

# The WHO's Proposed Treaty Will Increase Man-Made Pandemics

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This report is designed to help readers think about some big topics: how to really prevent pandemics and biological warfare, how to assess proposals by the WHO and its members for responding to pandemics, and whether we can rely on our health officials to navigate these areas in ways that make sense and will help their populations.

We start with a history of biological arms control and rapidly move to the COVID pandemic, eventually arriving at plans to protect the future.

## **Weapons of Mass Destruction: Chem/Bio**

Traditionally, the Weapons of Mass Destruction (WMD) have been labelled Chemical, Biological, Radiologic, and Nuclear (CBRN).

The people of the world don't want them used on us—for they are cheap ways to kill and maim large numbers of people quickly and indiscriminately. And so international treaties were created to try to prevent their *development* (only in the later treaties) and *use* (in all the biological arms control treaties). First was the Geneva Protocol of 1925, following the use of poison gases and limited biological weapons during World War I, which banned the use of biological and chemical weapons in war. The US and many nations signed it, but it took 50 years for the US to ratify it, and during those 50 years the US asserted it was not bound by the treaty.

The US used both biological and chemical weapons during those 50 years. The US almost certainly used biological weapons in the Korean War (see this, this, this and this) and perhaps used both in Vietnam, which experienced an odd outbreak of plague during the war. The use of napalm, white phosphorus, agent orange (with its dioxin excipient causing massive numbers of birth defects and other tragedies) and probably other chemical weapons like BZ (a hallucinogen/incapacitant) led to much pushback, especially since we *had* signed the Geneva Protocol and we were supposed to be a civilized nation.

In 1968 and 1969, two important books were published regarding our massive stockpiling and use of these agents. They had a great influence on the American psyche. The first book, written by the young Seymour Hersh about the US' chemical and biological warfare program was titled *Chemical and Biological Warfare; America's Hidden Arsenal*. In 1969 Congressman Richard D. McCarthy, a former newspaperman from Buffalo, NY published *The Ultimate Folly: War by Pestilence, Asphyxiation and Defoliation* about the US production and use of chemical and biological weapons. Prof. Matthew Meselson's review of the book noted,

*Our operation, "Flying Ranch Hand," has sprayed anti-plant chemicals over an area almost the size of the state of Massachusetts, over 10 per cent of its cropland. "Ranch Hand" no longer has much to do with the official justification of preventing ambush. Rather, it has become a kind of environmental warfare, devastating vast tracts of forest in order to facilitate our aerial reconnaissance. Our use of "super tear gas" (it is also a powerful lung irritant) has escalated from the originally announced purpose of saving lives in "riot control-like situations" to the full-scale combat use of gas artillery shells, gas rockets and gas bombs to enhance the killing power of conventional high explosive and flame weapons. Fourteen million pounds have been used thus far, enough to cover all of Vietnam with a field effective concentration. Many nations, including some of our own allies have expressed the opinion that this kind of gas warfare violates the Geneva Protocol, a view shared by McCarthy.*

## **A Biological Weapons Convention to End Biological Warfare**

Amid great pushback over US conduct in Vietnam, and seeking to burnish his presidency, President Nixon announced to the world in November 1969 that the US was going to end its offensive biowarfare program (but not the chemical program). Following pointed reminders that Nixon had not eschewed the use of toxins, in February 1970 Nixon announced we would get rid of our toxin weapons also. These included snake, snail, frog, fish, bacterial and fungal toxins that could be used for assassination, incapacitation and other purposes.

It has been claimed that Nixon's declarations resulted from careful calculations that the US was far ahead technically of most other nations in its chemical and nuclear weapons. But biological weapons were considered the "poor man's atomic bomb" and required much less sophistication to produce. Therefore, the US was not far ahead in the biological weapons arena. By banning this class of weapon, the US would gain strategically.

Nixon told the world that the US would initiate an international treaty to prevent the use of these weapons ever again. And we did so: the 1972 Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological (Biological) and Toxin Weapons and on their Destruction, or Biological Weapons Convention (BWC) for short, which entered into force in 1975.

But in 1973 genetic engineering (recombinant DNA) was discovered by Americans Herbert Boyer and Stanley Cohen, which changed the biological warfare calculus. Now the US had regained a technological advantage for this type of endeavor.

The Biological Weapons Convention established conferences to be held every 5 years to strengthen the treaty, making it verifiable and enforceable. The expectation was that these would add a method to call for 'challenge inspections' to prevent nations from cheating, and would add sanctions (punishments) if nations failed to comply with the treaty. However, since 1991 the US has consistently blocked the addition of protocols that would have an impact on cheating. By now, everyone accepts that cheating occurs and is likely widespread.

A leak in an anthrax production facility in Sverdlovsk, USSR in 1979 caused the deaths of about 60 people. While the USSR tried a sloppy cover-up, blaming consumption of contaminated black market meat, this was a clear BWC violation to all those knowledgeable about anthrax.

US experiments with anthrax production during the Clinton administration, detailed by Judith Miller et al. in the 2001 book Germes, were also thought by experts to have transgressed the BWC.

Meanwhile, a chemical weapons treaty did get negotiated, came into force in 1997, and it contains provisions for challenge inspections and punishments. It has taken many years, but by 2022 all declared stocks of chemical weapons had been destroyed by the USA, by Russia, and the other 191 member nation signatories.

It is now 2023, and during the 48 years the Biological Weapons Convention has been in force the wall it was supposed to build against the development, production, and use of biological weapons has been steadily eroded. Meanwhile, especially since the 2001 anthrax letters, many nations (with the US at the forefront) have been building up their “biodefense” and “pandemic preparedness” capacities.

Under the guise of preparing their defenses against biowarfare and pandemics, nations have conducted “dual-use” (both offensive and defensive) research and development, which has led to the creation of more deadly and more transmissible microorganisms. And employing new verbiage to shield this effort from scrutiny, biological warfare research was renamed as “gain-of-function” research.

### **How Would You Create a Biological Warfare Agent?**

Gain-of-function research is a euphemism for biological warfare research aka germ warfare research. It is so risky that funding it was banned by the US government (but only for SARS coronaviruses and avian flu viruses) in 2014 after a public outcry from hundreds of scientists. Then in 2017 Drs. Tony Fauci and Francis Collins lifted the moratorium, with no real safeguards in place. Fauci and Collins even had the temerity to publish their opinion that the risk from this gain-of-function research was ‘worth it.’

What does gain-of-function actually mean? It means that scientists are able to use a variety of techniques to turn ordinary or pathogenic viruses and bacteria into biological weapons. The research is justified by the claim that scientists can get out ahead of nature and predict what might be a future pandemic threat, or what another nation might use as a bioweapon. The *functions gained* by the viruses or other microorganisms to turn them into biological warfare agents consist of two general but overlapping categories: *enhanced transmission* and *enhanced pathogenicity* (illness severity).

1) **Enhanced transmissibility** may result from:

- a. needing fewer viral or bacterial copies to cause infection,
- b. causing the generation of higher viral or bacterial titers,
- c. a new mode of spread, such as adding airborne transmission to a virus that previously only spread through bodily fluids,
- d. expanding the range of susceptible organs (aka expanded tissue tropism); for example, not only respiratory secretions but also urine or stool might transmit the virus, which was found in SARS-CoV-2,
- e. expanding the host range; for example, the virus is passaged through humanized mice and thus acclimated to the human ACE-2 receptor, infecting humans preferably to bats or other animals, which was found in SARS-CoV-2,

f. improving the ability to enter cells; for example, by adding a furin cleavage site, which was found in SARS-CoV-2.

## 2) Enhanced pathogenicity:

a. Instead of causing a milder (or no) illness, the pathogen would be reengineered to cause severe illness, incapacity or death, using a variety of different strategies, including the production of toxins or ability to evade immunity,

b. SARS-CoV-2 had unusual homologies (identical short segments of nucleotides) to human tissues and the HIV virus, which may have caused or contributed to the late autoimmune stage of illness, an impaired immune response and 'long COVID.'

## **Funding for (Natural) Pandemics, Including Yearly Influenza, was Lumped Together with Biological Defense Funding**

Perhaps the comingling of funding was designed to make it harder for Congress and the public to understand what was being funded, and how much taxpayer funding was going to gain-of-function work? Understanding the huge sums involved might have led Americans to question why this research was being done at all, given its prohibition by the Biological Weapons Convention, and could have raised additional questions about its lack of benefit for human health. Former CDC Director Robert Redfield, a physician and virologist, told Congress in March of 2023 that gain-of-function research had not resulted in a single beneficial drug, vaccine, or therapeutic to his knowledge.

So-called nonprofits and universities (for example, EcoHealth Alliance and its affiliation with Professor Jonna Mazet at the University of California, Davis veterinary school) were used as financial intermediaries to obscure the fact that US taxpayers were supporting scientists in dozens of foreign countries, including China, for research that included capturing dangerous viruses and performing gain-of-function work on coronaviruses.

Perhaps to keep the lucrative funding going, government agencies have fanned the fear of pandemics over the past several decades. Huge sums have been spent on alleged "pandemic preparedness" over the past 20 years, routing funds through many federal and state agencies. President Biden's proposed 2024 CDC budget requested "\$20 billion in mandatory funding across DHHS for pandemic preparedness" while the DOD, DHS, USAID and the State Department have additional budgets for pandemic preparedness for spending on both domestic and international projects.

The current jargon for this spending is pandemic prevention, preparedness and response or PPPR. While this may be a feel-good way for politicians to spend money, scientifically there is no known way to prevent pandemics, and the methods that governments are spending money on are actually going to make this problem a great deal worse. The concept of a "response": withholding cheap, available generic drugs in favor of the warp speed

development of patentable drugs and vaccines, which will undergo minimal testing and have no liability, is another disaster in the making. Pandemic preparedness is a myth, a smokescreen behind which lies a fascist approach to social management.

### **The Steady Drumbeat of Pandemic Fear**

Although the 20th century experienced only three significant pandemics (the Spanish Flu of 1918-19 and 2 influenza pandemics in 1957 and 1968) the mass media and World Health Organization have presented us with almost non-stop pandemics during the 21st century: SARS (2002-3), avian flu (2004-on), swine flu (2009-10), Ebola (2014; 2018-19), Zika (2016), COVID (2020-2023), and monkeypox (2022-23). And we are incessantly told that more are coming, and that they are likely to be worse. WHO Director-General Tedros Adhanom Ghebreyesus has declared three “public health emergencies of international concern” during his six years in office.

We have been assaulted with warnings and threats for over 2 decades to induce a deep fear of infectious diseases. It seems to have worked.

### **Illogical Responses to Odd Pandemics**

The genomes of both SARS-CoV-2 (Session 1, start at minute 5:10) and the 2022 monkeypox (MPOX) virus led to early suspicions that both were pathogens originating in laboratories. The group of virologists assembled by Drs. Fauci and Farrar for a secret phone call on February 1, 2020 identified 6 unusual (probably lab-derived) parts of the SARS-CoV-2 genome — and more have been suggested subsequently.

I do not know if these viruses leaked accidentally or were deliberately released, but I am leaning toward the conclusion that both were deliberately released, based on the locations where they first appeared, the well-orchestrated but faked videos of people dropping dead in the streets rolled out by the mass media for COVID, and the illogical and harmful official responses to each. In neither case was the public given accurate information about the infections’ severity or treatments, and the responses by Western governments never made scientific sense. Why *wouldn’t* you treat cases early, the way doctors treat everything else? It seemed that our governments were trading on the fact that few people knew enough about viruses and therapeutics to make independent assessments about the information they were being fed.

Yet by July and August 2021, when it became crystal clear to health authorities that the vaccines were not preventing cases or transmission, there was no corresponding course correction. Instead, the federal government doubled down, imposing vaccine mandates on 100 million Americans in September 2021 *in spite of* ‘the science.’ Heavy-handed, universal medical mandates can never be justified due to human beings’ different risk-benefit profiles. But when the mandated vaccine failed to prevent spread to others, failed to provide herd immunity, and was known to cause harm, mandating it became malicious.

There has been no accurate statement yet from any federal agency about the lack of utility of cotton and surgical masks for an airborne virus (which is probably why the US government and WHO delayed acknowledging airborne spread by COVID for many months); the lack of efficacy of social distancing for an airborne virus; and the risks and poor efficacy of 2 dangerous oral drugs (paxlovid and molnupiravir) purchased for billions by the US government for COVID treatment, even without a doctor's prescription.

Never have any federal agencies acknowledged the truth about the COVID vaccines' safety and efficacy. Instead, the CDC turns definitional and statistical cartwheels so it can continue to claim they are "safe and effective." Even worse, with all that we know, a third generation COVID vaccine is to be rolled out for this fall and the FDA has announced that yearly boosters are planned.

All this goes on, even a year after we learned (with continuing corroborations) that children and working age adults are dying at rates 25 percent or more above the expected averages, and the vascular side effects of vaccination are the only reasonable explanation.

### **Maiming with Myocarditis**

Both of the two US monkeypox/smallpox vaccines (Jynneos and ACAM2000) are known to cause myocarditis, as do all 3 COVID vaccines currently available in the US: the Pfizer and Moderna COVID-19 mRNA vaccines and the Novavax vaccine. The Novavax vaccine was first associated with myocarditis during its clinical trial, but this was downplayed, and it was authorized and rolled out anyway. The Novavax vaccine was considered a solution for those who refused the mRNA vaccines due to the use of fetal tissue in their manufacture.

Here is what the FDA's reviewers wrote about the cardiac side effects noted in the *Jynneos* clinical trials:

*Up to 18.4% of subjects in 2 studies developed post-vaccination elevation of troponin [a cardiac muscle enzyme signifying cardiac damage]. However, all of these troponin elevations were asymptomatic and without a clinically associated event or other sign of myopericarditis. p. 198*

*The applicant has committed to conduct an observational, post-marketing study as part of their routine PVP. **The sponsor will collect data on cardiac events that occur and are assessed as a routine part of medical care.** p. 200*

*[emphasis added]*

In other words, while the only way to cause an elevated troponin level is to break down cardiac muscle cells, the FDA did not require a specific study to evaluate the extent of cardiac damage that might be caused by *Jynneos* when it issued the vaccine's 2019 license.

How frequently does myocarditis occur after these vaccines? If you use elevated cardiac enzymes (above twice the upper limit of normal) as your marker, *ACAM2000* caused this in one in thirty people receiving it for the first time. If you use other measures like abnormal cardiac MRI or echo, according to the CDC it occurs in one in 175 first-time vaccine recipients.

I have not seen a study with rates of myocarditis for *Jynneos*, but there was an unspecified elevation of cardiac enzymes in 10 percent and 18 percent of *Jynneos* recipients in two unpublished prelicensure studies available on the FDA website. My guess for the mRNA COVID vaccines is that they cause myocarditis, if defined as a rise in troponin levels following vaccination, in the same general range (between 1 in 5 and 1 in 250 recipients per dose). However, the vast majority of cases are probably asymptomatic and will not be diagnosed unless you screen for them.

Why would our governments push 5 separate vaccines *all known to cause myocarditis* on young people who are at extremely low risk from COVID? Monkeypox simply causes a few eruptions (like shingles) for 1-4 weeks unless the infected person is severely immunocompromised.

Why dangerous vaccines are being pushed on young, low-risk populations for whom the health risks from vaccination are considerably greater than the risks from the disease is an important question. It does not make medical sense. Especially for a monkeypox vaccine (*Jynneos*) that probably does not work. *Jynneos* didn't prevent infection in the monkeys in whom it was tested, nor did it do well in people.

The health agencies first incited terror with apocalyptic predictions; then demanded patients be medically neglected until their lips turned blue; and finally enforced vaccinations and treatments that were tantamount to malpractice.

There can be no question about it: our health agencies are guilty of malfeasance, misrepresentation, and deliberate infliction of harm on their own populations.

### **COVID Vaccines: The Chicken or the Egg?**

The health authorities could have just been ignorant — that could possibly explain the first few months of the COVID vaccines' rollout. But once they figured out, and even announced in August 2021 that the vaccines did not prevent catching COVID or transmitting it, why did our health authorities then *mandate* COVID vaccines for 100 million mostly low-risk Americans who were at greater risk from vaccine side effects than from COVID? And why did they double down on mandates as time went on and newer variants were less and less virulent?



And that wasn't all the federal authorities did. Understanding that mandates could not legally be issued unless the vaccines were licensed (not just authorized under an Emergency Use Authorization, or EUA) FDA issued a license for the Pfizer vaccine on August 23, 2021. It is important to understand that while the licensed vaccine had liability attached – if it caused injuries, the manufacturer could be sued for damages – the “authorized” (EUA) COVID vaccines had all liability waived for the manufacturers, government officials and healthcare workers administering them under the PREP Act.

So the FDA performed a deliberate bait and switch. It led Americans to believe they were receiving a licensed product that had gone through a full FDA approval process, when in fact what they actually received was the EUA product that was unlicensed, and for which they could not sue if injured. FDA hid this by using peculiar language when it issued the license to Pfizer, by claiming the two vaccines were “legally distinct” in a footnote.

Once you understand these basic facts, you realize that perhaps the vaccines were not made for the pandemic, and instead the pandemic was made to roll out the vaccines. While we cannot be certain, we should at least be suspicious. And the fact that the US contracted for *10 doses per person* (review purchases [here](#), [here](#), [here](#), [here](#) and [here](#)) and so did the European Union ([here](#) and [here](#)) and [Canada](#), it should make us even more suspicious. There is no medical justification for agreeing to purchase so many doses of vaccines at a time when the virus was rapidly mutating, the vaccines' ability to prevent infection and transmission was questionable and its safety was suspect or worse.

Australia bought 8 doses per person. By December 20, 2020 New Zealand had secured triple the vaccines it needed, and offered to share some with nearby nations. Why would governments buy so many doses per person? Three maybe. But ten? Even if yearly boosters were expected, there was no reason to sign contracts for enough vaccine for nine years. No one has ever explained the reason for these excessive, lockstep purchases by so many nations.

Furthermore, you don't need a vaccine passport (aka digital ID, aka a phone app that in Europe included a mechanism for an electronic payments system) *unless you are monitoring whether people are up to date on their boosters*. Were the vaccines conceived of as the means for putting our vaccinations — and most importantly, shifting our financial transactions — online, all to be managed on a phone app? This would be an attack on privacy as well as the enabling step for a China-style social credit system in the West. Interestingly, vaccine passports were already being planned for the European Union pre-COVID, in 2018. Why?

**A Pandemic Treaty and Amendments: Brought to You by the Same People who Mismanaged the Past 3 Years, to Save Us from Themselves?**

The same US government, other governments and the WHO that imposed draconian measures on citizens to force us to be vaccinated and to take dangerous, expensive, experimental drugs; withheld effective treatments; refused to tell us that most people who required ICU care for COVID were vitamin D-deficient; and never said that taking vitamin D would lessen COVID's severity— these same entities decided in 2021 we suddenly needed an international pandemic treaty. Why? To prevent and ameliorate future pandemics or biological warfare events... so we would not suffer again as we did with the COVID pandemic, they insisted. The WHO would manage it.

What the WHO and our governments conveniently failed to mention is that we suffered so badly from the COVID catastrophe *because* of their medical mismanagement and merciless economic shutdowns and mismanagement. According to the World Bank, an additional 70 million people were forced into extreme poverty in 2020 alone. This was due to policies issued by our nations' rulers, their handpicked advisors and the World Health Organization, which issued guidance to shut down economic activity that most nations adopted without question. The WHO is acutely aware of the consequences children have had to pay for the economic lockdowns it imposed, having published the following:

*Malnutrition persisted in all its forms, with children paying a high price: in 2020, over 149 million under-fives are estimated to have been stunted, or too short for their age; more than 45 million – wasted, or too thin for their height...*

Starvation may have killed more people than COVID, and they were disproportionately the youngest, rather than the oldest. Yet the tone deaf WHO prattles on about equity, diversity, and solidarity — having itself caused the worst starvation crisis of our lifetime, which was not due to nature but was man-made.

To paraphrase Ronald Reagan, the words, “I’m from the WHO, and I’m here to help” should be the most terrifying words in the English language, after what we learned from the COVID fiasco.

How can anyone take seriously claims by the same officials who mishandled COVID that they want to spare us from another medical and economic disaster – by employing the same strategies they applied to COVID, after they masterminded the last disaster? And the fact that no governments or health officials have admitted their errors should convince us never to let them manage anything for us ever again. Why would we let them draw up an international pandemic treaty and new amendments to the existing International Health Regulations (IHR) that will bind our governments to obey the WHO's dictates forever?

Those dictates, by the way, include vaccine development at breakneck speed, the power to enforce which drugs we may use and which drugs will be prohibited, and the requirement to monitor media for “misinformation” and impose censorship on our media so that only the

WHO's public health narrative will be conveyed to the public. Which is a First Amendment violation.

### **The WHO's Pandemic Treaty Draft Requires the Sharing of Potential Pandemic Pathogens. This is a Euphemism for Bioweapons Proliferation.**

Obviously, the best way to spare us from another pandemic is to immediately stop funding gain-of-function (GOF) research and get rid of all existing GOF organisms. Let all nations build huge bonfires and burn up their evil creations at the same time, while allowing other nations to inspect their biological facilities and records.

But the WHO in its June 2023 *Bureau Text of the Draft Pandemic Treaty* has a plan that is the exact opposite of this. In the WHO's draft treaty, which most nations' rulers appear to have bought into, all governments will share all viruses and bacteria they come up with that are determined to have "pandemic potential" — share them with the WHO and other governments, putting their genomic sequences online. No, I am not making this up. (See screenshots from the *draft treaty* below, which calls for "*global sharing of emerging pathogens with pandemic potential.*") Then the WHO and all the Fauci's of the world would gain access to all the newly identified dangerous viruses. Would hackers also gain access to the sequences? This pandemic plan should make you feel anything but secure.

Fauci, Tedros, and their ilk at the WHO, and those managing biodefense and biomedical research for nation states are on one side, the side that gains access to ever more potential biological weapons, and the rest of us are on the other, at their mercy.

This poorly conceptualized plan used to be called ***proliferation of weapons of mass destruction*** — and it is almost certainly illegal. (For example, see Security Council Resolution 1540 adopted in 2004.) The US State Department considers biological weapons proliferation "a grave threat." But this is the plan of the WHO and of many of our leaders. Governments will all share the weapons.

### **The Genomic Sequencing Conundrum**

And governments are to commit to building biolabs that must include **genomic sequencing**. No explanation has been forthcoming about why each nation needs to install its own genome sequencing laboratories. Of course, they would sequence the many viruses that will be detected as a result of the pathogen surveillance activities nations must perform, according to the WHO treaty draft. But the same techniques can be used to sequence human genomes. The fact that the EU, UK, and US are currently engaged in projects to sequence nearly 2 million of their citizens' genomes provides a hint that they may want to collect additional genomes of Africans, Asians, and others.

Genomic sequencing might fly as simply sharing state-of-the-art science with our less-developed neighbors. But it is curious that there is so much emphasis on genomics, compared to the absence of any discussion about developing repurposed drugs for pandemics in either the draft treaty or IHR amendments. Some might suppose the proposed treaty was a disguised business plan for the biodefense industry.

We must not forget that virtually all developed nations, in lockstep, restricted the use of safe generic hydroxychloroquine, ivermectin, and related drugs during the pandemic. In retrospect, the only logical explanation for this unprecedented action was to preserve the market for expensive patentable drugs and vaccines, and possibly to prolong the pandemic.

US law only allows the use of unlicensed, emergency use authorized (EUA) vaccines and drugs if there is no adequate, approved (licensed) and available drug for the same purpose. If the US government admitted that existing, approved drugs could prevent and/or treat COVID, it would need to immediately revoke all the EUAs issued to vaccines and drugs for COVID, and none could be used any longer. This is one explanation for why hydroxychloroquine and ivermectin have been vilified and suppressed by our state and federal agencies.

Genomes offer great potential profits, as they may reveal the secrets of immunity to certain diseases. However, they may also reveal genetic weaknesses at which weapons could be aimed. They may also provide the substrate for transhumanist experiments that could include designer babies among other things.

The latest version (aka the WHO Bureau's text) of the pandemic treaty can be accessed here. I provide screenshots below to illustrate additional points.

## **Bureau's text of the WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response (WHO CA+)**

Draft pages 10 and 11:

3. The Parties commit to establishing, or building on existing, genomics, risk assessment, and laboratory networks in order to conduct epidemiological genomic surveillance and the global sharing of emerging pathogens with pandemic potential, and drug-resistant pathogens.

(d) sustained national and/or regional laboratory capacity, including for genomic sequencing, as well as for analysing and sharing such information;

### **The WHO Treaty Draft Incentivizes Gain-of-Function Research**

What else is in the Treaty? Gain-of-Function research (designed to make microorganisms more transmissible or more pathogenic) is explicitly incentivized by the treaty. The treaty demands that administrative hurdles to such research must be minimized, while unintended consequences (aka pandemics) should be prevented.

Draft page 14:

5. Each Party shall implement and apply relevant international standards for the biorisk management of laboratories and research facilities that carry out research to better understand the pathogenicity and transmissibility of pathogens with pandemic potential, and to prevent the unintended consequences of such research, while minimizing unnecessary administrative hurdles for research.

But the problem is that you cannot prevent escapes and unintended consequences when you do this type of research. Leaks and losses of agents will always occur. Smallpox leaked out of British labs several times. After the same lab caused two smallpox outbreaks, the scientist responsible for the lab committed suicide in 1980.

There were six identified lab escapes of SARS-1 in China, Singapore and Taiwan in 2003 and 2004.

The joint CDC-USDA Federal Select Agent Program (FSAP) keeps track of research on designated potential pandemic pathogens, including, for example, SARS coronaviruses, anthrax and Ebola. As the FSAP describes itself,

*The Federal Select Agent Program oversees the possession, use and transfer of biological select agents and toxins, which have the potential to pose a severe threat to public, animal or plant health or to animal or plant products.*

FSAP reports reveal that there are about 200 accidents or escapes yearly of these dangerous pathogens from labs situated in the US. (There is no accounting for accidents outside the US.) The FSAP annual report for 2021 notes:

*In 2021, FSAP received 8 reports of losses, 177 reports of releases, and no reports of thefts.*

While scientists do their best to protect themselves and maintain lab safety, research on deadly pathogens simply *cannot be performed without risks both to the researchers and the outside world.*

### **Vaccines Will be Rolled Out Speedily Under Abbreviated Future Testing Protocols**

Vaccines normally take 10-15 years to be developed. In case you thought the COVID vaccines took too long to be rolled out (326 days from availability of the viral sequence to authorization of the first US COVID vaccine) the WHO treaty draft has plans to shorten testing. There will be new clinical trial platforms. Nations must increase clinical trial capacity. (Might that mean mandating people to be human subjects in out-of-the-way places like Africa, for example?) And there will be new “mechanisms to facilitate the rapid interpretation of data from clinical trials” as well as “strategies for managing liability risks.”

Draft page 14:



7. The Parties, in accordance with their national and regional legal and regulatory frameworks and contexts, and as appropriate, shall increase clinical trial capacity and strengthen clinical trials policy frameworks, particularly in developing countries, in order to enable a greater number of clinical trial sites that can conduct well-designed and well-implemented clinical trials, and to ensure readiness for the coordination of trials through existing, new or expanded clinical trial networks that meet relevant regulations and internationally harmonized standards, promoting the sharing of information and best practices on efficient and ethical clinical trial design and delivery, and in designing, preparing and conducting clinical trials that ensure human subject protections.

(b) further strengthening international coordination and collaboration on clinical trials, through existing mechanisms, where established, to support well-designed and well-implemented trials, including new clinical trial platforms operating on multi-country footprints, where scientifically appropriate, to address priority infectious and non-infectious diseases, with mechanisms to pivot protocols to support pandemic response, where necessary and appropriate;

(c) supporting new and existing mechanisms to facilitate the rapid interpretation of data from clinical trials to develop or amend, as necessary, relevant clinical guidelines, including during a pandemic; and

(d) ensuring that clinical trials conducted during health emergencies are equitable, address geographical, socioeconomic and health disparities, and promote racial, ethnic and gender diversity for a better understanding of the safety and efficacy of new vaccines and treatments in subgroups of the population.

#### **Article 10. Liability risk management**

1. The Parties shall establish, no later than XX, using existing relevant models as a reference, regional or international vaccine injury compensation scheme(s) for injuries resulting from the use and/or administration of vaccines developed for response to pandemics that is/are transparent and complement(s) any liability protections and/or other liability risk management mechanisms.

### **Manufacturer and Government Liability for Vaccine Injuries Must be “Managed”**

Nations are supposed to use “existing relevant models” as a reference for compensation of injuries due to pandemic vaccines. Of course, most countries do not have vaccine injury compensation schemes, and when they do the benefits are usually minimal.

Is the US government’s program to be a model of what gets implemented internationally?

There is only one way under US law to obtain compensation for an injury sustained from an EUA product. This is because under the PREP Act, lawsuits against manufacturers, government administrators and medical personnel administering vaccines and drugs are prohibited.

The sole US government scheme for injuries due to COVID pandemic products is called the Countermeasures Injury Compensation Program or CICP. It is extremely difficult to obtain any benefits through this program, even if your doctors assert that your injury resulted from

an EUA product. Therefore, few people bother to apply, and few are even aware the program exists.

The statute of limitations for the CICIP is a very brief twelve months, which means you must have documented that your injury was due to a vaccine or drug and mailed your application within 12 months of receiving the medical product. This can be extremely difficult when the federal health agencies usually deny such injuries are due to the drugs or vaccines.

Furthermore, the program will only pay for lost wages or health expenses that have not been covered by insurance or other sources. The CICIP is legally a “payor of last resort,” so if your health insurance covered your injury and your disability insurance covered lost wages, you cannot collect benefits. The CICIP will provide no compensation for attorney fees, expert witnesses, document preparation or pain and suffering, although the federal Vaccine Injury Compensation Program for childhood vaccine injuries can pay those costs. There is no time limit by which a case must be adjudicated, so most cases languish for years without a decision. The program is purely administrative, and decisions regarding benefits are made by the DHHS employees. There are no courts or judges and no published standards.

All pandemic EUA drugs and vaccines convey immunity from legal liability to their manufacturers and to everyone else involved in their use.

The CICIP has compensated exactly 4 (yes, four) of the 12,000 applications for COVID product-related injuries as of August 1, 2023. The total amount paid out for the first three of the four compensated claims was \$4,635, or less than \$1,600 apiece, on average.

Slightly more than 1,000 claims have been adjudicated, while 10,887 are pending review.

In summary, 2% of the COVID cases reviewed by the CICIP were deemed medically eligible for benefits (in other words, DHHS agreed that the injury was caused by the EUA product), while only 0.03% of all COVID injury applications have received a payment from the CICIP. No wonder so few people even bother to apply.

### **“Regulatory Strengthening“**

The pandemic treaty draft also demands weakening the strict national regulation of medical drugs and vaccines during emergencies, under the rubric of “Regulatory Strengthening.” As announced in the UK recently, ‘trusted partner’ approvals will be used to speed licensure of medical products there. This means that if a drug or vaccine has been approved by a partner country, the UK can adopt the partner’s decision on licensure and bypass an independent analysis by UK regulators. What this does is move nations in the direction of a single regulatory agency approval or authorization, which could be immediately adopted by other nations.

Draft page 25:



#### Article 14. Regulatory strengthening

1. The Parties shall align and, where possible, harmonize technical and regulatory requirements and procedures; promote and facilitate the use of regulatory reliance and mutual recognition; use common technical documents; and share relevant information and assessments concerning the quality, safety and efficacy of pandemic-related products, including after regulatory approvals are granted.
2. The Parties, for the purposes of regulating pandemic-related products, shall strengthen the capacity and performance of relevant national and regional regulatory authorities, including through technical assistance, with the aim of expediting regulatory approvals and authorizations and ensuring the quality, safety and efficacy of pandemic-related products.
3. Each Party shall make publicly available information on national and/or regional processes, in accordance with relevant laws, for authorizing or approving use of pandemic-related products during a pandemic, and any additional relevant regulatory pathways that may be activated during a pandemic to increase efficiency, and shall ensure that such information is kept updated in a timely manner.
4. The Parties shall, as appropriate, monitor, regulate and strengthen the existing rapid alert systems among neighbouring countries, against substandard and falsified pandemic-related products, including through existing Member State mechanisms on substandard and falsified medical products.
5. Each Party shall take steps to ensure that it has legal, administrative and financial frameworks in place to support emergency regulatory approvals for the effective and timely regulatory approval of pandemic-related products during a pandemic.
6. Each Party shall, in accordance with national laws, encourage manufacturers, as appropriate, to generate relevant data and diligently pursue regulatory authorizations and/or approvals of pandemic-related products with WHO-listed authorities, other priority authorities and WHO.

One might predict that if this plan goes forward, the least rigorous regulator would quickly be selected by product manufacturers to make licensing decisions on their products.

Most nations' drug regulators are funded by pharmaceutical firms, who pay for the evaluation of new drug and vaccine applications. It should come as no surprise that the % of the regulators' budgets that is funded by pharma is directly related to the % of drug approvals issued. We might even see the cost of drug evaluations paid by Pharma go up as the quality of the evaluations goes down. Below is fascinating information on the regulators of drugs and vaccines around the world and the public versus private funding they receive.

Table 1 | How the regulators compare

	Australia TGA	Europe EMA	UK MHRA	Japan PMDA	USA FDA	Canada HC
Budgets and fees						
Proportion of budget derived from industry <sup>o</sup>	96%	89%	86%	85%	65%	50.5%
Total annual budget <sup>†</sup>	AU\$170m (£95m)	€386m (£331m)	£159m	¥29.1bn (£175m)	US\$6.1bn (£5bn)	C\$2.7bn (£1.7bn)
Transparency, COIs, and data						
Proportion of covid-19 vaccine committee members that declared financial COIs	50%	3%	32%	75%	<10%	0%
Declared COIs available as public information	No	Yes	Yes	Yes	Yes	No
Regulator routinely receives patient level datasets*	No	No	No	Yes	Yes	No
Drug approvals						
Proportion of decisions to approve new medicines (v not approve)	94%	88%	98.5%	Not disclosed	69% <sup>^</sup> 29% <sup>#</sup>	83%
Proportion of new drugs approved through expedited pathways in 2020	20%	50%	36% <sup>†</sup>	26%	68%	16%

<https://www.bmj.com/content/bmj/377/bmj.o1538.full.pdf> BMJ June 2022. Maryanne Demasi

## Next Up: Vaccines Developed in 100 Days

A plan to develop vaccines in 100 days and have them manufactured in 30 additional days has been widely publicized by the vaccine nonprofit CEPI, founded in 2017 by Bill Gates, Dr. Jeremy Farrar and others. Farrar is now the WHO's Chief Scientist. The same plan has been echoed by the US and UK governments and received buy-in from the G7 in 2021. This time frame would only allow for very brief testing in humans, or would limit testing to animals. Why would any country sign up for this? Is this what we want, to vaccinate the entire world, then find out the bad news later?

The plan furthermore depends on the vaccines only being tested for their ability to induce antibodies, which is termed immunogenicity, rather than being shown to actually prevent disease, at least during the initial vaccine rollout. My understanding of FDA regulation is that antibody levels are not an acceptable surrogate for immunity unless they have been shown to correlate with protection.

However, the FDA's recent vaccine decisions have ignored that requirement and vaccines are now being approved based on antibody levels alone. But the induction of antibodies does not tell you whether they prevent infection. Sometimes they have promoted infection.

The FDA's vaccine advisory committee has asked for better indicators of efficacy than just antibody levels for COVID vaccines. But despite lacking such data, the advisers voted anyway to approve or authorize vaccines over the past year, without knowing whether they actually work. I learned this from watching the FDA vaccine advisory meetings, as I provide a live blog of them and often detailed summaries on my substack.

We all know how long it took for the public to become aware that the COVID vaccines failed to prevent transmission and only prevented cases for a period of weeks to months. The US government has still not officially admitted this, even though CDC Director Rochelle Walensky told CNN's Wolf Blitzer the truth about transmission on August 6, 2021, 8 months after the Pfizer vaccine launched. Two years after Walensky's admission on CNN, the CDC still claims the COVID vaccines are "safe and effective." How long will it take to learn whether vaccines launched in 100 days actually work, the side effects they cause, and how severe those side effects really are?

### **You Can't Do Safety Testing for 100 Day Vaccines**

It is very important for the public to understand that **safety testing** can only be accomplished in human beings, because animals react differently to drugs and vaccines than humans do. Therefore, limited testing in animals would mean *there was no real safety testing*. But testing vaccines in humans for only short periods is also unacceptable.

Testing vaccines during brief trials in humans (the Pfizer trials only followed a minority of subjects in a "safety subset" for a median of two months when the vaccine was authorized) allowed COVID vaccines to be rolled out without the public being aware they could cause serious side effects, let alone myocarditis and sudden deaths.

### **You Can't Assess the Soundness of the Manufacturing Process for 100 Day Vaccines**

Finally, following this rapid manufacturing plan, thorough testing for potential failures in the manufacturing process could not be performed. Scaling up from producing pilot lots to large scale manufacturing requires a whole new evaluation. With the current plan for far-flung, decentralized manufacturing facilities that are said to be necessary to achieve vaccine equity for all, there are nowhere near enough regulators who know how to inspect vaccine manufacturers.

Furthermore, the concept of so-called remote inspections of drug and vaccine manufacturers was introduced during the pandemic, and if continued as planned, this will successfully drive down the quality and value of facility inspections.

### **Will the WHO Respect Human Rights?**

The need to respect "human rights, dignity, and freedom of persons" is embedded in the current International Health Regulations (IHR), as well as other UN treaties. However, the language guaranteeing human rights, dignity, and freedom of persons was peremptorily removed from the proposed IHR Amendments, without explanation. The removal of human rights protections did not go unnoticed, and the WHO has been widely criticized for it.

The WHO apparently is responding to these criticisms, and so the language guaranteeing human rights that was removed from the drafts of the International Health Regulations has been inserted into the newest (Bureau's text) version of the pandemic treaty.

## Conclusions

As long predicted by science fiction, our biotech, cyber and surveillance achievements have finally gotten away from us. We can produce vaccines in 100 days and manufacture them in 130 days—but **there will be no guarantees that the products will be safe, effective, or adequately manufactured**. And we can expect large profits, but no consequences for the legally shielded manufacturers and government officials from any injuries to the public.

**If we do face another pandemic, being able to access existing repurposed drugs will be the only rapid and safe solution.** Yet existing drugs have been deliberately excluded by the WHO's IHR amendments and treaty draft, presumably because no one gets rich off non-patentable and available old drugs.

**Our genes can be decoded by genomic sequencing**, and the fruits of personalized medicine made available to us. Or perhaps our genes will be patented and sold to the highest bidder. We might be able to select for special characteristics in our children, but at the same time, **a human underclass of test-tube babies could be created**.

Our electronic communications can be completely monitored and censored, and **uniform messaging can be imposed on everyone**. But for whom would this be good?

**New biological weapons will be discovered and/or engineered. They will be shared.**  
This virtually guarantees future pandemics.

We can hope the GOF research that studied and created them will speed up the development of vaccines and therapeutics for the public, but it never has so far.

**Who really benefits from the gain-of-function scam?** Those who seek to control us. It is the public who pays the cost of the research, then pays again for the accidents and deliberate leaks. Wouldn't it be better to end gain-of-function research entirely, by restricting funding or closing the laboratories, rather than **encouraging the distribution of biological weapons**? If we want a decent future, it is crucial that we control these weapons instead of proliferating them.

**Centralized dictates for managing the COVID pandemic resulted in catastrophe.**  
Wouldn't we be insane to allow the WHO to control our responses to future pandemics?

These are important issues for all of humanity, and I encourage everyone to pay attention to them, think about them, and become part of this very important conversation.