WORLD GOVERNMENT BY STEALTH

The threat posed by the WHO Pandemic Treaty and its International Health Regulations

A background paper by Philippa D'Arcy

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GLOBAL BRITAIN

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Pictured: World Health Organisation (WHO) HQ in Geneva

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Executive Summary

1. Proposals are currently being negotiated in secret that will fundamentally change our individual freedoms, our sovereignty and our democracy in relation to health care in the UK (and globally). Our elected officials need to educate themselves urgently on what is quietly going on behind closed doors, so they can better understand why a) the pending changes to the International Health Regulations (IHR) regulations and b) remaining a WHO Member State, represent a significant risk to national sovereignty.

2. These proposals if adopted in May 2024 will ostensibly become legally binding, may over-ride our national sovereignty, be (intentionally) extremely difficult to get out of, and give the WHO's Director General unprecedented levels of completely unfettered power, through the ability to dictate UK public health policy and restrict fundamental freedoms and human rights with no recourse.

3. Such new powers may include the WHO gaining the authority to:

- Declare a pandemic or even a potential pandemic at which point all decision making powers fall under WHO;
- Impose lockdown restrictions on all individuals in member states;
- Make vaccinations mandatory, such vaccines made in 100 days by skipping human trials and reducing safety and efficacy testing down to bare bones;
- Specify use of certain medications in medical emergencies, and ban others, ie to decide the health care for every person, with local doctors being forced to follow WHO edicts;
- Create an obligation to carry a global health passport;
- Require nations required to surveil and censor the press and social media so that no dissenting voices can be heard;
- Remove the clause in the previous IHR regulations relating to Individual Sovereignty;

- Force implementation of massive nationwide bio surveillance to identify potential; pathogens "with pandemic potential"; and,
- charge member states the vast sum to put this into effect and run it on a budget of $31bn per annum.

4. Although it is possible that the UK government would ignore its obligations under the IHRs (if it is indeed true that a treaty in International Law does not bind Britain's Westminster Parliament), it is highly likely any UK Government would automatically follow the duties purportedly imposed on it by the Pandemic Treaty and the IHRs. During the Covid Pandemic there was no such legal obligation but nevertheless most nations, including UK, followed the same WHO protocols in lockstep - to disastrous effect. It is the ACTIONS that our government would take that is important to us, not whether they are obliged or not to take them.

5. The WHO is now captured by private interests that fund it to the tune of 87% and wield immense power over it. Essentially this is a huge private/public partnership, with taxpayers primarily providing the money (while having no say in the matter), while the private sector sets the direction and reaps the rewards. The 'global elite' behind these private interests will in this way take control over most Western governments. This is a subversion of democracy.

6. This 'globalist takeover' hinges on the successful creation of a feedback loop of surveillance for virus variants, a declaration of potential risk, followed by lockdowns and restrictions, followed by mass vaccinating of populations to "end" the pandemic restrictions, followed by more surveillance and so on. What results is a system which will funnel money from the taxpayers into multinational corporations and elite groups.

7. Time is of the essence. One IHR amendment adopted in May 2022 (Article 59) has to be actively rejected by Dec 1st, or by default it will come into force. We need to opt out using Article 61. The 307 amendments proposed in May '23 are still being debated. There have been several 4-day long sessions in Geneva since May with another one due in December. The final version, which should be ready in January will be voted in in May 2024. We then have only another 10 months to reject these before they too will by default come into force.

8. We need to act now to protect against this imminent massive power grab at the hands of WHO and preserve the UK's authority to manage our own public health. We need to protect patients' right to informed consent for medical procedures and for individualised care without coercion by regulatory agencies.

1. What is the WHO and what is its mandate?

WHO is the United Nations agency responsible for global public health. WHO has 194 member states whose responsibilities are outlined in the International Health Regulations (IHR) set out initially in 1969 and amended in 2005. These regulations are not currently legally binding and serve as guidance rather than enforceable mandates. In the wake of the Covid-19 event, however, this is set to change.

WHO was set up after the Second World War as the health arm of the United Nations, to support efforts to improve population health globally. Its constitution was premised on the concept that all people were equal and born with basic inviolable rights. It was intended to put populations in charge of their health. While the WHO's Constitution includes a role in coordinating cross-border health emergencies, the organisation originally emphasised community and individual rights. These culminated in the Declaration of Alma Ata in 1978, emphasising the importance of community participation and 'horizontal' approaches to care.

WHO Funding

In recent decades, WHO's core funding model has changed. Originally, its support base of core funding was allocated by countries based on GDP (*Assessed* Contributions), but this has evolved into a model where most funding is via *Voluntary* Contributions, with spending directed by the donors towards specified uses (meaning that it is designated for specific projects rather than being used at WHO's discretion to address the greatest disease burdens). 'Voluntary' actually refers to funding from -private and corporate interests and by public-private partnerships (see below).

The priorities of WHO have evolved accordingly, moving away from community-centred care to a more vertical, commodity-based (vaccines and medicines) approach. This inevitably follows the interests and self-interests of these funders. Understanding these changes is important in order to put the proposed amendments to the existing International Health Regulations (IHR) in context.

Current net assets: $5bn. Income in 2022 of $4.354bn of which 11% was A*ssessed* contributions. 87% meanwhile came from *Voluntary* contributions of which Bill Gates is by far the biggest donor, via 3 entities: Bill & Melinda Gates organisation, GAVI and CEPI.

Partners to WHO

WHO is not alone in the international health space. Organisations such as Unicef (originally intended to prioritise child health and welfare), private foundations and NGOs have long partnered with the WHO. However, the past two decades have seen a huge growth of the global health industry, with multiple organisations, particularly 'public-private partnerships' (PPPs) growing in influence. Notable PPPs are:

- Gavi – The Vaccine Alliance, founded and heavily funded by Bill Gates and dedicated to pandemics;

- The Bill & Melinda Gates Foundation; and,
- CEPI – an organisation set up at the World Economic Forum meeting in 2017 by the Bill & Melinda Gates foundation and Wellcome Trust specifically to manage pandemics.

All of these PPPs have representatives of private interests on their governing boards (ie pharma companies) and address a narrow health focus that reflects the priorities of private sponsors. They influence the WHO through voluntary-specific funding and through funding within WHO Member States. Taken overall, Bill Gates is directly and indirectly by far the largest funder of WHO. **This system is wide open to conflicts of interest corruption, and we simply cannot give this entity even more power to dictate global health policy.**

Other UN agencies have evolved in similar ways:

- UNICEF now heavily focused on implementing mass Covid vaccination among populations that are already immune, whilst children, its former focus, have had rapidly deteriorating health metrics; and,
- The World Bank, with WHO as 'technical partner', has developed a Financial Intermediary Fund (FIF) announced on 9 September 2022 to support pandemic preparedness through funding the development of a surveillance, identification and response network, that is envisioned in the two WHO pandemic instruments (below) and backed by the recent G20 meeting in Indonesia.

Pandemic prevention

In response to member states calling for more effective global cooperation to protect countries from health emergencies, a new international ***legally binding instrument*** is being developed to strengthen pandemic prevention, preparedness, and response. This process was initiated in late 2021 at a Special Session of WHO's governing body, the World Health Assembly. One aspect of this process is the amendments of the IHR, which will become enforceable under international law. Another aspect is the drafting of a 'Pandemic Treaty' known as WHO CA+, which describes financing, governance, and supply network responsibilities in the event of future disease outbreaks and other public health emergencies.

The draft IHR amendments lay out new powers for WHO during health emergencies and broaden the context within which they can be used. The draft CA+ ('treaty') is intended to support the bureaucracy, financing and governance to underpin the expanded IHR.

These proposed instruments, as currently drafted, would fundamentally change the relationship between the WHO, its Member States, and in turn their populations; promoting an autocratic colonial-style approach to healthcare and governance that would overrule sovereignty. The documents need to be viewed together, and in the far wider context of the global/globalist pandemic preparedness agenda.

The threat of pandemics

The current rapidly increasing funding for pandemics and health emergencies is based on several fallacies, frequently repeated in white papers and other documents, as well as in the mainstream media, as if they were facts; in particular:

- Pandemics are increasing in frequency.
- Pandemics are causing an increasing health burden.
- Increased contact between humans and wildlife will promote more pandemics, as most are caused by zoonotic viruses.

The last pandemic to cause major mortality was the 1918-19 'Spanish Flu', estimated to have killed 20-50m people. As noted by the National Institutes of Health, most of these people died of secondary bacterial pneumonia, as the outbreak occurred in the pre-antibiotic era. Since then, there has **only been 2 significant pandemics**: Asian Flu (1957-8) and HK Flu (1968-9) each with c.1m deaths. Notwithstanding this, the media have presented us with almost non-stop pandemics during the 21st century:

- SARS-1 (2002-3) – c150,000 deaths
- Bird flu (H5N1) (2004-5) – 583 cases, 338 deaths
- Swine flu (H1N1) (2009-10) - 150 - 575,000 deaths (probably the lower end)
- Ebola (2014, 2018-19) – 2287 deaths
- SARS-CoV-2 (COVID) (2020-23) – 5.4m deaths supposedly attributable
- Monkeypox (2022-23) – 2500 cases in 40 countries and not a single death outside of Africa (it simultaneously appeared in 20 countries on 4 continents; this virus has never spread like this before).

For context 290,000 to 650,000 die of flu every year, and 1.6m die of tuberculosis. So these outbreaks have been insignificant.

And we are incessantly told that more are coming and they are likely to be worse. We have been assaulted with warnings for over 2 decades to induce a deep fear of infectious diseases, and it seems to have worked. (The genomes of both SARS-CoV-2 and the 2022 Monkeypox virus led to suspicion that both were bioengineered pathogens originating in laboratories).

In Western countries, Covid-19 was associated with deaths at an average age of about 80 years, and global estimates show an overall infection mortality rate of about 0.15%, which is similar to that for influenza.

Thus, pandemics in the past century have killed far fewer people, and at an older age, than most other major infectious diseases. Understanding the devastating effects on health (and economics) of locking down, with the reductions in cancer and heart disease screening and increases in poverty and stress, the WHO advised in late 2019 to "not under any circumstances" impose lockdown-like measures for pandemic influenza.

The Covid-19 event stands out from previous pandemics due to the aggressive and disproportionate responses employed, which were instituted contrary to these existing WHO guidelines. The harms of this response are not for this discussion. There is little doubt, however, that the resultant disruptions to health systems and increased poverty will cause far higher mortality, at a far younger age, than would have been expected from Covid-19 itself. Despite the historical rarity of pandemics, WHO and partners are pushing forward with a rapid process that will ensure the repetition of such responses, rather than first analysing the costs and benefits of the recent pandemic response. This is clearly reckless and a bad way to develop policy.

2. What the WHO instruments propose

As currently drafted, the CA+ and IHR amendments complement each other. The IHR amendments concentrate on the specific powers and processes sought by WHO and its sponsors. The CA+ concentrates more on the governance and funding to support these. Specificities in both instruments will change between now and the WHA vote on them in May 2024. However, in broad terms, they are currently written to achieve the following:

WHO CA+ (the treaty draft)

(NB: The name of each draft changes. The latest October draft omits this term 'CA+' for the Treaty, used on the Feb draft. The June draft was called the Bureau Text and the October draft (attached) is simply called "The Negotiating Text of the WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response")

"This Pandemic Treaty intends to create a complicated managerial structure with a new WHO Secretariat and Conference of the Parties to perform activities that have never been shown to prevent or respond to pandemics effectively or provide any other benefits. In fact these efforts are most likely to increase pandemics and encourage the use of hasty regulatory structures and problematic, liability-waived drugs and vaccines produced too quickly" (Meryl Nass 23/10/23 Analysis of the Oct 2023 Negotiating Text)

This Pandemic Treaty starts off with all sorts of reassurance about respecting human dignity, human rights and fundamental freedoms. But once you dig beneath the surface, you are faced with a clear plan to centralise and bring all public health decisions and policies globally, under the auspices of the WHO. This should trigger major alarm bells that health is being hijacked by politics to allow a technocratic elite to control every area of our lives in an undemocratic way.

If passed into law, this Treaty does the following:

- Sets up an international supply network overseen by WHO;
- Funds the structures and processes – a proposed budget of $31bn per annum. (They appear to have dropped the required for each member nation to assign ≥5% of national health budgets to health emergencies);
- Sets up a 'Governing Body', under the auspices of WHO, to oversee the whole process; and,
- Expands scope by emphasising the 'One Health' agenda, an ideology that combines human health, animal health and environmental concerns into one. It claims that "all life is equal and of equal concern", and that a very broad range of aspects of life and the biosphere can impact health and therefore have the 'potential' to spread harm across borders. This allows the Director General a very broad scope to declare an international health emergency.

Specifically:

- Article 2 #2 states it is applicable at ALL times, not just in times of health emergency.

- Article 4 #3 – Pandemic Prevention and Public Health Surveillance, which is designed to set up a global laboratory and diagnostics infrastructure with the capacity to perform genomic sequencing, data science to assess risk of detected pathogens and ability to safely handle samples.

- Article 6 #4/Article 12 – Pathogen Access and Benefit-Sharing System (WHO PABS System). Members need to set up genomics, risk assessment and lab networks, in order to conduct surveillance and sharing of emerging pathogens, with the goal of seeking out 'pathogens of pandemic potential' that would allow them to facilitate rapid and timely development of pandemic-related products (and to declare a pandemic). It proposes in Article 12 that the genetic sequences are uploaded to one or more publicly accessible databases of its choice.

- Article 10 #1(d) - Sustainable production. Encourage manufacturers to grant, on agreed terms, non-exclusive, royalty free licences to any manufacturers, particularly from developing countries, to use their intellectual property and other protected products, technology, know-how, information, in particular for diagnostics, vaccines and therapeutics for use in agreed developing countries.

- Article 13 #3 (e) – Global Supply Chain and Logistics. The terms of the WHO SCL Network shall include facilitating the negotiation of 'advance purchase commitments and procurement contracts for pandemic-related products. This means member states are obliged to buy products for pandemics in advance, sight unseen. Neither the manufacturer nor the nation knows what is coming, but once WHO issues a pandemic declaration, the contracts are activated and the UK would have to buy what the manufacturer produces. The 2009 Swine Flu pandemic provides a useful example, where advance purchase commitments led to tens of $billions in vaccine purchases in North America and Europe for a flu that was less severe than normal. The GSK Pandemrix brand of vaccine led to over 1300 cases of severe narcolepsy, primarily in adolescents. Rapid production of vaccines for which profits are guaranteed and liability is waived has never been a win for the public.

- Article 21 sets up a Conference of Parties (COP) comprised of representatives from nation states. 4 Committees are proposed: Implementation & Compliance committee, Pandemic Products Committee, Panel of Experts to provide scientific advice, Benefit-Sharing Expert committee. All highly industry and economically focussed; nothing about doctor-patient relationship or practice of medicine or health of the public.

  Worryingly the COP would be empowered to introduce new protocols (whatever they want) into the Treaty once it is signed, provided there is a 2/3 majority vote within the COP – essentially becoming a World Government for health policy with nation states merely being agents of delivery.

- Article 14 – Regulatory Strengthening: this legally forces Member States to take steps to ensure it has the 'legal, administrative and financial frameworks in place to support emergency regulatory approvals for the effective and timely regulatory approval of pandemic-related products'. This incentivises a race to the bottom of drug and vaccine approval standards, particularly during emergencies eg support for the 100 day approval of vaccines in a pandemic.

- Article 18 (and 16) – Communication and public awareness. This requires countries to cooperate across borders to control dissent and coordinate a single global messaging across countries. Member states will inform policies based on their research into what hinders adherence to public health measures and trust in science and public health institutions. It references and defines a new word 'infodemic' which basically means misinformation. (Also Article 9, #2 (d), Article 1 (c))

- Article 20 – Financing. A sustainable funding mechanism will be in place by no later than 31/12/26, which will ensure adequate and accessible funds. Like the WHO itself it appears that this will involve annual monetary contributions by members, but also voluntary monetary contributions – possibly allowing interested parties to buy their way in. It also involves an endowment for pandemic prevention, preparedness and response, resourced by voluntary contributions from all sectors who benefit from this prevention/preparedness, and from donations from philanthropic organisations. All this funding will provide assistance to developing countries to meet their obligations, and will also fund the Secretariat of the WHO Pandemic Agreement.

The power grab through proposed IHR Amendments

This is a totally separate legal instrument to the Pandemic Treaty. The International Health Regulations are negotiated at the WHA by unelected delegates. They have already passed 5 proposed amendments in May 2022, and they are currently negotiating 307 more which they propose adopting May 2024. All amendments will be accepted/passed if a simple majority (50%) of countries' representatives vote yes. (There has been no national or international public comment or vote sought as part of the negotiation process. It seems that the public aren't considered to be relevant stakeholders in the very secretive negotiation process that takes place at the WHA).

The previous version of the IHR was agreed in 2005. Unlike the proposed Pandemic Treaty which must be scrutinised by parliament before being ratified by government, the IHR 2005 **is already an instrument of international law which is legally binding on 194 countries**. Any new, adopted amendments will require no UK parliamentary scrutiny or vote, so this is the more dangerous legal instrument. The WHO has already stated its intention to use the IHRs to strengthen their control over future pandemic policy, because they are already legally binding and there is no need for ratification by any parliament around the world. All they need is a majority vote (50%) by representatives of the nations that show up to the World Health Assembly meeting.

Dr Abdullah Assiri, Co-Chair of IHR Amendments Working Group, spoke in the World Health Assembly IHR working group meeting in May 2023. He gave a 3 minute very chilling speech

outlining their goals. He commented that the implementation of IHRs had been problematic to-date, so enhancements are required. “The world requires a different level of legal mandates, prioritising actions that may restrict individual liberties, mandating the sharing of information, knowledge and resources and providing funds for control efforts. The means for carrying out these actions is simply not currently at hand.”

The proposed IHR amendments rely on the following assumptions:

- That the WHO is the directing and coordinating authority on international health
- That international spread of disease demands the widest international cooperation (ignoring the fact that the spread may be limited to only a few countries and each will demand a different level of response);
- That nations retain national sovereignty through their ability to pass health laws, while they will be simultaneously bound and accountable to obey direction from the WHO on health;
- That we were unprepared for COVID and this caused the pandemic’s suffering and that all we need in future is a central authority to direct us;
- That lack of equity led to failure to share drugs, vaccines, PPE, ignoring the fact that it was nations withholding generic drugs from their populations and not lack of equity that caused many treatment shortages;
- That pandemics invariably arise at the animal-human interface, are natural in origin and the vaguely defined “One Health” approach can prevent or detect them early;
- That increasing the capture and study of potential pandemic pathogens can be done safely and provide useful pandemic products – when neither has been true in the past;
- That pharmaceutical manufacturers will agree to give up some IP rights. (In response a pharma manufacturers’ association said in October it would prefer no treaty to this one);
- The UN adopted a declaration on pandemic preparedness on 20 Sept 2023. In fact 11 countries objected and the declaration was only approved by the UN Secretary-General;
- That censorship of misinformation (“infodemic”) is legal and desirable.

Of the 5 amendments that were adopted in May 2022, one in particular is of concern:

Article 59: halves the time that countries can object to/reject an amendment, from 24 months to 12 months from a WHA vote. After this 12 months period, the amendment would then enter into force. This speeding up of the process would impede the normal democratic process, because it would introduce a considerable time restriction for lobbying groups in nation states to raise awareness and apply political pressure and would increase the chances of undesirable amendments from slipping through, unnoticed by public or politicians.

The amendments in question were submitted on 24 May 2022 by 10 member states. They were adopted just 3 days later on 27 May 2022 without any opportunity for public discussion, debate or comment. It is unclear whether the UK delegates even informed our elected officials of the ramifications of their actions.

We are currently 17 months into the 18 month period ending 1 Dec 2023, during which the UK government has the right to reject to any of the amendments adopted in 2022. To reject an amendment the government has to actively invoke Article 61 of existing IHRs before the deadline passes. If the deadline passes, these amendments will become binding under international law, and there is nothing that the government can do about it. **The deadline to opt out of this is 30 November 2023.**

The proposed 307 amendments being debated at the moment would have the following effect:

1. Change the recommendations of the IHR from **'non-binding' to binding** instructions that the States undertake to follow and implement, ie WHO will now direct not recommend.

2. Expand the definitions of pandemics and health emergencies, including the introduction of 'potential' for harm rather than actual harm. It also considerably expands the definition of health products that fall under this to include any commodity or process that may impact on the response or "improve quality of life".

3. Solidify the Director General's ability to independently declare emergencies. He will have sole authority to declare a pandemic or even a potential pandemic, at which point all decision making powers fall under WHO. There are no standards that must be met before a public health emergency can be declared – he can act on suspicion, and more disturbing, the treaty will be in force all the time, so he doesn't actually need to declare an emergency. He will have the authority to dictate public health even when there is no pandemic.

(These two points together would result in an unelected, unaccountable individual having unprecedented levels of completely unfettered power, who could dictate UK public health policy and restrict fundamental freedoms and human rights with no recourse.)

4. Set up an extensive surveillance process in all member states, which WHO will verify regularly through a country review mechanism to identify potential pathogens with pandemic potential. This will include swabbing and testing humans, domesticated animals, farm animals, wildlife, farms, factories, wastewater and more. (Every two years they will inspect the country, and the country will be told where it needs to shape up. There will be a large division funded by billions of taxpayers' money being put in place to handle this).

5. Enable the WHO to share country data without consent.

6. Remove the clause relating to individual sovereignty which till now has required the WHO to uphold **"full respect for the dignity, human rights and fundamental freedoms of individuals".**

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

8. Formalise the creation and implementation of a globally interlinked health certification system, that would be recognised by all WHO member states, and which would enable nations to enforce travel restrictions with vaccine certificates, prophylaxis certificates, passenger locator forms, health declarations – all tied to a personal QR code.

9. Mandate systematic global collaboration to counter any dissent to any official government or WHO guidance. The amendments will ensure national support for promotion of censorship activities by WHO to prevent contrary approaches and concerns from being freely disseminated, **ie censorship of all dissenting voices**. The WHO's narrative will be the only one allowed. YouTube has already implemented this policy even though the treaty is not yet in place.

10. Change existing IHR provisions affecting individuals from non-binding to binding, including border closures, travel restrictions, confinement (quarantine), medical examinations and **medication of individuals**.
    - Binding provisions affecting individuals could therefore encompass requirements for injection with vaccines or other pharmaceuticals. This means vaccines could be mandatory.
    - Article 8 also provides for provisions to accelerate vaccine development, approvals and licensing for emergency use – undercutting regulatory oversight developed over decades, and safety trials, thus greatly reducing costs to pharma manufacturers.
    - It will enable the WHO to decide which medications can be used in medical emergencies, and which can't. The DG will decide health care for every person in every member state, and local doctors will be required to follow his edict. There will be no medical freedom or bodily autonomy anymore.

An adoption of these amendments, along with ratification of a new Pandemic Treaty, would result in highly significant change to global public health governance, permanently undermining and even removing national sovereignty in a health emergency, handing it over to the WHO and potentially to their sponsors and funders.

It is important to consider these texts together, and in the context of the wider pandemic preparedness agenda that includes agencies such as Gavi and CEPI, their private and corporate sponsors and private industry lobby groups including the World Economic Forum (WEF). The WEF has been influential in promoting the agenda; CEPI was inaugurated at the 2017 WEF meeting in Davos.

The pandemic agenda must also be seen in the context of the unprecedented profits and wealth transfers, (global billionaire total wealth increased more over the 17 months of the pandemic than it did in the 15 years prior – by $5.5trn, a gain of over 68%) and the suspension of basic human rights, that the Covid-19 public health response promoted.

3. The cost of the WHO's power grab

The impact of the changes to the way the WHO will operate will be felt democratically – in the loss of national sovereignty and political accountability – and financially – as the WHO's budget balloons to tenfold the current size.

Funding of the infrastructure that needs to be put in place to effect these changes

The funding of all this is going to be $31bn per annum, at least over the next 5 years and maybe beyond, about two-thirds of which will have to come from domestic financing (5% of health budgets is envisaged). This is supposedly required "to strengthen the PPR (Pandemic Preparedness Response) capacity of low and middle income countries". Just for context, the WHO's budget is currently $3.5bn.

Concerns over sovereignty

The Pandemic Treaty:
The latest draft actually does not appear to be a direct attack on national or individual sovereignty.

- Article 3.1 (Individual Sovereignty) says it will be implemented "with full respect for the dignity, human rights and fundamental freedoms of persons".
- Article 3.2 (National Sovereignty) says "States have, in accordance with the Charter of the United Nations and general principles of international law, the sovereign right to legislate and to implement legislation in pursuance of their health policies.
- Article 3.12 (Proportionality) says "Public health decisions for preventing, preparing for and responding to pandemics should be proportionate, such that the benefit of measures implemented outweigh their costs".

However, it is also states in the document that the Treaty is intended to work with the IHR and proposed amendments. **It is these amendments that threaten to remove national and individual sovereignty and cede it to the WHO and partner agencies. So the concern to sovereignty comes from the IHR amendments and their integration with the Pandemic Treaty, which creates the infrastructure and bureaucracy that enables them, and the industry that flows from it.** (See the comments on the proposed amendments above, where infringement of national sovereignty is highlighted)

IHR Focal Points:
People ask, 'how can the WHO actually make us do anything?' IHR focal points are the way in which WHO will enforce their diktats. There are already IHR Focal points in every country. A Russian amendment is currently seeking to strengthen and empower these local focal points within each country to enforce the national IHR obligations. The WHO is keen to encourage countries to adopt legislation to allow local enforcement.

The IHR amendments:
These propose to remove the Individual Sovereignty phrase (Article 3.1). And the National Sovereignty phrase in CA+ Article 3.2 could end up being a fudge because in fact the

Member states will be obligated to enact the legislation of the pandemic treaty through their own national **IHR focal points,** using new national laws to fulfil their surveillance, testing, financial and other obligations both during and between health emergencies. Effectively, the WHO would be legislating for nations to draw up legislation to enact in their own countries. It is slightly obtuse, but it **will** still threaten our member states' sovereignty at the end of the day.

Although other European countries appear to be clear that the IHR amendments are going to be binding on their respective governments, this is challenged by some UK MPs who argue a treaty in international law does not bind Britain's Westminster parliament, even if it has been ratified by a majority of MPs. Their view is that the IHRs will be binding in international law, but the Westminster Parliament is not bound to follow international law. Its sovereignty, they claim, cannot be fettered by international law.

It is *possible* the UK government would ignore its obligations under the IHRs, but it is surely more likely the government would automatically follow the duties purportedly imposed on it by them – especially as the UK government had not chosen to opt out of such impositions in the first place. During the Covid Pandemic there was no such legal obligation to follow WHO guidance, but nevertheless most nations, including the UK, followed in lockstep the same WHO protocols – to disastrous effect. Ultimately, it is the ACTIONS that our government would take that are important, not what agreements it is signed up to.

4. How will the UK respond?

Timelines

The final iteration of the WHO Pandemic Treaty will be voted in at the next World Health Assembly meeting in May 2024. It requires 2/3 vote of the 194 member states. It then requires at least 30 countries to ratify it after this vote, and ultimately comes into force 30 days later (July 2024) and applies to the countries that ratify.

The 307 amendments of the IHR (proposed by 16 entities on behalf of 94 countries) are still being debated between the delegates of the member states. The Working Group (WGIHR) have met several times during the last six months, for 3 to 4 days at a time, and are planning to meet again in December. They have already overrun the timetable for agreeing the final version.

Like the Pandemic Treaty, the final version of the IHR amendments (which the public are not likely to be able to view) will also be voted on at the World Health Assembly in May 2024. In this case **all that is needed is a simple majority** – a 50% vote in favour, out of 194 members and 2 associate members.

If a majority vote passes, which looks likely, there is a 10 month rejection period, which takes you to March 2025, and then it **automatically** comes into force 2 months later ie May 2025. IF THE UK DOES NOTHING BEFORE MARCH 2025, THE AMENDMENTS BECOME LAW. WE HAVE TO ACTIVELY OPT OUT BY INVOKING ARTICLE 61 OF THE EXISTING IHRs.

Article 59

This was one of the 5 amendments proposed and adopted in May 2022. (See above for its relevance) **We are currently 17.5 months into the 18 month period ending 30 November 2023**, during which time the UK government has the right to reject to any of the amendments adopted in 2022. To reject an amendment the government has to actively invoke Article 61 of existing IHRs before the deadline passes. If the deadline passes, these amendments will become binding under international law, and there is nothing that the government can do about it. **The deadline to opt out of this is 30 November 2023.**

Opting Out

While both texts are intended to have force under international law, countries can theoretically opt out (by exercising Article 61) in order to preserve their sovereignty and protect their citizens' rights. Opting out of any amendment would mean the current version of that amendment continues to apply to the UK.

However, low-income countries could potentially face financial pressures, restrictions and sanctions from entities such as the World Bank that are also heavily invested in this agenda. Of relevance, the 2022 United States National Defence Authorization Act (HR 7776-960) includes wording concerning adherence to the IHRs, and action concerning countries that are uncooperative with its provisions.

Momentum

There is terrific momentum around this project, with many global entities all contributing. The globalists are absolutely intent on getting this through.

An international bureaucracy is currently being built with funding envisioned of up to $31 billion per year for at least the first 5 years. The World Bank is closely involved in making this happen. This same bureaucracy will survey populations for new and variant viruses, identify them, determine their 'threat' level and then implement a response. **This essentially creates a self-perpetuating pandemic industry, fraught with major internal conflicts of interest, funded by the world's taxpayers but, as a UN agency, having no national legal oversight and little accountability. Its justification for continued funding will rely on declaring and responding to perceived threats, restricting the lives of others whilst accruing profit for its sponsors through pharmaceutical recommendations and mandates.**

On 5 June WHO launched a digital health partnership with The European Commission. They laid out their plans very clearly. They fully intend to reactivate the EU Covid 19 digital certificates, and to expand and develop it to become the global digital health certification network that they desire. They say in their statements that the WHO and EC will work together to encourage maximum global uptake and participation.

Another mechanism (much lesser known)

…by which the global elites are seeking to centralise power and control over our lives.

The UN "Our Common Agenda" is not a standing body, but a set of protocols that can be activated when needed. In effect, it is an emergency platform to respond to emergencies. It would bring together the same players to respond to "global shocks" that threaten sustainable development goals. Here are some examples: climatic/environmental events, pandemics, high impact biological events, large scale disruptive or destructive activity in cyberspace, Major event in outer space (!), Unforeseen risks.

In the list of key principles and objectives of this emergency platform ("high level political leadership, equity and solidarity, inclusive and networked multilateralism, securing commitments and accountability" blah blah blah) there is no mention of health care or wellbeing of the public.

The document's conclusion states, "I propose that the General Assembly provide the Secretary General and the United Nations system with a standing authority to convene and operationalise automatically an Emergency Platform in the event of a future complex global shock of sufficient scale, severity and reach".

5. In Conclusion

This 'globalist takeover' hinges on the successful creation of a feedback loop of surveillance for virus variants, a declaration of potential risk, followed by lockdowns and restrictions, followed by mass vaccinating of populations to "end" the pandemic restrictions, followed by more surveillance and so on. What results is a system which will funnel money from the taxpayers into multinational corporations and elite groups.

We have already experienced the WHO's chaotic handling of the COVID 19 pandemic. And that was when they were merely advising. Its advice was not science based, not rational, moral or ethical, and it was heavily influenced by vested interests. Yet here it is negotiating new and binding legal instruments without bothering to undertake a full analysis of its handling of the last pandemic, or take stock of the catastrophic negative impact of its misguided policies on economies, healthcare systems, education, social cohesion, physical and mental health and more.

This is a very deep movement within international public health and the financial sector to increase control of member countries and individuals in the case of health emergencies, super- broadly defined as anything that could potentially harm the wellbeing of human population. This is a subversion of democracy by centralised organisations, many of whom are private entities or public/private entities that have direct financial interests in this whole process, who are strongly directing and supporting by way of funding.

Essentially this is a huge private/public partnership with taxpayers primarily providing the money (while having no choice in the matter), while the private sector sets the direction and reaps the profit rewards. It feels like we have turned the clock back to the colonial era, with a pseudo-government that isn't answerable to the people but is closely tied to large organisations, controlling the rest of the world in order to extract benefits from those populations.

I fear our politicians are sleepwalking into these treaties – believing them to be similar to previous health related treaties – where the WHO is given some limited, non-binding power to make recommendations, but does not interfere with a sovereign nation's ability to manage public health crises to suit their own national needs and interests. This 'take' could not be further from the truth.

These treaties violate nearly all western constitutions by allowing a foreign power the ability to nullify and void, for indefinite amounts of time, the existing constitutional laws and civil rights protections of member countries upon proclamation of a public health crisis by the WHO. It must be opposed.

Appendix I

Summary by Dr Liz Evans

"If this comes to pass, it has huge ethical and moral implications for the practice of medicine and for wider society. It's an aggressive move by WHO and partner agencies who are seeking to arrest control of healthcare decisions from local, regional and national bodies and instead place them into a centralised system with global conformity, compliance and top down control. This is sinister and is a threat to us all. It is protocol-driven medicine on steroids. And there are so many red flags when you read the documents which show an underlying lack of recognition for the sanctity and dignity of every human life. There is no mention of fundamental principles of medical ethics, like informed consent, or the doctor-patient relationship. And yet medical ethics are vitally important and should be non-negotiable in a civilised society. They exist to hold doctors and medical professionals accountable for their actions to protect vulnerable patients from abuse. They recognise the doctor-patient relationship is an intimate one with an unavoidable power imbalance. Hence the importance of the Hippocratic oath to First Do No Harm; that doctors must ensure that they obtain voluntary, uncoerced, informed consent to any medical intervention for their patients, following a full disclosure of risks, benefits and all treatment options, including the option to do nothing; that healthcare professionals maintain confidentiality and that they respect the value and dignity of each human life and act as their patient's advocate.

"What the WHO is proposing will have a catastrophic impact on the sacred patient-doctor relationship and the wider practice of medicine. Arguably, when it is most important to hold firm to medical principles is when there is an emergency, because that is the time when abuse and atrocities are most likely to occur – when people are panicking and when there is fear. To overlook ethics in these documents is a massive red flag. We have essentially moved to a situation where you have government and public health officials who believe they can practice medicine on individuals they don't know, and yet politicians and bureaucrats don't have a place in making medical decisions for individual patients. It is unethical, dangerous and it constitutes a medical tyranny. Emergency public health policies adopted an ideology that favoured the greater good over the sanctity of individual life – it was dehumanising and morally reprehensible.

"We have at least been able to write to our elected representatives, to challenge and lobby for changes to unethical policies, and we have seen the public protesting all over the world on the streets against their government policies. But imagine what would happen in the future if all health policies and protocols are instead set by the WHO Director General and various committees who are unelected, and unaccountable and pretty much invisible. You would then have absolutely no recourse for the public to protest or lobby their politicians for change. The governments and elected representatives would simply say they had no choice, that they were obligated to enact WHO policies under international law, so they were simply following orders."

Dr Liz Evans, of Doctors For Patients UK

Appendix II

Treaties and Regulations:

1. IHR 2005 Third Edition (inc revisions adopted in 2014)
2. IHR proposed amendments
3. Working Group on Amendments to the IHR (2005)
4. Latest Draft of the WHO Pandemic Treaty Oct 2023, replaying June '23 ('Bureau's Text')
5. The WHO old pandemic guidelines, superseded in Nov 2019

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