectenwald author of ‘*Google Archipelago: The Digital Gulag and the Simulation of Freedom*, that under the guise of preserving freedom, a digital passport system

‘means restraints on movement and living for the unvaccinated and forced vaccination to participate in life’.

The EU was among the strongest proponents of vaccine passports during the ongoing negotiations for the WHO ‘Pandemic Treaty’ and the IHR (2005) amendments. They are the ones primarily pushing for the global health certificate. During the negotiations for the IHR (2005) amendments they put forth proposals that seek to ‘normalize the implementation of a global health certificate’, says Roguski.

Under Article 36 Certificates of vaccination or other prophylaxis, the proposed amendments called for ‘other types of proofs and certificates maybe used … particularly where a vaccine or prophylaxis has not been made available for a disease in which a public health emergency of international concern has been declared. Such proofs may include test certificates and recovery certificates’. The EU is thus proposing certificates not just for vaccination purposes.

These proposals and initiatives appear to be closely aligned with the UN’s SDGs, in particular, Target 16.9 which calls for the provision of a digital identity for all, including newborns by 2030.

Rectenwald called ‘pandemic passports’ a ‘death sentence for millions’. ‘Despite the studies demonstrating that vaccines to curb pandemics have been deadly and useless, the WHO is doubling down on vaccine mandates’.

‘Pandemic passports equal a death sentence for millions and the abrogation of rights for the non-compliant. The WHO should be stopped before it completes the construction of a global totalitarian system’, he stressed.

Referring to the IHR (2005) and the Pandemic Treaty, Francis Boyle, professor of international law at Illinois University, author of several law textbooks and a bioweapon expert who drafted the US *Biological Weapons Anti-Terrorism Act 1989*, states that he has ‘never read treaties and draft international organizations that are so completely totalitarian as the IHR regulations and the WHO Treaty ... Either one or both will set up a totalitarian medical and scientific police state that will be beyond the control of national, state and local government authorities. Both the IHR and the WHO Treaty, as far as I can tell from reading them, are specifically designed to circumvent national, state and local government authorities when it comes to pandemics, the treatment of pandemics and also including in there, vaccines’.

He questioned the legality of the above documents citing that ‘the proposed WHO Treaty violates the WHO and US Constitution and also normal practice under the *Vienna Convention on the Law of Treaties* ratified in 1969, an international agreement governing treaties between states’. Boyle described the latter as ‘the international law of treaties for every state in the world … does not provide for treaties to provisionally come into force after they are signed or approved’.

Article 19 of the WHO Constitution gives the WHA, the authority to adopt conventions or agreements (like the Pandemic Treaty) by a two-thirds vote.

Because there is no quorum requirement in the WHA, Boyle said 'it could be a very small number of states that actually show up. As a result, the Chair of the WHA could get up and say, "I move for it to be adopted by consensus if no one dissents" and that's that'.

Boyle explained the difference between the latest pandemic treaty and the IHR (2005) proposals as 'the WHO treaty would set up a separate international organization, whereas the proposed regulations would work within the context of the WHO we have today'.

He further warned that … 'Either they'll get the regulations or they'll get the treaty, but both are existentially dangerous. These are truly dangerous, existentially dangerous and insidious documents'.

As can be seen, the effect of these amendments will elevate the status of the WHO from a public health advisory organisation to a supra-national public health executive. As Bell notes: 'they provide the DG and those delegated by the DG with exceptional and arbitrary power with measures in place that make the exercise of such power inevitable'.

If such changes are adopted it will permit the WHO its ECs and DG to issue legally binding instructions to Member States which legal experts say that 'with the exception of the UN Security Council acting under chapter VII of the UN charter, no other UN organ or specialised UN agency has, let alone the DG of one of these specialised agencies'.

On top of this, there is no mechanism for oversight of the WHO, the DG and the ECs. They enjoy diplomatic immunity from all national jurisdictions.

At the individual level, these approaches would impact human rights and norms, among them the right to health, the principle of informed consent, the right to access safe and effective medical products, as well as the right not to be subjected without free consent to medical or scientific experimentation which forms part of the prohibition of torture under Article 7 of the International Covenant on Civil and Political Rights 1966.

V. Background to the International Health Regulations (2005) and the Amendments

The WHO governing body, the World Health Assembly (WHA) adopted the International Sanitary Regulations in1951. This was further revised and superceded by the International Health Regulations (IHR) in 1969. In 1995 the WHA raised concerns that the emergence and re-emergence and international spread of infectious disease required the revision of the IHR to address these threats.

In the wake of the 2003 SARS (severe acute respiratory syndrome) outbreak and the 2004 avian influenza epidemic; a renewed sense of urgency led to the revision of IHR in 2005. The IHR (2005) an international treaty is currently binding on 196 state parties namely the 194 WHO Member States plus the Holy See and Liechtenstein.

The IHR (2005) is currently the most important multilateral treaty regulating the global architecture for health emergency, preparedness, response and resilience (HERP).

So far there has been virtually no public awareness or debate on the substantial and far-reaching amendments to the IHR (2005). There is also some confusion over the IHR (2005)

as it has been mistaken for the new pandemic treaty that is undergoing drafting and being negotiated.

At the 74 WHA 2021 the Working Group on Strengthening WHO Preparedness and Response to Health Emergencies (WGPR) was established, as well as the decision to convene a special session of the WHA (WHASS2) in November – December 2021 to consider the new pandemic treaty. The WGPR in its report to the WHASS also proposed to revise and amend the IHR (2005) within the same time frame in which the new treaty is to be negotiated.

Meanwhile in January 2022, the US unilaterally initiated a major revision process which took the Member States by surprise.

On 6 October 2022, the Review Committee was convened by the DG of the WHO. Its purpose was to provide technical recommendations to the DG on the proposed amendments to the IHR (2005) submitted by States Parties and affiliated stakeholders. The International Health Regulations Review Committee (IHRRC) answers directly to the WHO DG. The proceedings of the IHRRC are confidential. On 6 February 2023, the IHRRC published its final 97-page Report, which was based on the 'Article by Article Compilation' in November 2022, collated by the WHO. The IHRRC Report was referred to the Working Group on Amendments to the International Health Regulations (2005) (WGIHR – see page 28).

The IHRRC is critical of many of these proposed amendments to the IHR (2005). Their assessments of some of the significant amendments are found in Part VI.

There were 307 amendments proposed by 16 States Parties (some on behalf of groups of countries) that are currently being negotiated by 194 country delegates.

i. Breach of Article 55 of IHR (2005)

Unknown to many the IHR (2005) was amended in May 2022 at the 75 WHA. Following is a summary of the background to the events.

- On 18 January 2022 the US government made 13 far reaching proposals to amend the IHR (2005). These proposals were officially published by the WHO on 12 April for consideration at the Seventy Fifth World Health Assembly in late May 2022.

- The proposals were co-sponsored by 19 countries plus the European Union. The proposals received pushback from the Global South especially the African countries who saw it as a colonialist ambush. Brazil threatened to withdraw from the WHO and the African group of almost 50 countries along with India argued that the amendments were being rush through without adequate consultation. Russia, China and Iran also objected.

- On 24 May counter proposals mainly from the European Union, the UK, the US, Australia, Japan and Korea among others were presented on the same day the US proposals were rejected. These revised amendments were discussed and further amended. The negotiations over the proposed amendments include Member States as well as non-State stakeholders with relations to the WHO.

- These changes in international law were achieved by 'consensus' in secret informal meetings and delegates by remaining silent (tacit consent) while the document is being considered publicly (in plenary).

- The 'silence procedure' method by which amendments to the IHR (2005) are adopted does not require further ratification or consent of Parliament. Neither is the Prime Minister's signature required. Often the 'silence procedure' is the last step in adopting or agreeing to specific texts after the basic premises of the text have been agreed upon in previous negotiations. Those who remain silent are taken to agree.

- Adoption of the Amendments only require a simple majority of Member Nations in the WHA. However according to Professor Francis Boyle, because there is no quorum requirement in the WHA, a small number of states who actually are present could result in the WHA Chair to move for adoption by consensus if no one dissents (through the silence procedure).

- On 27 May, Amendments to five articles (55, 59, 61, 62, 63) of the IHR (2005) were adopted by the 75 WHA. This is in clear violation of the IHR (2005) rules. Article 55 of the IHR (2005) states very clearly that a four-month advance notice period is required for any amendments. This was not adhered to when the WHA delegates voted to adopt the 27 May amendments.

The "silence procedure" is a form of tacit consent or acceptance.

> *... a proposal with strong support is deemed to have been agreed unless any member raises an objection to it before a precise deadline: silence signifies assent – or, at least, acquiescence. This procedure relies on a member in a minority fearing that raising an objection will expose it to the charge of obstructiveness and, thereby, the perils of isolation.*
> G. R. Berridge (2010) *Diplomacy: Theory and Practice* (Fourth Edition). Palgrave Macmillan. ISBN 978-0-230-22960-0. Page 158.

ii. Amendments to Art.59 shortens period changes become international law

- The amendment to article 59 refers to the period future amendments would enter into force. It has now been shortened from 24 months to 12 months. The time period in which Member States could exercise their right of rejection of any amendments under Article 61 of the IHR (2005) is now shortened from 18 months to 10 months.

- This means that each and every Member State has the authority to reject any or all the five amendments; but they must do so before late November 2023.

- Unless rejected before late November 2023 the amendments to Article 59 will reduce the time period for rejection from 18 months to 10 months and the time period for enactment to go into force will be reduced from 24 to 12 months.

- Thus in future if States Parties do not opt out within 10 months, amendments will automatically enter into force for them in line with Article 22 of the WHOC and the amended Article 59 of the IHR 2005.

- This leaves States Parties a limited amount of time to thoroughly evaluate the legal and practical implications of the IHR (2005) amendments, including for their national or domestic health policies and national budgets.

- The amendments to Article 62 clarify the details by which reservations can be made to future amendments

Amendments to Article 59: Entry into force; period for rejection or reservations

Ibis The period provided in execution of Article 22 of the Constitution of WHO for rejection of, or reservation to, an amendment to these Regulations shall be [9 DEL] 10 months from the date of the notification by the Director-General of the adoption of an amendment to these Regulations by the Health Assembly. Any rejection or reservation received by the Director-General after the expiry of that period shall have no effect.

… amendments to these Regulations shall enter into force 12 months after the date of notification referred to in paragraph 1bis of this Article,

Amendments to Article 62: Reservations

1. States may make reservations to these Regulations or an amendment thereto in accordance with this Article. Such reservations shall not be incompatible with the object and purpose of these Regulations.

iii. States submit proposals for amendments

- The above mentioned events started a wider process which called for amendments to the IHR (2005) to be proposed by States Parties.

- Thus 16 State Parties either on their own or in association with regional blocs like the EU, the WHO African Region, the Eurasian Economic Union and MERCOSUR filed proposals by 30 September 2022 to meet the dateline for submissions.

- A working group which became the WGIHR was formed to accept Member States proposals on IHR 2005 Amendments by the end of September 2022. The objective is to have fresh set of proposals when the 77 WHA meets in May 2024. The WGIHR comprises selected delegates from States Parties which will draft a final proposal during the course of 2023 based on the IHRRC Report. WGIHR had their first meeting on 14-15 November 2022. The final proposal for the amendments will be submitted to the DG in early 2024 who will circulate it to the Member States at least four months before the 77 WHA in 2024.

iv. WHO breaks rules on dissemination of finalised IHR (2005) Amendments

In a sudden unexpected turn of events, the Working Group on amendments to the IHR (WGIHR) dropped a bombshell at the fifth meeting of the WGIHR on October 2, 2023. The Saudi Arabia co-chair Dr. Abdullah Assiri informed the meeting that the Working Group may not complete their work by January 2024, to meet the dateline for submission of the IHR amendments to be voted on in May 2024.

In a WHO Press Release, the Co-Chairs noted that, in reference to Decision WHA 75(9) 'it appeared unlikely that the package amendments would be ready by January 2023. In this regard, the Working Group agreed to continue its work between January and May 2024. The Director-General will submit to the 77 World Health Assembly the package of amendments agreed by the Working Group'.

This is in clear violation of Article 55 of the IHR (2005) which requires amendments to WHO documents be offered to Member States and the public four months in advance of a vote. Hence, the finalised amendments will not be made available to Member States and the public in timely manner; and country delegates as well as the public will not have adequate time to understand the proposals and weigh in on them.

It appears the WHO ignores its own rules and reinterprets them to keep the finalised IHR (2005) Amendments hidden from public scrutiny until after the vote is taken or consensus is reached at the 77 World Health Assembly in May 2024.

> Article 55 Amendments (IHR (2005))
>
> 1. Amendments to these Regulations may be proposed by any State Party or by the DirectorGeneral. Such proposals for amendments shall be submitted to the Health Assembly for its consideration.
>
> 2. The text of any proposed amendment shall be communicated to all States Parties by the Director-General at least four months before the Health Assembly at which it is proposed for consideration.

VI Annotated Summary of Significant Amendments to the IHR (2005)

Following is an annotated summary of significant amendments to the IHR (2005)*

Legend

~~Strikethrough~~ = delete existing text

<u>Underlined and bold</u> = new text proposed

*****This section is largely sourced from Bell, D., February 1, 2023 and Roguski, J., April 9, 2023

1. Promoting health products from Big Pharma

Article 1 Definitions

Proposed Amendment (Malaysia)

<u>"health products" include medicines, vaccines, medical devices, diagnostics, assistive products, celland gene-based therapies, and other health technologies, but not limited to this course</u>

Health products should not be confined to modern medicine alone. The ancient 'pharmacopoeia' of non-western health systems like Ayurveda, Chinese Traditional Medicine and Unani medicine have a long and proven history of treatment procedures, diagnosis and success with their own scientific methods. They have improved health and saved lives for centuries and officially recognised as part of the health system in many countries. Health products should also include health supplements like vitamins, minerals, herbal remedies and other natural therapies which are widely used across societies and cultures.

The proposed amendments to the definition of health products caters to the pharmaceutical industry and promotes its products.

This proposed amendment cannot be considered.

IHRRC Recommendation

None apply

2. ***Establishing WHO authority over individuals and States in health-related decision making***
Article 1 Definitions

Proposed Amendment (Bangladesh)

"standing recommendation" means ~~non-binding~~ advice issued by WHO for specific ongoing public health risks pursuant to Article 16 regarding appropriate health measures for routine or periodic application needed to prevent or reduce the international spread of disease and minimize interference with international traffic;

"temporary recommendation" means ~~non-binding~~ advice issued by WHO pursuant to Article 15 for application on a time-limited, risk-specific basis, in response to a public health emergency of international concern, so as to prevent or reduce the international spread of disease and minimize interference with international traffic;

The proposed amendment to Article 1 would seek to alter the definitions of the terms "standing recommendations" and "temporary recommendations" by removing the phrase "non-binding" from each term. This would alter the meaning of a basic concept that would fundamentally change the nature of the IHR (2005) as well as the scope and purpose of the WHO. This is consistent with the requirement later for States to consider the 'recommendations' of the DG as obligatory.

When seen together with "Article 42 Implementation of health measures" which states: "Health measures" … including the recommendations made under Article 15 and 16, shall be

initiated and completed without delay by all State Parties'. This turns the WHO advisory role into an authoritarian one.

This proposed amendment must be removed from consideration.

IHRRC Recommendation

'…given that substantial proposals were made in relation to WHO recommendations in other related articles, the proposed amendments to these definitions could be understood as aiming to change the nature of these recommendations from nonbinding to binding, and giving a binding effect to WHO recommendations and requests as proposed in other articles. That change would require a fundamental reconsideration of the nature of recommendations and the process for their adoption and implementation'. (page 26)

3. *Expanding the scope and purpose of IHR (2005)*

Article 2 Scope and purpose

Proposed Amendment (India)

The purpose and scope of these Regulations are to prevent, protect against, **prepare**, control and provide a public health response to the international spread of diseases **including through health systems readiness and resilience** in ways that are commensurate with and restricted to ~~public health risk~~ **all risks with a potential to impact public health**, and which avoid unnecessary interference with international traffic and trade, **livelihoods, human rights, and equitable access to health products and health care technologies and know how**.

The change from 'restricted to public health risk' to 'restricted to **all** risks with a **potential** to impact public health' would mean virtually anything could fall within the WHO's purview. Public health is an extremely broad term, and potential risks can be any virus, toxin, human behavioural change, article or other information source that could affect anything in this vast area.

This would give the WHO jurisdiction over anything 'potentially vaguely' pertaining to some change in health or well-being, as perceived by the DG or delegated staff. Such broad rights to interfere and take control would not normally be allowed to a government department. In this case, there is no direct oversight from a parliament representing people, and no specific legal jurisdiction to comply with. It allows the WHO DG to place himself and give recommendations which are no longer 'nonbinding' to almost anything regarding societal life (health is physical, mental and social well-being). This amendment would open the door to massive abuse beyond what the world has witnessed in the past three years.

This proposed amendment must be removed from consideration.

IHRRC Recommendation

‘The Committee considers that the proposed amendment to replace “public health” with “all risks with a potential to impact public health” may not increase the clarity of this Article’. (page 27)

4. *Removing the full respect for dignity, human rights and fundamental freedoms*

Article 3 Principles

Proposed Amendment (India)

The implementation of these Regulations shall be ~~with full respect for the dignity, human rights and fundamental freedoms of persons~~ **based on the principles of equity, inclusivity, coherence and in accordance with their common but differentiated responsibilities of the States Parties, taking into consideration their social and economic development.**

The proposed amendment is clearly the most blatant and egregious violation as Article 3 describes the core principles and intent of the IHR 2005 and the WHO Constitution. The current version of the IHR does defend the inalienable rights of people. The proposed amendment focuses on the transfer of wealth and would replace individual rights with ‘inclusivity’.

This is a fundamental change in the human rights approach of the UN including the Universal Declaration on Human Rights (UDHR) that all UN Member States have signed on. The concept of broad, fundamental rights (equal in all) is removed and replaced with vacous wording “equity, inclusivity, coherence”. Human rights (of the individual) are seen as based on “social and economic development”. This implies that the rich and poor have different rights, and there is a hierarchy of “development” that defines one’s rights.

This is a return to a feudalist and or colonialist view of human rights (in many respects the excuses used to justify slavery), that the post-war WHO and UDHR had sought to move away from.

In the proposed amendments to Parts 1 and 2 of Article 3, the repeated use of the phrase “Common but Differentiated Responsibilities and Respective Capabilities (CBDR-RC)” is used to mask what is inherently discriminatory and unequal treatment of people around the world under the guise of “equity and inclusivity”. Note that the phrase “Common but Differentiated Responsibilities and Respective Capabilities” is not defined in Article 1.

This proposal must be removed.

IHRRC Recommendation

‘The Committee strongly recommends the retention of the existing text “full respect for the dignity, human rights and fundamental freedoms of persons” as an overarching principle in the first paragraph, and notes that the concepts of human rights, dignity and fundamental freedoms are clearly defined within the framework of treaties to which many of the States Parties to the Regulations have adhered. The inclusion of human rights in Article 3 of the current International Health Regulations (2005) was a major improvement on the previous 1969 Regulations. The reference to “respect for dignity, human rights and freedoms of

persons" works not only as an overarching principle in Article 3, but also as a concrete reference point in the operationalization of all articles concerning public health response, response measures, additional health measures and recommendations'. (page 28)

5. The National IHR Focal Point: the local health police

Article 4 Responsible authorities

Proposed Amendment (The Russian Federation)

New (1bis) States Parties shall/ALT **may enact or adapt legislation to provide National IHR Focal Points with the authority and resources to perform their functions, clearly defining the tasks and function of then entity with a role of National IHR Focal Point in implementing the obligations under these Regulations.**

The proposed amendments requiring each nation or States Parties to pass laws or adapt legislation to give the National IHR Focal Point authority to implement the amendments which will remove the rights and freedoms of its citizens via the infiltration of a nation's own government agencies is akin to allowing them to police and abuse their own people.

This proposal cannot be accepted.

IHRRC Recommendation

'Another set of proposals would impose an obligation on States Parties to establish an entity responsible for the overall implementation of the Regulations, not only the "health measures" as required of the "competent authority". The institutional positioning, organization and functioning of such an authority would be a matter of sovereignty'. (page 30)

6. *Establishing a global 'pandemic' preparedness bureaucracy*

Article 5 Surveillance

Proposed Amendment (The United States)

1. Each State Party shall develop, strengthen and maintain, as soon as possible but no later than five years … the capacity to detect, assess, notify and report events

These amendments would establish a periodic review mechanism similar to the UN Human Rights Office. This will be a large drain on the resources of especially the countries of the Global South. This would require a large international bureaucracy (WHO) and a consultant base. The WHO will require regular detailed reports, send assessors to the countries and require changes. This will have implications on national sovereignty in health matters and the rational and appropriate use of resources for nation states.

The WHO is not assessing the urgent and real concerns of countries. It is assessing a narrow and specific aspect namely "pandemic events" and a country's capacity to prepare and respond to it. The WHO will dictate the resources a country will have to spend irrespective of other pressing health burdens a country faces. This is fundamentally a short-sighted approach

to public health where a country's resources are not invested in the health needs of the entire population.

This proposal must be removed.

IHRRC Recommendation

'Introducing a new obligatory review mechanism … would introduce inflexibility … the inclusion is premature'. (page 32)

'this … may be too prescriptive for countries and may not reflect their differing internal government structures, division of responsibility and resource levels', (page 36)

7. *Sensitive information from States can be shared by WHO*

Article 6 Notification

Proposed Amendment (The European Union)

<u>… the WHO shall make the information received available to all Parties in accordance with modalities to be adopted by the Health Assembly.</u>

The proposed amendments will require State Parties to make public health information available to the WHO at the WHO's request and the WHO can make available this information to other parties in a manner yet to be determined by the WHA. This removes State sovereignty over data (which had been significant prior to the 2005 IHR amendment). Such information can have significant economic and social implications. It is unlikely than powerful States will comply, but smaller nations will be left with little choice.

This proposal cannot be considered.

IHRRC Recommendation

'Finally the proposal introducing an obligation of WHO to share with all States Parties information received … in accordance with modalities to be adopted by the Health Assembly … raises questions of consistency with the scope and purpose of the Regulations'. (page 38)

8. Sharing genetic material

Article 7 Information-sharing during unexpected or unusual public health events

Proposed Amendment (The United States)

2. **<u>Following notification pursuant to Article 6 of an event caused by an infectious agent, a State Party shall make available to WHO the microbial and genetic material and samples related to the notified event, as appropriate, not later than (…) hours after such material and samples become available.</u>**

The proposed amendments states in no uncertain terms that WHO's Global Executive Emergency powers are all encompassing in a public health emergency and nations will have

no choice but to abide by them – even if sharing would result in profit making for third parties.

This was a major bone of contention with developing countries when in February 2007, Indonesia's Minister of Health declared it will no longer send further bird flu virus samples to the WHO Collaborating Centres, all of which are located in the West.

This happened when Indonesia was approached by an Australian drug company wanting to sell it a vaccine at $20 a dose (clearly unaffordable for any developing country) from the viruses that Indonesia had supplied freely to the WHO collaborating centres. The latter had been providing viruses and data on them to companies and other institutions without the permission of Indonesia.

Other developing countries had also discovered that their viruses had been used in patenting, commercial development and production of vaccines and publication of research materials without their permission or even their knowledge. This is in direct conflict with the *Convention on Biological Diversity 1993* which establishes a country's sovereign rights to its genetic resources, and prior informed consent as well as the *Nagoya Protocol 2010* on access to genetic resources and fair and equitable sharing of benefits.

The inequitable system is even more stark when it is realised that the avian flu viruses which are crucial in the R & D and manufacture of vaccines comes overwhelmingly from the Global South, where the human cases of avian influenza are located.

As well, the sharing of genetic materials in the IHR (2005) complements the Pandemic Treaty, if adopted would establish the WHO Pathogen Access and Benefit Sharing System (PABS System) for the same exact purpose raising biosafety and other security concerns.

The proposed amendments cannot be accepted.

IHRRC Recommendation

… ' requiring the sharing of samples and the transfer of genetic material to WHO may raise issues of the mandate, capabilities and liabilities of WHO. At the same time, the aspect of benefit sharing needs to be addressed in the light of provisions of the Convention on Biological Diversity and its Nagoya Protocol.' (page 39-40)

9. *WHO can share information without State Party consent*

Article 10 Verification

Proposed Amendment (The United States)

4. If the State Party does not accept the offer of collaboration **within 48 hours**, WHO ~~may~~ **shall**, when justified by the magnitude of the public health risk, **immediately** share with other States Parties the information available to it, whilst encouraging the State Party to accept the offer of collaboration by WHO, ~~taking into account the views of the State Party concerned~~.

The proposed amendments gives the WHO power to share information from a State Party or pertaining to it with other State Parties without consent. This makes WHO essentially unaccountable (beyond the WHA).

The proposed amendment must be removed.

IHRRC Recommendation

'Many of the amendments have the net effect of making this Article punitive in nature rather than genuinely collaborative'. (page 43)

10. ***The WHO can share or withhold information as it deems fit.***

Article 11 ~~Provision of information by WHO~~ **Exchange of information**

Proposed Amendment (The United States)

1. … WHO shall send to all States Parties and, as appropriate, to relevant **UN and** ~~intergovernmental~~ **international and regional** organizations, as soon as possible and by the most efficient means available, in confidence, such public health information which it has received

2. WHO shall use information received under Articles 6, ~~and~~ 8 and ~~paragraph 2 of Article~~ 9 for verification, assessment and assistance purposes under these Regulations and, unless otherwise agreed with the States Parties referred to in those provisions, shall ~~not~~ make this information generally available to other States Parties, ~~until such time as~~ **when**:

(a) the event is determined to constitute a public health emergency of international concern, **a public health emergency of regional concern, or warrants an intermediate public health alert,** in accordance with Article 12; or

(e) WHO determines it is necessary that such information be made available to other States Parties to make informed, timely risk assessments.

The change from "relevant intergovernmental" to "relevant international and regional organizations" would now include organisations **not** related to national governments. The proposed amendments would enable the WHO to share information on "events" and public health risks obtained as in Article 10, with both UN and non-governmental bodies. The changes made in paragraph 1 effectively includes all organisations not related to national governments.

As such, the WHO can share information from States Parties with "relevant international organizations". This would include "international" organisations such as CEPI, GAVI, Unitaid which have both private and corporate representation on their boards with direct financial conflicts of interest.

It also expands the criteria when the WHO can disseminate information from Sovereign States, from "PHEIC" to "health alert" (which the DG or WHO officials could apply to almost anything in practice). This could occur, as specified later in the Article when the WHO staff decide that a sovereign "State Party lacks … capacity" to handle a problem or when the

WHO staff decide (with unspecified criteria) that it is necessary to share information with others "to make timely risk assessments".

This allows unelected WHO staff, on salaries supported from external conflicted entities to disseminate information from Member States which are relevant to those entities based on their own personal assessment of risk and response, against undefined criteria.

The proposed amendments would change the text of Article 11 resulting in an absolutely unacceptable text.

IHRRC Recommendation

No recommendations apply

11. ***Widening 'public health emergency' to include any health or pathogen-related event and removing States' rights to oppose this within their jurisdictions.***

Article 12 Determination of a public health emergency of international concern ***public health emergency of regional concern, or intermediate health alert***

Proposed Amendment (The United States)

2. If the Director-General considers, based on an assessment under these Regulations, that a **potential or actual** public health emergency of international concern is occurring, the Director-General shall **notify all States Parties and seek to** consult with the State Party in whose territory the event arises regarding this preliminary determination **and may, in accordance with the procedure set forth in Article 49, seek the views of the Committee established under Article 48 (hereinafter the "Emergency Committee")**. If the Director-General **determines that the event constitutes a public health emergency of international concern,** ~~and the State Party are in agreement regarding this determination~~, the Director-General shall **notify all the States Parties**, in accordance with the procedure set forth in Article 49, seek the views of ~~the Committee established under Article 48 (hereinafter~~ the "Emergency Committee") on appropriate temporary recommendations.

~~3. If, following the consultation in paragraph 2 above, the Director-General and the State Party in whose territory the event arises do not come to a consensus within 48 hours on whether the event constitutes a public health emergency of international concern, a determination shall be made in accordance with the procedure set forth in Article 49.~~

5. If the Director-General, following consultations with the **Emergency Committee and relevant States Parties** ~~the State Party within whose territory the public health emergency of international concern has occurred~~, considers that a public health emergency of international concern has ended, the Director-General shall take a decision in accordance with the procedure set out in Article 49.

NEW (6) The Director-General, if the event is not designated as a public health emergency of international concern, based on the opinion/advice of the Emergency Committee, may designate the event as having the potential to develop into a public

health emergency of international concern, communicate this and the recommended measures to States parties in accordance with procedures set out in Article 49

New 7. A Regional Director may determine that an event constitutes a public health emergency of regional concern or issue an intermediate health alert and implement related measures to provide advice and support for capacity-building to States Parties in the region either before or after notification of the event.

New 7. In case of any engagement with non-State actors in WHO's public health response to PHEIC situation, WHO shall follow the provisions of Framework for Engagement of Non-State Actors (FENSA). Any departure from FENSA provisions shall be consistent with paragraph 73 of FENSA.

Under these proposed amendments in Article 12, the WHO DG does not need the agreement of State Parties to determine that events in their own countries (under their jurisdictions) constitute a PHEIC. They have wide implications on national sovereignty which the IHRRC has raised as well. Article 12 both reduces the threshold for the DG to declare an emergency (a "potential" outbreak should suffice) and greatly increases the power of the DG to act. The deleted paragraph 3 assures the DG can act alone.

It removes requirement for the State to agree to the release of information pertaining to the State. In other words, the WHO DG can declare a PHEIC against the wishes and instructions of the sovereign State. This inverts the relationship between the WHO and Member States. WHO which is supposed to support and serve nation states which are the ultimate repositories of power and authority within their jurisdictions now find the WHO dictating to them.

The Emergency Committee can give its opinion or advice but the DG is not bound by it. The DG can act completely on his own to determine and declare a PHEIC – which can have immense social and economic consequences and is allowed to abrogate basic human rights norms. These similar powers appear to be granted to the Regional Directors, though the full implications are unclear.

The fact that an 'actual PHEIC is occurring' or the 'event' has 'a potential to become a PHEIC', the DG shall issue 'temporary recommendations in accordance with procedure set out in Article 49'. Read with Article 15 Temporary recommendations 'such temporary recommendations may be modified or extended as appropriate, including after it has been determined that a public health emergency of international concern has ended, at which time other temporary recommendations may be issued as necessary for the purpose of preventing or promptly detecting its recurrence'. This means the potential PHEIC can go on virtually forever.

The WHO Framework for Engagement of Non-State Actors (FENSA) allows the DG 'to exercise flexibility in the application of the procedures of FENSA' in the case of a health emergency.

The proposed amendments must be removed from consideration.

IHRRC Recommendation

'Proposed amendments in paragraph 2 dilute the consultation requirements with the State Party in whose territory the event occurs, by removing the obligation of the Director-General to convene an Emergency Committee, and by removing the agreement between the Director-General and the State Party. It is unclear what the purpose is of the proposed amendments to eliminate the consultation with the State Party in whose territory the event occurs. … Excluding this consultative step can result in sovereignty concerns from the State Party in whose territory the event occurs'.

12. ***WHO takes charge of new global public health order***

NEW Article 13A WHO Led International Public Health Response

Proposed Amendment (Bangladesh)

1. States Parties recognize WHO as the guidance and coordinating authority of international public health response during public health Emergency of International Concern and undertake to follow WHO's recommendations in their international public health response.

4. Upon request of WHO, States Parties with the production capacities shall undertake measures to scale up production of health products, including through diversification of production, technology transfer and capacity building especially in the developing countries.

5. Upon request of WHO, States Parties shall ensure the manufacturers within their territory supply the requested quantity of the health products to WHO or other States Parties as directed by WHO in a timely manner in order to ensure effective implementation of the allocation plan.

7. [WHO] shall collaborate with other international organizations, and other stakeholders consistent with the provisions of FENSA, for responding to public health emergency of international concern.

The proposed amendments require State Parties to abide by the WHO recommendations in a PHEIC, declared by the WHO DG who is open to extensive influence from private and corporate largesse. The criteria for a PHEIC are deliberately vague and at the discretion of the DG, which clearly abrogates state sovereignty. States are required to submit to an external authority, whenever that authority wills it, as the DG can pronounce a PHEIC on the grounds of just perceiving the potential for an infectious disease event.

WHO's COVID-19 response including negating its own guidelines and policies should give pause for thought. The WHO could mandate forced medication, vaccination, and or testing thus ending the right of states to protect the bodily autonomy of their citizens. It could instruct countries to scale-up production of certain products to interfere with markets and commerce at the WHO's (DG's) discretion. WHO can collaborate with non-state actors that is private individuals, Foundations, and private corporations like Big Pharma and its sponsors.

FENSA which restricts such contacts can be varied by the DG in a 'health emergency' the DG declares.

The authority given to the DG would directly conflict with the sovereign authority of the 194 Member States and the fundamental freedoms of all people.

This proposed amendment cannot be considered.

IHRRC Recommendation

'The Article goes further, however, in attributing to WHO several obligations that it does not currently have under the International Health Regulations (2005), including to conduct an assessment of availability and affordability of "health products"; to develop an allocation and prioritization plan in the event that such an assessment reveals shortages in supply; and to direct States Parties to increase and diversify production and distributive functions for health products within individual states' (page 54-55).

'This proposal also renders mandatory the temporary and standing recommendations addressed under Articles 15 and 16. The State Party making this proposal has also provided corresponding proposals to change the definitions of temporary and standing recommendations under Article 1' (page 55).

'More fundamentally, it remains unclear how WHO could discharge the unprecedented set of new responsibilities attributed to it relating to health products and know-how under this proposed amendment, as these may arguably exceed its constitutional mandate. In order to be legally feasible, this amendment will require coherence with State Parties' relevant national laws and other international obligations.' (page 55).

13. ***The WHO can require States to provide resources, intellectual property, and know-how***

New Article 13A: Access to Health Products, Technologies and Know-How for Public Health Response

Proposed Amendment (The WHO African Region Member States)

2. States Parties shall co-operate with each other and WHO to comply with such recommendations pursuant to paragraph 1 and shall take measures to ensure timely availability and affordability of required health products such as diagnostics, therapeutics, vaccines, and other medical devices required for the effective response to a public health emergency of international concern.

3. States Parties shall provide, in their intellectual property laws and related laws and regulations, exemptions and limitations to the exclusive rights of intellectual property holders to facilitate the manufacture, export and import of the required health products, including their materials and components.

4. States Parties shall use or assign to potential manufacturers, especially from developing countries, on a non-exclusive basis, the rights over health product(s) or technology(ies),

5. Upon request of a State Party, other States Parties or WHO shall rapidly cooperate and share relevant regulatory dossiers submitted by manufacturers concerning safety and efficacy, and manufacturing and quality control processes, within 30 days.

6. WHO shall

> **c) develop appropriate regulatory guidelines for the rapid approval of health products of quality including development of immunogenicity co-relative protection (ICP) for vaccines,**
>
> **d) establish a database of raw materials and their potential suppliers,**
>
> **e) establish a repository for cell-lines to accelerate the production and regulatory of similar biotherapeutics products and vaccines,**

7. The States Parties shall take measures to ensure that the activities of non-state actors, especially the manufacturers and those claiming associated intellectual property rights, do not conflict with the right to the highest attainable standard of health and these Regulations and are in compliance with measures taken by the WHO and the States Parties under this provision, which includes:

> **a) to comply with WHO recommended measures including allocation mechanism made pursuant to paragraph 1.**
>
> **b) to donate a certain percentage of their production at the request of WHO.**
>
> **c) to publish the pricing policy transparently.**
>
> **d) to share the technologies, know-how for the diversification of production.**
>
> **e) to deposit cell-lines or share other details required by WHO repositories or database established pursuant to paragraph 5.**
>
> **f) to submit regulatory dossiers concerning safety and efficacy, and manufacturing and quality control processes, when called for by the States Parties or WHO.**

The above amendments to New Article 13A gives power to the WHO to determine the required response from States within their borders. States are required to provide aid to other Member States at the WHO's behest. States shall change their intellectual property (IP) laws to allow sharing of IP on the DG's determination of a PHEIC, at the latter's discretion.

The WHO can require IP to be shared with other States, thereby IP is passed to private corporations within those States. States Parties are required to release confidential regulatory dossiers to other States including the WHO.

The WHO shall create a database of 'raw materials and repository for cell lines'. This extends WHO's role into an area it was not mandated to do. It is not stated under what laws and regulatory requirements this would be achieved neither who would be responsible and accountable for any damage or harm should this occur.

The powers and authority granted to the DG are without precedent. The WHO can require any State to release any confidential product and IP on any product related to the health sector. The WHO and the DG can declare an emergency event, then require a State to contribute resources; give up sole rights to IP of its citizens; and share information to allow others to manufacture their citizen's products in direct competition.

To understand the sweep of IP rights to be forfeited to the DG it is pertinent to refer to Article 1 which defines as

"health technologies and know-how" includes organized set or combination of knowledge, skills, health products, procedures, databases and systems developed to solve a health problem and improve quality of life, including those relating to development or manufacture of health products or their combination, its application or usage. "Health technologies" are interchangeably used as "health care technologies".

New Article 13A would also empower the WHO to craft an 'Allocation Plan' to mandate the manufacturing, donation and distribution of various pandemic response products. If the amendments were to be adopted, the WHO would effectively be placed in control of the means of production of any and all nations globally. Upon the dictate of the WHO, sovereign nations would be obligated to ensure the manufacturers within their borders gear up production and donate their products as directed by the WHO.

These amendments cannot be accepted.

IHRRC Recommendation

'WHO recommendations, as currently stated under Articles 15 and 16, were not envisioned for the purposes of establishing a medicines allocation mechanism or otherwise directing States Parties on the increasing access to health products'. (page 52)

'The Committee has concerns regarding the proposal in paragraph 1 to use Article 15 (temporary recommendations) for the purposes of establishing an "allocation mechanism". Temporary recommendations, as defined under Article 1, are 'non-binding advice and do not authorize WHO to direct States…. A different mode of authority may be required to establish an allocation mechanism…. It is unclear to the Committee what it means to comply with non-binding recommendations as per Articles 15 or 16' (page 53).

14. *WHO claims control of individuals and their rights within States if proposals are mandated.*

Article 18 Recommendations with respect to persons, baggage, cargo, containers, conveyances, goods and postal parcels

1. Recommendations issued by WHO to States Parties with respect to persons may include the following advice:

- no specific health measures are advised;
- review travel history in affected areas;
- review proof of medical examination and any laboratory analysis;
- require medical examinations;
- review proof of vaccination or other prophylaxis;
- require vaccination or other prophylaxis;
- place suspect persons under public health observation;
- implement quarantine or other health measures for suspect persons;
- implement isolation and treatment where necessary of affected persons;
- implement tracing of contacts of suspect or affected persons;
- refuse entry of suspect and affected persons;
- refuse entry of unaffected persons to affected areas; and
- implement exit screening and/or restrictions on persons from affected areas.
- ensure mechanisms to develop and apply a traveller's health declaration in international public health emergency of international concern (PHEIC) to provide better information about travel itinerary, possible symptoms that could be manifested or any prevention measures that have been complied with such as facilitation of contact tracing, if necessary

The current version of the IHR (2005) contains sample recommendations that are non-binding. These could be made legally binding if the proposed amendments are adopted. The WHO will now be able to order States to incarcerate their citizens, inject them, require identification of medical status, medically examine, isolate and restrict travel.

The proposed amendments also seek to create mechanisms to develop and apply a 'traveller's Health Declaration' that would require personal information about a person's travel itinerary, possible symptoms and any prevention measures that had been complied with in order to facilitate contact tracing.

It also appears to make it mandatory for countries to allow foreign 'health care workers' to enter their countries.

The draconian measures if adopted are unacceptable. The proposals must be rejected if they are made mandatory.

IHRRC Recommendation

None Apply

15. ***Digital Locator Forms to track individuals***

Article 23 Health measures on arrival and departure

Proposed Amendment (The European Union)

New 6. Documents containing information concerning traveller's destination (hereinafter Passenger Locator Forms, PLFs) should preferably be produced in digital form, with paper form as a residual option. Such information should not duplicate the information the traveller already submitted in relation to the same journey, provided the competence authority can have access to it for the purpose of contact tracing.

The “Passenger Locator Forms” is to facilitate the tracking and tracing of individuals. The text is aimed at future requirements for vaccine passports for travel.

This proposal cannot be accepted.

IHRRC Recommendation

‘Regarding the proposal to introduce the possibility of health documents to include information related to laboratory tests, … However, given that Article 23 applies to all situations, not only PHEICs, the Committee is concerned that such a requirement may overburden travellers, and may even raise ethical and discrimination-related concerns’. (page 62)

16. ***States authorised to violate rights of citizens from other nations***

Article 35 General rule

Proposed Amendment (European Union)

Digital health documents must incorporate means to verify their authenticity via retrieval from an official web site, such as a QR code.

Health documents meeting the conditions approved by the Health Assembly shall be recognized and accepted by all Parties.

A person’s inalienable right to privacy, especially with regards to health issues would be clearly violated by the digitalisation of medical records and an ever-increasing assault on bodily autonomy. This further presages digital IDs containing health information, that must be available to enable a person to travel.

This proposed amendment must be rejected.

IHRRC Recommendation

‘This article states that, as a general rule, no health documents, other than those provided for under the Regulations or in recommendation issued by the WHO shall be required in international traffic’.

‘some aspects of the proposals seem internally inconsistent’.

‘Introducing an obligation for States Parties to recognize the health documents of other State Parties may pose many practical difficulties, especially considering that domestic legislation concerning privacy and personal information protection differs from one State Party to the next.

Another concern, depending on how the amendments are implemented, is the appropriate level of protection of personal data under the applicable regional and international instruments’. (page 66)

17. *Global Digital Health Certificates*

Article 36 Certificates of vaccination or other prophylaxis

Proposed Amendment (The European Union)

Such proofs may include test certificates and recovery certificates. These certificates may be designed and approved by the Health Assembly according to the provisions set out for digital vaccination or prophylaxis certificates, and should be deemed as substitutes for, or be complementary to, the digital or paper certificates of vaccination or prophylaxis.

The assumption that vague and undefined test certificates, recovery certificates, vaccination certificates and or prophylaxis certificates often "proof" of safety on any level is deeply flawed and is merely designed to define and enforce compliance.

The proposed amendment cannot be accepted.

IHRRC Recommendation

'It is unclear how the specifications and requirements for such "other types of proofs and certificates" would be formulated and by whom, since the proposal only mentions a possibility for the Health Assembly to design and approve such certificates. It is also unclear whether "substitutes for" and "complementary to" are to be used interchangeably. This matters because the meaning is different'. (page 67)

18. *Recommendations would become legally binding orders*

Article 42 Implementation of health measures

Proposed Amendment (Malaysia)

Health measures taken pursuant to these Regulations, **including the recommendations made under Article 15 and 16, shall be initiated and completed without delay by all State Parties,**

This amendment along with the Amendment to Article 1 would dramatically alter the balance of power and sovereignty in the world by changing the nature of the WHO from an advisory body to an organisation that exerts control over Nation states.

This proposal cannot be accepted.

IHHRC Recommendation

The proposed amendment to include a reference to temporary and standing recommendations seems to make application of these recommendations obligatory … The Committee is concerned that the proposed amendment goes too far in implying that States Parties must oblige, through legislation or other regulatory measures, non-State actors to comply with measures under the Regulations. While the reference to compliance by non-State actors

strengthens the spirit of Article 42, there may be feasibility limits due to the regulatory powers of States under national and international law'. (page 67)

19. ***The WHO empowered to order changes within States.***

Article 43 Additional health measures

Proposed Amendment (The WHO African Region Member States)

Measures implemented by States shall not be more restrictive of … would ~~achieve~~ attain the ~~appropriate~~ **highest achievable** level of health protection.

WHO ~~may request that~~ **shall make recommendations to** the State Party concerned ~~reconsider~~ **to modify or rescind** the application of the **additional health** measures

6. ~~A State Party implementing a health measure pursuant to paragraph 1 or 2 of this Article shall within three months review such a measure taking into account the advice of WHO and the criteria in paragraph 2 of this Article.~~ **Recommendations made pursuant to paragraph 4 of this Article shall be implemented by the State Party concerned within two weeks from the date of recommendation. State Party concerned may approach WHO, within 7 days from the date of recommendations made under paragraph 4 of this Article, to reconsider such recommendations. Emergency Committee shall dispose the request for reconsideration within 7 days and the decision made on the request for reconsideration shall be final. The State Party concerned shall report to the implementation committee established under Article 53A on the implementation of the decision.**

The proposed changes to Article 43 are highly significant. The word 'Appropriate' which was deleted meant taking into account the costs and balancing these against potential gains. This is a sensible approach that takes the whole of society and the needs of the population into account which is good public health.

Whereas the phrase "highest achievable level of protection" which was put in place means elevating the problem of an infectious disease or potential disease above all other health and human-societal concerns. The changes made here reflects a poor understanding of public health.

The proposals give the WHO overriding power and authority to intervene in health measures implemented at the national level, with the Emergency Committee having the final authority to decide on the appropriateness of health measures and whose decision is final.

This proposed amendment must be rejected.

IHRRC Recommendation

'This Committee is concerned that these proposals may unduly impinge on the sovereignty of States Parties and give binding effects to what are supposed to be recommendations'. (page 68)

20. ***Control of information and free speech***

Article 44 Collaboration and assistance

Proposed amendment (The Russian Federation and the WHO African Region Member States)

1. States Parties shall ~~undertake~~ to collaborate with **and assist** each other, **in particular developing counties States Parties, upon request,** ~~to the extent possible~~, in:

> (i) (d) the formulation of proposed laws and other legal and administrative provisions for the implementation of these Regulations.
>
> (h) **(new)in countering the dissemination of false and unreliable information about public health events, preventive and anti-epidemic measures and activities in the media, social networks and other ways of disseminating such information**

Paragraph 1 of the proposed amendments effectively removes sovereignty from Member Nations. Nations should collaborate and assist each other in solidarity but to change the language into an obligation is a violation of national sovereignty. And what will be the relationship of the WHO in the process: will it facilitate or will it dictate?

Under the proposed amendments States will work with the WHO to control information and limit free speech. States also agree to pass laws to implement restrictions on free speech and sharing information. The WHO will work with countries to control free speech and the flow of information based on their own criteria of what is true and fake. Differing opinions will be censored under the guise of misinformation or disinformation.

This proposal is dangerous and must be rejected.

IHRRC Recommendation

Under the section on general considerations regarding the proposed amendments, the IHRRC suggests that 'A balanced is needed between ensuring more accurate scientific information on one hand and freedom of speech and the press on the other … The Committee also suggests that the Working Group on Amendments to the International Health Regulations (2005) might consider how misinformation and disinformation may relate to obligations for WHO to verify information coming from sources other than State Parties'. (page 21)

21. ***Funding for developing countries***

New Article 44A - Financial Mechanism for Equity in Health Emergency Preparedness and Response

Proposed Amendment (The WHO African Region Member States)

1. A mechanism shall be established for providing the financial resources on a grant or concessional basis to developing countries.

2. The WHA shall make arrangements to implement the above-mentioned provisions, within 24 months of the adoption of this provision,

There is no discussion of the amount to be raised nor any details as to the method the distribution of financial resources would be determined. There are no details concerning controls and metrics to guide, determine and ensure beneficial results. The amendments also state that the details of the financing mechanism would not be decided until 24 months after the adoption of the amendments to the IHR (2005). This can be a recipe for abuse and corruption as massive amounts of funding would be involved.

The proposal needs clarity to be considered.

IHRRC Recommendation

'The Committee notes a divergence of views as to whether WHO has a financing function … The Committee … cautions against creating an explicit financing function for WHO under the Regulations'. (page 71)

22. ***A new bureaucracy to ensure countries follow WHO dictates***

NEW Chapter IV (Article 53 bis-quater): The Compliance Committee
53 bis Terms of reference and composition

Proposed Amendment (The United States)

1. The State Parties shall establish a Compliance Committee that shall be responsible for:

(a) Considering information submitted to it by WHO and States Parties relating to compliance with obligations under these Regulations;

(b) Monitoring, advising on, and/or facilitating assistance on matters relating to compliance with a view to assisting States Parties to comply with obligations under these Regulations;

(c) Promoting compliance by addressing concerns raised by States Parties regarding implementation of, and compliance with, obligations under these Regulations; and

(d) Submitting an annual report to each Health Assembly describing:

(i) The work of the Compliance Committee during the reporting period;

(ii) The concerns regarding non-compliance during the reporting period;

and

(iii) Any conclusions and recommendations of the Committee.

2. The Compliance Committee shall be authorized to:

(a) Request further information on matters under its consideration;

(b) Undertake, with the consent of any State Party concerned, information gathering in the territory of that State Party;

(c) Consider any relevant information submitted to it;

(d) Seek the services of experts and advisers, including representatives of NGOs or members of the public, as appropriate; and

(e) Make recommendations to a State Party concerned and/or WHO regarding how the State Party may improve compliance and any recommended technical assistance and financial support.

3. The Members of the Compliance Committee shall be appointed by States Parties from each Region, comprising six government experts from each Region. The Compliance Committee shall be appointed for four-year terms and meet three times per year.

This New Chapter IV sets up the permanent review mechanism to monitor the compliance of States with the WHO's dictates on 'public health'. This is a huge centralised bureaucracy (WHO) and which would impose a significant drain on the resources of each State. This Compliance Committee also reflects the review mechanism of the UN Human Rights Office.

The proposed amendments must be rejected.

IHRRC Recommendation

'… the proposal to establish a "compliance committee' seems to give significant powers to 36 appointed government experts, without clearly explaining the rules under which such a committee would function, … In addition the Committee notes that the potential power given to the "compliance committee" proposed in Article 53 bis – quater, to freely gather and use information is far reaching' (page 76).

23. ***WHO wants States to provide more to WHO's work and restricts population to question this work***

ANNEX 1

A. CORE CAPACITY REQUIREMENTS FOR **DISEASE DETECTION,** SURVEILLANCE AND **HEALTH EMERGENCY** RESPONSE

Proposed Amendment (Bangladesh)

New 1 bis. Developed Countries States parties shall provide financial and technological assistance to the Developing Countries States Parties in order to ensure state-of-the-art facilities in developing countries States Parties, including through international financial mechanism as envisaged in Article 44.

New 7. At the Global level, WHO shall strengthen capacities to:

e. Counter misinformation and disinformation

The proposed amendments constitute a considerable extension of Member States duties which will impose increasing burdens especially on countries of the Global South.

States would be obligated to provide aid funding to help other States develop capacity. An enormous amount of obligations are being placed on nations to build infrastructure to treat an unknown problem that has no valid metrics by which its effectiveness in prevention or preparedness can possibly be measured.

This has a clear opportunity cost in other disease-societal programmes where funding must accordingly be reduced. However, this will no longer be within the budgetary control of Member States but required by the WHO an external entity.

As shown earlier WHO plays the role of policing and countering free speech and exchange of information. This will be funded by the taxes of those whose speech they are suppressing.

The proposed amendments cannot be considered.

IHRRC Recommendation

'A number of the proposed amendments to Annex I represent a potentially significant expansion in the nature and scope of the obligations' (page 34).

A number of proposals would extend States Parties' capacity requirements beyond surveillance to include, for example: infrastructure; personnel; technologies and access to health care products; health information systems; coordinating mechanisms; epidemiological intelligence; research; the manufacture and deployment of medical countermeasures; and sustainable financing' (page 79).

'Annex 1 covers States Parties' legal obligations and is limited to core public health capacities, rather than all health systems … including the proposed requirements in Annex 1 may raise feasibility challenges. For example, not all States Parties may be able to assume responsibility for the "supply of affordable health care products". Some States Parties will have difficulty reporting and reviewing within the time frame specified … given their level of development … Moreover, some requirements may be feasible for States Parties at the national level, but unfeasible at subnational levels where resources may be insufficient (page 79-80).

VII. CAP Proposals

CAP calls on the government to:

National

- Immediately REJECT the amendments to the five Articles (55, 59, 61, 62, 63) of the International Health Regulations (2005), which were adopted by the 75th World Health Assembly in May 2022. This was accomplished in breach of Article 55 of the IHR (2005).

- Under Article 61 of the IHR (2005) each and every nation including Malaysia has the authority to reject any or all the amendments but they must do so before late November 2023.

- Unless rejected before late November 2023 the amendments to the five Articles will automatically become international law. No signature by the Prime Minister and no approval by Parliament is required.

- Call for a Parliamentary sitting to discuss the WHO Amendments to the International Health Regulations (2005), the 'Pandemic Treaty' and its implications for Malaysia.

- REJECT the Amendments to the International Health Regulations (2005) when they will be voted on and adopted at the 77th World Health Assembly in May 2024. Adoption of the Amendments only require a simple majority of 98 countries.

- Initiate a thorough enquiry on the government's management of the SARS-CoV-2 pandemic and its response to the COVID-19 crisis and their impact on the lives of Malaysians and their families, and livelihoods, and continue to have on their health and existence.

- Thoroughly review and evaluate the government's management and response to the COVID-19 pandemic in light of its legal duties and responsibilities to protect the dignity, human rights, fundamental freedoms of Malaysians: i.e. the principle of informed consent; the right to access safe and effective drugs; the right to bodily autonomy; the right not to be subjected without free consent to experimental 'vaccines'; and the right to livelihood.

- Thoroughly review and evaluate the structural problems in the Ministry of Health and its management and response to the COVID-19 pandemic, which should include the existing implementation (or absence) of an effective system to monitor, record and analyse adverse reactions and deaths as a result of the experimental 'vaccines' in the population; the mitigation strategies taken and treatment protocols instituted for the injured 'vaccinees'; and the registry (or absence thereof) of post mortems conducted to ascertain and analyse 'vaccine' injuries and their extent.

- Release the data on the incidence of diseases and deaths above expected levels (or excess deaths) for the last three years 2021-2023, which the Government of Malaysia/Ministry of Health is obligated to report to the WHO in accordance with the IHR (2005).

- Institute a transparent and accountable process and mechanism where the government through its officials in the various Ministries currently involved in the negotiations of the two international instruments will inform the public and relevant stakeholders e.g. health and consumer bodies, human rights groups, the Bar Council and the mass media on the progress and positions taken by them on behalf of the people of Malaysia and the government in the negotiations.

- Release the names of the officials (and their affiliations) who are involved in the IHR (2005) and Pandemic Treaty negotiations so that they can be accessible to the public and their elected representatives to receive comments and inputs. Malaysia's delegation to the WHA has a critical and heavy responsibility and duty, who have been given the task to speak and negotiate on behalf of the people and the nation and to decide its fate, despite being unelected, unaccountable, and inaccessible. There needs to be a transparent and accountable process and mechanism available for the public to contact their country delegates to express their positions on the matter.

- Enact laws to prevent any decision-making power that can override national democratic institutions to be handed to any supranational body.

- Enact laws to protect the principle of informed consent, the inviolable doctor-patient relationship, and the right of patients to decide on individual medical treatment based on the clinical judgement and advice of their chosen doctor and informed consent.

- Give legal protection to the repurposing of safe off-patent drugs and substances and its sale despite the vested interests of Pharma and captured health agencies to curtail its use.

International

- Request the WHO to initiate a thorough review and evaluation of its management of the SARS-CoV-2 pandemic in the last three years; WHO and Member States failure to comply with existing legal obligations under the IHR (2005) and international human rights law, in their responses to the COVID-19 pandemic and their effects on human lives and livelihoods.

(ends)

Tuan Mohideen Abdul Kader
President
Consumers' Association of Penang

References

1. AGENCE FRANCE-PRESSE, 'WHO, UNICEF, Gates in major push for declining child vaccination' April 25, 2023 https://www.dailysabah.com/life/health/who-unicef-gates-in-major-push-for-declining-child-vaccination

2. Alma Ata Declaration https://cdn.who.int/media/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167_2

3. Ashley Sadler, 'Big Tech, world leaders are quietly preparing digital IDs to monitor, crush freedom fighters around the globe'. *LifeSite News*, March 2, 2022. https://www.lifesitenews.com/blogs/in-the-wake-of-covid-jab-passports-digital-ids-could-usher-in-chinese-style-social-credit-system/

4. Bill & Melinda Gates Foundation, 'Bill Gates Challenges Global Leaders at 64th World Health Assembly: Make Vaccines a Priority to Save 10 Million Lives'. Press Release. https://www.gatesfoundation.org/ideas/media-center/press-releases/2011/05/bill-gates-challenges-global-leaders-at-64th-world-health-assembly-make-vaccines-a-priority-to-save-10-million-lives

5. Constitution of The World Health Organization https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1

6. David Bell, 'What the WHO Is Actually Proposing', *Brownstone Institute*, March 3, 2023 https://brownstone.org/articles/what-the-who-is-actually-proposing/

7. David Bell. 'Amendments to WHO's International Health Regulations: An Annotated Guide', *Brownstone Institute*, February 1, 2023. https://brownstone.org/articles/amendments-who-ihr-annotated-guide/

8. David Solway, 'Canada: the World's Most Comfortable Gulag', *The Pipeline*, 7 May, 2022. https://the-pipeline.org/canada-the-worlds-most-comfortable-gulag/

9. Deborah Cohen and Philip Carter, 'WHO and the pandemic flu "conspiracies" ', *BMJ* 2010;340:c2912 https://www.bmj.com/content/340/bmj.c2912

10. Derrick Broze, 'Exposing The "Digital ID is A Human Right" Scam'. *The Last American Vagabond*, May 13, 2022. https://www.thelastamericanvagabond.com/exposing-digital-id-human-right-scam/

11. Derrick Broze, 'Technocracy in Action: WHO and European Commission Partner For "Digital Health" With New COVID-19 Digital Certificate', *The Last American Vagabond*, June 7, 2023 https://www.thelastamericanvagabond.com/who-eu-digital-health/

12. Dr Tess Lawrie 'The planning is still occurring in plain sight', *Substack* April 11, 2023. https://drtesslawrie.substack.com/p/the-planning-is-still-occurring-in

13. Dr. Silvia Behrendt and Dr. Amrei Muller, 'The far-reaching US proposals to amend the International Health Regulations at the upcoming 75th World Health Assembly: A call for attention'. *European Journal of International Law* https://www.ejiltalk.org/the-far-reaching-us-proposals-to-amend-the-international-health-regulations-at-the-upcoming-75th-world-health-assembly-a-call-for-attention/

14. Dr. Silvia Behrendt, and Dr Amrei Muller, 'Why the rush? A call for critical reflection on the legal and human rights implications of a potential new international treaty on pandemics' *ejiltalk.org* July 29, 2021 https://www.ejiltalk.org/why-the-rush-a-call-for-critical-reflection-on-the-legal-and-human-rights-implications-of-a-potential-new-international-treaty-on-pandemics/

15. Euzebiusz Jamrozik, 'Public health ethics: critiques of the "new normal" ', *Monash Bioethics Review* (2022) 40:1-16. https://doi.org/10.1007/s40592-022-00163-7 https://link.springer.com/article/10.1007/s40592-022-00163-7#citeas

16. F. William Engdahl, 'Can We Trust the WHO?' *Land Destroyer Report*, April 4, 2020.

17. Hansard (UK Parliament), 'Pandemic Prevention, Preparedness and Response: International Agreement. Volume 731: debated on Monday 17 April 2023 https://hansard.parliament.uk/commons/2023-04-17/debates/12BE683F-A25C-46E5-9FE9-B9C12CCDA9B7/PandemicPreventionPreparednessAndResponseInternationalAgreement

18. Jacob Nordangard, 'What's Next to the Moon? – An Apex Body and Digital ID to rule us all'. *Truth comes to Light*, June 10, 2023. https://truthcomestolight.com/whats-next-to-the-moon-an-apex-body-and-digital-id-to-rule-us-all/

19. James Corbett, 'CBDC: A Country-by-Country Guide' *The Corbett Report*, May 16, 2022. https://www.corbettreport.com/cbdcs-a-country-by-country-guide/

20. James Roguski, 'Openly Plotting To Break The Rules', *Substack* October 18, 2023. https://jamesroguski.substack.com/p/openly-plotting-to-break-the-rules

21. James Roguski, 'Reject Digital Enslavement', *Substack* Mar 8, 2023 https://jamesroguski.substack.com/p/reject-digital-enslavement

22. James Roguski, 'Silence Procedure', *Substack* March 9, 2023. https://jamesroguski.substack.com/p/silence-procedure

23. James Roguski, 'We Won', *Substack* May 29, 2022. https://jamesroguski.substack.com/p/we-won

24. James Roguski, '50 Really Bad Amendments' *Substack* 20 Feb 2023. https://jamesroguski.substack.com/p/50-really-bad-amendments?utm_source=substack&publication_id=746475&post_id=103695755&utm_medium=email&utm_content=share&isFreemail=true

25. James Roguski, 'A Simplified Guide To: The amendments to Article 55, 59, 61, 62 and 63 of the International Health Regulations that were adopted by the 75th World Health Assembly on May 27, 2022. The proposed amendments to the International Health Regulations (2023). The Zero Draft of the proposed WHO CA+ which is commonly referred to as the "Pandemic Treaty" or "Pandemic Accord" ', *Substack*, April 9, 2023.

26. Martin Khor and Sangeeta Shashikant, ' "Sharing" of avian flu virus to be a major issue at WHA', *SUNS#6247*, 8 May 2007.

27. Martin Khor, 'Indonesia to share bird-flu samples only if there is new system', *SUNS#6195*, 21 February 2007.

28. Merly Nass, 'The WHO will ignore its own rules and refuse to share the finalized IHR Amendments with the public and member states 4 months before the vote in May 2024: CHD-TV', *Substack* October 10 2023 https://merylnass.substack.com/p/the-who-will-ignore-its-own-rules?utm_source=profile&utm_medium=reader2

29. Meryl Nass, '3 things I want to emphasize about the WHO's proposed IHR Amendments', *Substack* 28 Dec 2022 https://merylnass.substack.com/p/3-things-i-want-to-emphasize-about

30. Meryl Nass, 'Sir Jeremy Farrar helped Fauci cover up the origin of COVID, was central in the Recovery and Solidarity trials that overdosed 2600 patients with hydroxychloroquine, now heads to WHO for world take over', *Substack* 21 Feb 2023. https://merylnass.substack.com/p/sir-jeremy-farrar-helped-fauci-cover

31. Meryl Nass, 'WHO, Gro Brundtland, the Plan to leave no one unjabbed using untested 100 day vaccines, and how portable vaccine factories will allow the entire human herd to be jabbed simultaneously…but with what?, *Substack*, 17 Apr. 2023. https://merylnass.substack.com/p/who-gro-brundtland-the-plan-to-leave

32. Meryl Nass, 'Would you trust WHO to manage your pandemic?', *Substack* 29 Dec 2022. https://merylnass.substack.com/p/would-you-trust-who-to-manage-your

33. Michael Nevradakis, 'Death Sentence for Millions': WHO, EU Launch New Global Vaccine Passports Initiative', *the Defender*, June 6, 2023 https://childrenshealthdefense.org/defender/who-eu-global-vaccine-passport-initiative/

34. Michael Nevradakis, 'Exclusive: WHO Proposals Could Strip Nations of Their Sovereignty, Create Worldwide Totalitarian State, Expert Warns', *the Defender*, January 13, 2023 https://childrenshealthdefense.org/defender/who-proposals-sovereignty-totalitarian-state/

35. Michael Nevradakis, 'Is WHO a Front Organization for the Takeover of U.S. Government?', *the Defender*, 9 May 2023 https://childrenshealthdefense.org/defender/who-takeover-us-government/

36. Michele Greenstein and Jeremy Loffredo 'Why the Bill Gates global health empire promises more empire and less public health', *The Gray Zone*, July 8,2020. https://thegrayzone.com/2020/07/08/bill-gates-global-health-policy/

37. Molly Kingsley, 'The Most Dangerous International Treaty Ever Proposed', *Brownstone Institute*, March 29, 2023 https://brownstone.org/articles/most-dangerous-international-treaty-ever-proposed/

38. Paul Frijters, Gigi Foster, Michael Baker, 'WHO Wants To Run the World?', *Brownstone Institute*, July 11, 2022. https://brownstone.org/articles/who-wants-to-run-the-world/

39. Paula Jardine, 'How Big Pharma sold vaccines to the world – Part I', *TCW Defending Freedom*, April 12, 2023 https://www.conservativewoman.co.uk/how-big-pharma-sold-vaccines-to-the-world-part-1/

40. Rhoda Wilson, 'Drs Silvia Berendt and Astrid Stuckelberger: GAVI, Gates, The WHO an International Health Regulations', *The Expose* Feb 19, 2022. https://expose-news.com/2022/02/19/gavi-gates-who-international-health-regulations/

41. Richard Gale and Dr Gary Null, 'Hell No to the WHO Pandemic Treaty', November 4, 2022. https://www.globalresearch.ca/hell-no-who-pandemic-treaty/5798100

42. Ron Law, 'WHO Changed Definition of Influenza Pandemic', https://www.bmj.com/rapid-response/2011/11/02/who-changed-definition-influenza-pandemic

43. Sam Husseini, 'Farrar, Key Covid Origins Propagandist, is Set to Be Head Scientist for the WHO as it Attempts "Power Grab" ', *Substack* 21 Feb. 2023. https://husseini.substack.com/p/farrar-key-covid-origins-propagandist

44. Silvia Behrendt and Dr. Amrei Muller, The Proposed Amendments to the International Health Regulations: An Analysis. *OpinioJuris.org* February 27,2023, http://opiniojuris.org/2023/02/27/the-proposed-amendments-to-the-international-health-regulations-an-analysis/

45. Stefan Anderson 'WHO Declares End to Mpox Global Health Emergency' *Health Policy Watch*, 11/5/2023 https://healthpolicy-watch.news/who-declares-end-to-mpox-global-health-emergency/#:~:text=The%20World%20Health%20Organization%20(WHO,deal%20with%20concurrent%20global%20pandemics.

46. The European Commission, 'Digital Health: Commission and WHO launch landmark digital health initiative to strengthen global health security', Press release 5 June 2023.

47. Thomas Fazi, 'How the WHO was captured', *UnHerd*, March 6, 2023. https://unherd.com/2023/03/how-the-who-was-captured/

48. USFORTHEM The WHO Pandemic Trety and IHR Amendments. Briefing Paper file:///D:/Downloads/https___usforthem.co.uk_wp-content_uploads_2023_05_03.05.23-WHO-Briefing-Note%20(3).pdf

49. Ventegodt S. 'Why the Corruption of the World Health Organization (WHO) is the Biggest Threat to the World's Public Health of Our Time'. *J Integrative Med Ther*. 2015;2(1): 5.

50. WHO (2022) Strengthening WHO preparedness for and response to health emergencies. Proposal for amendments to the International Health Regulations (2005) Draft resolution proposed by Australia, Bosnia and Herzegovina, Columbia, European Union and its Member States, Japan, Monaco, Republic of Korea, United Kingdom of Great Britain and Northern Ireland and United States of America. A75/A/CONF./7 Rev.1 27 May 2022 https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_ACONF7Rev1-en.pdf

51. WHO (2022). Strengthening WHO preparedness for and response to health emergencies. Proposal for amendments (2005). A75/18. 12 April 2022 https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_18-en.pdf

52. WHO (2023a). Proposed Amendments to the International Health Regulations (2005) submitted in accordance with decision WHA 75(9)(2022). https://apps.who.int/gb/wgihr/pdf_files/wgihr1/WGIHR_Submissions-en.pdf

53. WHO (2023b). Article-by-Article compilation of proposed amendments to the International Health Regulations (2005) submitted in accordance with decision WHA 75(9) (2022) https://apps.who.int/gb/wgihr/pdf_files/wgihr1/WGIHR_Submissions-en.pdf

54. WHO (2023c). Report of the Review Committee regarding amendments to the International Health Regulations (2005). https://apps.who.int/gb/wgihr/pdf_files/wgihr2/A_WGIHR2_5-en.pdf

55. WHO (2023d). Zero draft of the WHO/CA+ for the consideration of the Intergovernmental Negotiating Body at its fourth meeting. A/INB/4/3. 1 February 2023 https://apps.who.int/gb/inb/pdf_files/inb4/A_INB4_3-en.pdf

56. WHO Negotiating Text of the WHO convention agreement or other international instrument on pandemic prevention, preparedness and response (WHO Pandemic Agreement) Advanced unedited version – 16 October 2023, A/INB/7/x https://healthpolicy-watch.news/wp-content/uploads/2023/10/advance-DRAFT_Negotiating-Text_INB-Bureau_16-Oct-2023.pdf

57. WHO, 'Governments make progress towards agreeing amendments to the International Health Regulations (2005)', News release 7 October 2023. https://www.who.int/news/item/07-10-2023-governments-make-progress-towards-agreeing-amendments-to-the-international-health-regulations-(2005)

58. WHO. International Health Regulations (2005) Third Edition. file:///D:/Downloads/9789241580496-eng%20(2).pdf

59. WikiLeaks ‘Big Pharma inside the WHO: confidential analysis of unreleased WHO Expert Working Group draft reports, 8 Dec 2009. https://wikileaks.org/wiki/Big_Pharma_inside_the_WHO:_confidential_analysis_of_unreleased WHO_Expert_Working_Group_draft_reports,_8_Dec_2009

60. World Council For Health, *Rejecting Monopoly Power Over Public Health.* Policy Brief April 2023. https://worldcouncilforhealth.org/wp-content/uploads/2023/04/WHO-IHR-2005-Amendments-and-Pandemic-Treaty.-Rejecting-Monopoly-Power-Over-Global-Public-Health.pdf

61. World Health Organization, ‘The European Commission and WHO launch landmark digital health initiative to strengthen global health security’, News Release 5 June 2023.