CHEAT SHEET FOR SUBMISSIONS ON

THE PROPOSED AMENDMENT TO THE INTERNATIONAL HEALTH REGULATIONS

By Kirsten Murfitt

BACKGROUND

1. The existing International Health Regulations (2005) ("**IHR**") are legally binding regulations that set out a state party's obligations during an international public health risk.

2. Many New Zealanders are concerned, and the majority blissfully unaware, that the World Health Organization ("**WHO**") is designing the architecture for a singular controlling authority for global health for 99.44% of the world's population via the proposed amendments to the IHR and the new draft Pandemic Prevention, Preparedness and Response Accord ("**Pandemic Treaty**"). The proposed amendments to the IHR strengthen WHO's powers and extend their domain from an "*actual public health risk*" to cover *"**potential** or actual public health emergency of international concern".* In turn, the Pandemic Treaty includes climate change and environmental health surveillance.

3. The proposed amendments to the IHR only require a simple majority vote to be passed. If the amendments to the IHR are passed, they will come into effect 12 months later (New Zealand has 24 months due to rejecting the 1 December amendment), and state nations will have ten months to revoke or reserve their position (New Zealand has 18 months due to rejecting the 1 December amendment[1]).

4. If the proposed amendments to the IHR are adopted:

   (a) New Zealand's independent decision-making powers over health policy will be transferred and vested in WHO, an unelected and unaccountable body in Geneva, that may lack knowledge or concern for local circumstances; and

   (b) The provisions of the IHR will be integrated into domestic law via the usual parliamentary process. Article 59 of the current IHR contemplates the integration of the regulations into domestic law and states:

   > *"If a State is not able to adjust its domestic legislative and administrative arrangements fully with these Regulations within the period set out in paragraph 2 of this Article, that State shall submit within the period specified in paragraph 1 of this Article, a declaration to the Director-General regarding the outstanding adjustments and achieve them no later than 12 months after the entry into force of these Regulations for that State Party.[2]"*

5. For more information, please read my Open Letter to Members of Parliament dated 15 January 2024. You can access it by clicking on the link below:

   https://x.com/MurfittTauranga/status/1746808444949311679?s=20

HOW TO MAKE A SUBMISSION

6. The Ministry of Health ("**MOH**") is currently accepting submissions on the proposed amendments to the IHR. Submissions can be made via an online survey which can be accessed by clicking on the link below:

   https://consult.health.govt.nz/public-health-agency/proposed-amendments-international-health-regs/consultation/subpage.2023-11-08.7341477664/

[1] https://www.health.govt.nz/system/files/documents/information-release/minor_amendments_to_the_international_health_regulations_2005_approval_for_binding_action_watermarked_for_pr.pdf
[2] https://iris.who.int/bitstream/handle/10665/246107/9789241580496-eng.pdf?sequence=1

7. Both individuals and organisations can make submissions. I would encourage organisations to make submissions, as they may hold more weight in the political arena.

8. The consultation will run from **Wednesday 17 January to Sunday 18 February**. The consultation is one part of the process. There also needs to be Cabinet agreement, a National Interest Analysis, and presenting that Analysis and the text of the IHR changes to Parliament for Treaty Examination.

SUGGESTION POINTS FOR SUBMISSIONS

9. I have set out below several points that you may wish to include, amend, or add to your submissions. The suggestions are only a starting point for you to assist you with your submissions. You can access the following documents by clicking on the links below:

   (a) **Proposed Amendments to the IHR**: https://apps.who.int/gb/wgihr/pdf_files/wgihr1/WGIHR_Compilation-en.pdf
   (b) **Existing IHR:** https://www.who.int/publications/i/item/9789241580496

10. Please note that I have written this paper in my personal capacity as a concerned citizen of New Zealand, and it does not constitute legal advice.

SURVEY QUESTION 2: ARE THERE ASPECTS OF THE PROPOSED AMENDMENTS WHICH YOU THINK NEW ZEALAND SHOULD SUPPORT OR OPPOSE? WHERE POSSIBLE, PLEASE REFERENCE THE RELEVANT IHR ARTICLE THAT YOU ARE COMMENTING ON.

11. The Ministry of Health's ("**MOH**") website states that New Zealanders are being invited to comment on a "*proposal to update a significant global health agreement*". However, the lack of transparency and due process by the WHO is concerning and may result in New Zealand's public consultation process being farcical.

12. By way of background, in 2022 member states agreed *through Executive Board Decision 150(3) (2022) and WHA Decision WHA75(9) (2022)* to amend the existing IHR ("**2022 Amendments**"). Under the 2022 Amendment, there were 307 proposed amendments to 33 of the 66 articles of the IHR and five of the nine annexes, plus six new articles and two new annexes. However, we do not know what amendments will be presented at the World Health Assembly ("**WHA**") in May 2024, as the Working Group International Health Regulations ("**WGIHR**") has been working on them behind closed doors since early 2023, and only a summary report is broadcast at the delegate meetings.

13. In late 2023 the WGIHR stated that it intended to circumvent Article 55 of the current IHR, which allows state parties four months to consider any amendments prior to the WHA. The proposed amendments to the IHR should have been released on 27 January 2024- this has not occurred.

14. How can New Zealanders comment on the proposed amendments to "*a significant global health agreement*" without reference to the latest draft? If the government does not know the contents of the latest draft, how can it conduct a national interest analysis?

15. Based on the 2022 Amendments, the badly drafted amendments result in uncertainty as to the interpretation of various articles. Set out below are some of the objections to the proposed amendments to the IHR (which is not an exhaustive list):

    (a) **Definitions Section**: The references to ***"non-binding"*** in regard to the "*standing recommendation"* and *"temporary recommendations"* have been removed.

Given that the current IHR has standing under international law, the deletion of words such as "*non-binding*", implies that the standing recommendation will be binding. This view is supported by other language used in the proposed amendments to the IHR (see below).

The definition section states that:

> *"health products includes medicines, vaccines, medical devices, diagnostics, assistive products,* ***cell and gene-based therapies****, and other health technologies, but not limited to this course".*

What therapies are included in "*cell and gene-based therapies*" and "*health technologi*es", as the proposed amendments do not define the terms? A well-drafted legal instrument would include definitions for each of the terms rather than leaving terms open for interpretation which creates uncertainty and distrust in the current environment.

The introduction of the concept of health products into the IHR, without clear definitions, is alarming given the vested interests in WHO's public-private partnership funding model (refer to Question 3).

(b) Article 2 Scope and Purpose: removed the words *"public health risk"* and replaced them with *"all risks with a* ***potential*** *to impact public health".*

Once again what do these words mean? What type of events qualifies as a "*potential to impact on public health*"? Why has there been a move away from risk to potential impact? Does a potential impact on public health event include climate change and environmental health surveillance as set out in the draft Pandemic Treaty? Have provisions of the draft Pandemic Treaty been incorporated into the latest draft of the proposed amendments to the IHR?

(c) Article 3 Principles: the removal of the words ***"with full respect for the dignity, human rights and fundamental freedoms of persons"*** in regard to the implementation of the regulations and replacing them with *"based on the* ***principles of equity****, inclusivity, coherence and in accordance with their common but differentiated responsibilities of the States Parties, taking into consideration their social and economic development."*

Why does WHO want to remove references to the existing human rights laws and protections and establish equity? While this may sound benign to some, WHO is focused on *"vaccine equity"* rather than using established medicines which aim for positive health outcomes for people (see comments set out in question 3)

(c) Article 10 Verification: the removal of the words *"taking into account the views of the State Party concerned"* in regard to the "*failure*" of a state party to accept the offer of collaboration which in turn will allow WHO to share with other state parties the information available to it.

(d) Article 12 Determination of a public health emergency of international concern, public health emergency of regional concern, or intermediate health alert risk assessment: added the words *"**<u>potential</u>** or actual public health emergency of international concern"* for action to be taken (e.g. lockdowns, mandates etc.) and *"**determination of a Public Health Emergency of International Concern** and intermediate level of alert, including temporary recommendations and the convening and functioning of the Emergency Committee."*

It is perplexing that WHO's powers could be extended to decide on the response to a <u>potential</u> or actual public health emergency of international concern ("PHEIC") without reference to any standards or definitions of what constitutes such an emergency. PHEICS and potential PHEICs could be declared by WHO without the agreement of the concerned State or States (which was the case when WHO declared monkeypox a potential public health emergency in July 2022).

(e) Article 13 Public health response: the removal of the words *"At the request of a State Party"* and replaced them with *"**WHO shall clearly define assistance** to a State Party offer assistance to a State Party in response to public health risks and other events by providing technical guidance, health products, technologies, know-how, deployment of civil medical personals. The State has 48 hours to respond….in the*

case of rejection of such an offer, shall provide to WHO its rationale for the rejection, which the WHO shall share with other States Parties."

Why is New Zealand answerable to an unelected and undemocratic organisation that has serious vested interests in WHO's public-private partnership funding model (refer to question 3)?

(f) NEW Article 13A WHO Led International Public Health Response: "*States Parties recognize WHO as the guidance and coordinating authority of international public health response during public health Emergency of International Concern and* ***undertake to follow WHO's recommendations in their international public health response"*** *and "WHO shall carry out an assessment of the availability and affordability of the health products such as diagnostics, therapeutics, vaccines, personal and protective equipment and other tools required for responding to public health emergencies of international concern".*

Why would we "*undertake*", a legal term for a promise as required by law, to follow WHO's recommendations rather than assessing the situation in New Zealand? The unelected and unaccountable body in Geneva may lack knowledge or concern for local circumstances. This `one size fits all' approach may not be appropriate for the situation in New Zealand.

Following WHO's non-binding recommendation during the COVID-19 response has resulted in billions of dollars of national debt for New Zealand, which in turn has contributed to inflation, a crumbling health system with huge waiting lists partially due to diseases not being diagnosed early during the lockdowns and mandates and increased vaccine injuries, mental health issues and the damage to our children's education and development.

In this regard to the *`one size fits all'* approach, Australian Politician Craig Kelly has stated:

> *"The best way to handle any health crisis is with diversified & localised decision making (by those accountable legally & politically for their decisions) devoid of groupthink & Big Pharma influence - with rapid feedback and the ability to quickly change policies if needed…It would be a catastrophic mistake to hand decision-making to a cumbersome and slow-moving giant bureaucracy, run by unelected officials with zero accountability and easily influenced & corrupted by Big Pharma[3]."*

(g) New Article 13A: Access to Health Products, Technologies, and Know-How for Public Health Response: ***"States Parties*** shall ***co-operate with each other and WHO to comply with such recommendations*** *pursuant to paragraph 1 and shall take measures to ensure timely availability and affordability of required health products such as diagnostics, therapeutics, vaccines, and other medical devices required for the effective response to a public health emergency of international concern."*

The word "*shall*" indicates that compliance with the recommendations is mandatory. This is very concerning given that article 13A(6) states that:

> *"WHO shall take measures to ensure availability and accessibility through the local production of required health products including:*
>
> *a) develop and publish a list of required health products,*
>
> *b) develop and publish specifications for the production of required health products,*
>
> *c) develop appropriate regulatory guidelines for the rapid approval of health products of quality including development of immunogenicity co-relative protection (ICP) for vaccines,*
>
> *d) establish a database of raw materials and their potential suppliers,*
>
> *e) establish a repository for cell-lines to accelerate the production and regulatory of similar biotherapeutics products and vaccines,*

[3] https://x.com/CKellyUAP/status/1717954262347780366?s=20

f) review and regularly update WHO Listed Authorities so as to facilitate appropriate regulatory approvals,

g) any other measures required for the purposes of this provision.

(h) Information sharing: added the following "*For this purpose, WHO shall facilitate the exchange of information between States Parties and ensure that the **Event Information Site** for National IHR Focal Points offers a secure and **reliable platform** for information exchange among the WHO and States Parties and allows for interoperability with relevant data information systems*."

Information sharing in a genuine international public health crisis should be encouraged but this does not mean New Zealand should vote in favour of the proposed IHR before undertaking proper due diligence. We can still share information if another pandemic was to occur in the next few years. However, it must be highlighted that global pandemics are rare.

New Zealanders need to know what is meant by a "*reliable platform*"? Will New Zealand Citizen's personal medical information be stored offshore? If so, where will our personal medical information be stored, and what precautions will be taken by the New Zealand Government to protect this information?

(i) Vaccine Passport Provisions

Article 35 General rule: added ***"Digital health documents must incorporate means to verify their authenticity*** *via retrieval from an official web site, such as a QR code", and Health documents meeting the conditions approved by the Health Assembly shall be recognized and accepted by all Parties. Specifications and requirements for **certificates in digital form shall take into account existing widely used systems established at the international level** for the issuance and verification of digital certificates."*

Article 36 Certificates of vaccination or other prophylaxis: "Other types of proofs and certificates may *be used by Parties to **attest the holder's status as having a decreased risk of being the disease carrier,** particularly where a vaccine or prophylaxis has not yet been made available for a disease in respect of which a public health emergency of international concern has been declared. Such proofs may include test certificates and recovery certificates. These certificates may be designed and approved by the Health Assembly according to the provisions set out for **digital vaccination or prophylaxis certificates,** and should be deemed as substitutes for, or be complementary to, the digital or paper certificates of vaccination or prophylaxis.*

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We know from our experience in New Zealand that the traffic light system and vaccine passports were not intended, and it was known to the former Government the MOH's OIA response dated 10 September 2021 confirms this point, to dampen transmission but to push the uptake of the vaccine. Dr Michael Baker, a touted COVID-19 expert, was quoted in the Guardian newspaper as follows:

"…the traffic light system won't help us very much because it was never designed to dampen down transmission, it was only designed to nudge people towards vaccination.[4]"

As set out in question 3, there are significant vested interests in the public-private partnership funding model and WHO focusing on vaccines rather than other medications. Medical interventions must be proven safe and effective before they are rolled out on a healthy population, let alone mandated under provisional consent as was the case with the COVID-19 vaccine. Why does the WHO want the Government to agree for Big Pharma to vaccinate a predominately healthy population, with a vaccine that may not stop transmission or infection, when the medium and long-term effects will not be known for years? How is this a good public health policy?

Any requirement for vaccine passports has the potential to lead us into a biosecurity regime and social credit system with digital ID and international vaccine passports (will the vaccine passports only remain valid if you take the latest booster?).

Telekom reports on its website that the WHO selected T-Systems as an industrial partner. The company providing the technology states:

"The World Health Organization (WHO) will ***make it easier for its member states to introduce digital vaccination certificates in the future****. The WHO is setting up a gateway for this purpose.* ***It enables QR codes on electronic vaccination certificates to be checked across national borders****. It is intended to serve as* ***a standard procedure for other vaccinations****, such as polio or yellow fever after COVID-19. The WHO has selected T-Systems as an industry partner to develop the vaccination validation services[5]."*

In 2016, the United Nations held the inaugural ID2020 to discuss how to provide digital identity to all, a defined Sustainable Development Goal (under Agenda 2023). The 2018 summit focused on defining what constituted a "good" digital ID. In 2019, ID2020 was launched in conjunction with Global Alliance for Vaccines and Immunization ("**GAVI**")[6]. ID2020, a nongovernmental organisation[7], recently launched its Good Health Pass for a digital health pass system for global travel and the global economy. It is highly likely that any mandatory digital ID system will have more functions added over time.

As you may be aware, the previous Government introduced the Digital Identity Programme[8] , and the Digital Identity Services Trust Framework Bill was passed in March 2023[9]. In November 2023, the European Parliament and Member States reached an agreement to introduce Digital Identity.

(j) **Annex 1 Core Capacity Requirements for Disease Detection, Surveillance and Health Emergency Response**: specifically refers to leveraging "*communication channels to communicate the risk, countering misinformation and dis-information*".

16. If New Zealand is going to sign over the power for WHO to control the health narrative and potentially prevent scientific debate, we need to understand where WHO got it wrong during the COVID-19 response. For example, the risks and benefits of national lockdowns, masks and the vaccine, the definition and counting of COVID-19 death (e.g. dying <u>with</u> a COVID-19 positive test versus <u>from</u> the disease as the actual cause of death) and the threshold for the PCR Test which was originally used to "diagnose" a case.

17. However, the WHO refuses to be astute and undertake an independent inquiry to assess the merits of the recommendations it issued during the COVID-19 pandemic. How can we blindly trust an unelected and unaccountable organisation that does not wish to learn from an audit, given the medical and scientific debates surrounding the COVID-19 pandemic?

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4 https://www.theguardian.com/world/2022/jan/10/new-zealand-not-prepared-for-omicron-outbreak-expected-in-matter-of-weeks-experts-warn
5 https://www.telekom.com/en/media/media-information/archive/covid-19-who-commissions-t-systems-648634
6 https://en.wikipedia.org/wiki/ID2020
7 https://id2020.org/ and https://www.goodhealthpass.org/
8 https://www.digital.govt.nz/digital-government/programmes-and-projects/digital-identity-programme/
9 laws/document/BILL_116015/digital-identity-services-trust-framework-bill and https://www.newsroom.co.nz/government-to-introduce-vaccine-passports

18. We also need to commence and complete the promised independent inquiry into New Zealand's COVID-19 response, before we "undertake" to follow WHO's recommendations.

SURVEY QUESTION: 3 IS THERE ANY OTHER INFORMATION YOU WOULD LIKE TO PROVIDE THAT WOULD HELP TO DEVELOP OUR POSITION ON NEGOTIATIONS TO AMEND THE INTERNATIONAL HEALTH REGULATIONS (2005)?

19. By way of summary, New Zealand should not vote in favour of the proposed amendments to *"a significant global health agreement"* at the WHA meeting in late May 2024:

    (a) when there has been a lack of transparency and due process by the WHO;
    (b) there cannot be any meaningful parliamentary debate or Cabinet without a review of the latest draft of the proposed amendments to the IHR;
    (c) the financial cost of implementing the proposed amendments to the IHR is not known;
    (d) a number of poorer countries do not want to sign up to the proposed amendments to the IHR due to the cost.

Lack of Transparency and Due Process

20. There has been little public messaging to raise awareness about the proposed amendments to the IHR. However, it is clear from a recent parliamentary petition, which was signed by over 26,000 New Zealanders in less than three weeks[10], that there is significant public interest in the "*proposal to update a significant global health agreement*".

21. As noted in the response to Question 2, WHO intends to circumvent Article 55 of the current IHR, which allows state parties four months to consider any amendments prior to the WHA in May 2024. The WHO and its WGIHR are not being transparent and have failed to disclose the latest draft of the amendments and only a summary report is broadcast at the delegate meetings.

22. The above position was surprising to many state parties, and the delegate from Monaco asked for clarification, as she believed that she may have misunderstood the intention of the WGIHR not to follow the four-month rule in Article 55. Ashley Bloomfield, the co-chair of the WGIHR, responded by stating:

    "That the January letter is not going to include or append, the …another document [being the latest version of the IHR amendments] but just to simply update the Director General on our progress towards … and at this stage, it is not wise to provide a partially agreed set of amendments[11]".

Sovereignty and Independent Decision Making

23. Our elected representatives have a duty to ensure that the instruments do not impact the sovereignty of our nation and sovereignty over our bodies.

24. The existing IHR are currently the only legally binding global health laws which set out state parties' obligations during an international public health risk[12]. Under article 18 of the existing IHR, WHO can issue non-binding recommendations to the state parties with include:

    (a) proof of medical examination and any laboratory analysis;
    (b) requiring medical examinations;
    (c) proof of vaccination or other prophylaxis;
    (d) vaccination or other prophylaxis;
    (e) placing suspect persons under public health observation;
    (f) implementing quarantine or other health measures for suspect persons;
    (g) implementing isolation and treatment where necessary of affected persons;
    (h) implementing tracing of contacts of suspect or affected persons;
    (i) refusing entry of suspect and affected persons;
    (j) refusing entry of unaffected persons to affected areas; and
    (k) implement exit screening and/or restrictions on persons from affected areas.

[10] https://petitions.parliament.nz/ba284b7f-84ca-4059-0743-08dbd732584b
[11] https://apps.who.int/gb/wgihr/e/e_wgihr-6.html
[12] https://healthpolicy-watch.news/ihr-negotiations-to-continue-until-may-2024/

25. The recommendation under Article 18 impacted every New Zealander during the COVID-19 pandemic. For example:

    (a) The government changed legislation in defiance of a High Court ruling;
    (b) locked down the South Island despite there not being one case;
    (c) refused New Zealander's entry to their home country;
    (d) refused to consult with the public;
    (e) introduced vaccine mandates resulting in financial hardship for many families;
    (f) mandated vaccine passports despite the paradox of segregation given the vaccine does not provide immunity (i.e., it does not stop transmission or prevent infection).

26. The democratic process and human rights were harmed by the former overreaching Government which bred distrust in public institutions and took its toll on scientific debate and informed consent. Every New Zealander has a story of how the response to COVID-19 impacted their lives. loved ones.

27. Accordingly, it is concerning that the amendments to the IHR are designed to extend and strengthen the powers of WHO, which will be implemented by the Government of the day. The provisions contained in these legal instruments may be very dangerous in the hands of a controlling Government in the future.

28. If there are no issues around our nation's sovereignty and the transfer of independent decision-making powers to WHO, as claimed by the mainstream media, then Crown Law should release their advice to the Government. Crown Law has refused Kirsten Murfitt's request under the Official Information Act 1982 ("**OIA Act**") to access the documents on whether the IHR will impact on:

    (a) our nation's sovereignty; and
    (b) our obligations under the Treaty of Waitangi.

29. Crown Law has stated that they will not be releasing the documents due to legal professional privilege between Crown Law and the Government. This is outrageous, given that New Zealand taxpayers fund Crown Law.

30. WHO is meant to be an advisory body, not a governing body. Accordingly, it is a further concern that there is no entity to review the laws and regulations being made by the WHO to ensure that the basic principles of the Universal Declaration of Human Rights and other international human rights instruments are adhered to. It is imperative that we scrutinize whether there will be other independent checks and balances under the proposed regime, or will WHO have a monopoly over health? If WHO controls the narrative on health and science, this will flow into both international and domestic court decisions, as was the case over COVID-19 and the challenges to the mandates. This is a potential but serious threat to our democracy and sovereignty.

31. It may be argued that despite the current IHR being a legally binding instrument, they are `*toothless'* as there are no sanctions. However, Aljazeera reported in 2015 that the WHO was investigating ways to reprimand countries that disobey the IHR[13]. The drive to introduce sanctions is alarming, given the wording of the proposed amendments to the IHR and the removal of the word "non-binding".

Unknown Financial Cost of Implementation

32. The *Paper to Cabinet Social Wellbeing Committee on Minor Amendments to the International Health Regulations 2005: Approval for Binding Action dated 9 May 2023*[14] ("**NZ Cabinet Paper**") states that the cost of implementing the IHR was unknown. This is a concern given the prior Government's policies had budget blowouts and "*unintended consequences*". One overseas project forecast that over five years, an estimated $124 billion is needed for every country to reach demonstrated capacity for all IHR indicators.

33. It is claimed that the WHO is "*grossly underfunded*" and in January 2021, a Working Group on Sustainable Finance was set up to explore funding options. The working group discussed doubling members' assessed contributions (which does not factor in the cost of implanting the proposed IHR amendments and the Pandemic Treaty) from their 2022/23 levels, starting in 2024 and gradually increasing until 2028–2029. It is

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[13] http://america.aljazeera.com/articles/2015/10/22/health-sanctions-against-countries-misguided.html
[14] https://www.health.govt.nz/system/files/documents/information-release/minor_amendments_to_the_international_health_regulations_2005_approval_for_binding_action_watermarked_for_pr.pdf

essential that cost forecasting is undertaken for the implementation of the two legal instruments prior to adoption- given that New Zealand has spent billions on the COVID-19 response, which has had far-reaching effects. Surely members of Parliament have a duty to let the public know the forecasted cost.

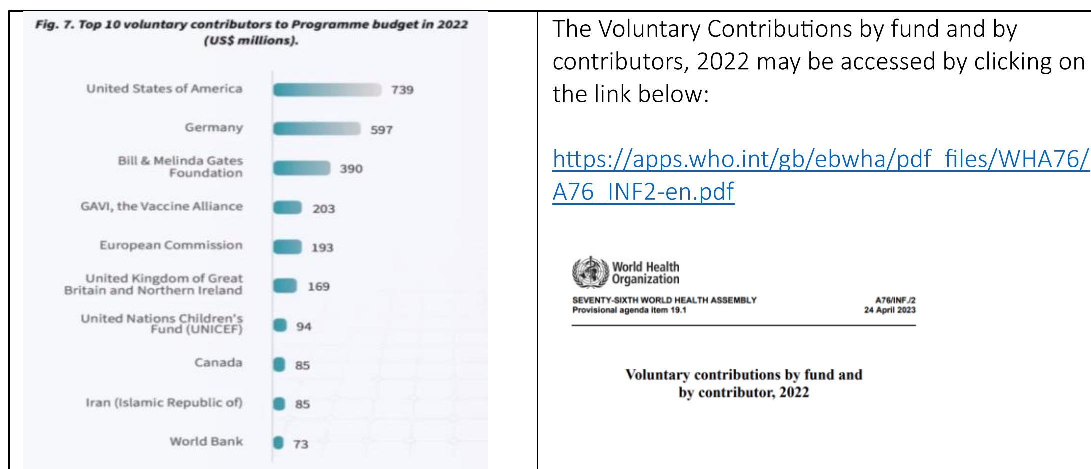
Conflict of Interest with the Financial Support

34. There have been past allegations of corruption of the WHO implementing policies and measures for the vested interests of various industries. Accordingly, the Government must consider WHO's public-private partnership funding model and any potential conflicts of interest.

35. WHO gets its funding from two main sources: assessed and voluntary contributions from the member states and other private partners. Many of these private partners are significant financial contributors to WHO and are also involved in the pharmaceutical and vaccine industries. There is a genuine concern that there may be a conflict of interest between WHO's loyalties to these private partners and human rights. This was illustrated during the COVID-19 pandemic, with WHO having a singular focus on vaccines rather than exploring legal and cheap medicines (which were no longer under patents) with an extensive safety history.

36. WHO's website states that:

> *"For much of the Organization's history most of its funds were provided* ***through assessed contributions made by Member States****, but in recent decades these have been capped and* ***today account for only 16% of WHO's total budget****. As these assessed contributions have declined in real terms, they have been replaced over time by an* ***increasing share of funding to WHO, coming as voluntary contributions where donors direct funding according to their priorities****.*
>
> *Contributions to WHO come largely from public funds. In both assessed and voluntary funding, Member States contribute directly nearly 60% of the programme budget, and another 14% comes from other organizations in the United Nations system, partnerships and development banks, which are themselves largely funded by governments.* ***Nearly 10% of WHO's funds come from philanthropic foundations, predominantly the Bill & Melinda Gates Foundation***
> *Through the results framework for the Thirteenth General Programme of Work* ***WHO holds itself accountable for the use of these funds, whether from government or philanthropic sources, and to ensure that they support significant outcomes***[15]*."*



The Voluntary Contributions by fund and by contributors, 2022 may be accessed by clicking on the link below:

https://apps.who.int/gb/ebwha/pdf_files/WHA76/A76_INF2-en.pdf

37. As noted above, donors of voluntary funding can direct funding according to their priorities. This creates investment opportunities that have the potential to provide returns far exceeding the financial contributions to WHO.

38. Private partners of WHO include top financial funders, such as the Bill & Melinda Gates Foundation, who also make further donations through parallel organisations such as the Strategic Advisory Group of Experts ("**SAGE**"), UNICEF, Rotary International and the Global Alliance for Vaccines and Immunisation ("**GAVI**"). CNBC

[15] https://www.who.int/about/funding/invest-in-who/investment-case-2.0/current-state

reported in 2019 that Bill Gates claimed that vaccines were his best investment, with 10 billion "*…yielding $200 billion over those 20 or so years"* when they interviewed him at the World Economic Forum's annual meeting in Davos[16].

39. The Bill and Melinda Gates Foundation purchased shares in BioNTech in September 2019, a few months before WHO declared a global pandemic. BioNTech is the German biotechnology company that partnered with Pfizer in bringing a mRNA COVID-19 vaccine to market under emergency use. It is reported that the Bill and Melinda Foundation downsized its BioNTech holdings by 86% in the third quarter of 2021, which was BioNTech's best-performing quarter. The foundation had purchased the shares at a pre-public offering price of $18.10 per share in 2019. In 2021 the foundation sold the shares at an average sale price of $300 per share, pocketing a profit of approximately $260 million, or more than 15 times its original investment[17].

40. The Bill and Melinda Gates Foundation is also a founding partner of GAVI, another top private partner of WHO, and has contributed $4.1 billion to date[18]. At the 2020 Global Vaccine Summit, the Bill & Melinda Gates Foundation announced US$ 1.6 billion for Gavi's next "strategic period" between 2021 and 2025.

41. In turn, GAVI is working with the International Finance Facility for Immunisation ("**IFFLm**"), another public/private vaccination initiative. IFFLm's website states[19]:

> *"Gavi is developing a Day Zero Pandemic Financing Facility for Vaccines, in line with the recent G7 and G20 discussions on the need for such instruments, to ensure that the right surge financing capacities are in place when the next pandemic hits. This Day Zero facility will use innovative financing instruments to mobilise, for example, up to US$ 2 billion in risk-tolerant surge and contingent capital and will be comprised of a number of innovative financing tools that complement one another, including a contingent financing capability for IFFIm.*
>
> *This contingent financing mechanism (CFM), currently under development, will allow IFFIm to raise funds for Gavi even faster in the next pandemic by pre-positioning donor commitments to IFFIm today, but only activating those commitments if and when a future pandemic occurs. Once activation happens, IFFIm could raise funding on the capital markets, just as it does now.*
>
> *The contingent mechanism's structure provides the flexibility and adaptability needed for the unpredictable nature of pandemics, while still benefiting from the many strengths of IFFIm. This mechanism has the potential to contribute substantially – and efficiently – to the standby resources proposed for pandemic response. The contingent pledge feature is another example of how IFFIm continues to adapt. It builds on IFFIm's 17 years of experience in frontloading funding through the capital markets to support immunisation."*

42. The World Bank is also involved with GAVI. The World Bank stated in the *International Bank for Reconstruction and Development and International Development Association Project Paper on a Proposed Additional Financing to the Covid-19 Strategic Preparedness And Response Program using the Multiphase Programmatic Approach (Global Covid-19 MPA) with an additional IBRD and IDA Financing of up to Us$12 Billion (of which up to Us$6 Billion from IDA and up to US$6 Billion from IBRD Dated October 13, 2020')* that:

> *"**The Bank is on the Board of GAVI (as a founding member) and CEPI and works closely with both partners**. The Bank also works closely with UNICEF and WHO under the Global COVID-19 MPA and broader global public health priorities. Both organizations, play a leading role in global vaccination efforts. The Bank is a member of the ACT-Accelerator Partnership and leads its health strengthening pillar. **The Bank's increased financial and technical support for vaccine purchase and deployment will also be a part of a broader global partnership to support COVID-19 response**. In addition to building on the Bank's existing robust health portfolio and efforts under the Human Capital Project, Bank vaccination support will build on other complementary initiatives underway globally and in each individual country, supported by partners that are*

[16] https://www.cnbc.com/2019/01/23/bill-gates-turns-10-billion-into-200-billion-worth-of-economic-benefit.html
[17] https://clarkcountytoday.com/news/pfizer-vaccine-bonanza-slows-but-bill-gates-sold-early-made-huge-profits/
[18] https://www.gavi.org/investing-gavi/funding/donor-profiles/bill-melinda-gates-foundation
[19] https://iffim.org/about-iffim

also providing financing, health and immunization system strengthening support, and support other COVID-19 interventions[20].”

43. Given the World Bank’s financial interest in the promotion of vaccines, it is curious that the founder of the World Economic Forum, Klaus Schwab, has stated that:

> *"I believe that the future is not state capitalism or shareholder capitalism. The future is what I call stakeholder capitalism, which is combined with social responsibility…* ***Under a WEF-imagined stakeholder system, banks wouldn't lend to businesses that don't comply with, say, climate change policies or, say, vaccination mandates****. Investors wouldn't invest if the WEF didn't approve. Insurers wouldn't insure — governments wouldn't permit — developers wouldn't develop — builders wouldn't build — and so forth and so on. The Government, through partners and friends in business, would be the behind-the-scenes' strings puller[21]."*

44. The WHO and the WEF have a working relationship, and the newly appointed Director-General, Tedros Adhanom Ghebreyesus, posted on Facebook in 2019 the following (other more recent examples are set available).

> *“Excellent discussion with Klaus Schwab, Founder & Executive Chairman of @wef, about how we can join forces to accelerate progress in health & development to deliver the @GlobalGoalsUN. I look forward to continuing our discussions with partners @Davos. #WEF20 #HealthForAll[22]”*

45. As noted above, the proposed amendments to the IHR have removed the words “*with full respect for the dignity, human rights and fundamental freedoms of persons”* as a principle for implementing the IHR and replacing them with principles based on equity. The WHO and its private funders, such as the Bill and Melinda Gates Foundation, promote the principle of equity in regard to vaccines. At *the New Zealand Association of the United Nations* Conference in August 2023, Bloomfield was asked by the chairperson what would be the singular thing he would do differently in another pandemic. Bloomfield responded by stating that:

> *“The absolute, fundamental argh shift should we need to make this and this is at the heart of our negotiations on updating the International Health Regulations is equity, equity, equity needs to be front and centre. It’s not something that you can just do on the spur of the moment. It needs to be built into the way that we support, the low-income and lower-middle-income countries to develop the capabilities capacity that they need[23]”.*

46. Equity has little to do with health and is a world trade perspective, which likely explains the World Bank's involvement in the push for vaccinating entire healthy populations with vaccines that have not undergone the standard clinical trials and overprescribing approved medicines for people who become sick.

47. While some may argue that vaccine equity is a good thing, others contend that vaccine equity presents the organisation structure of top funders of WHO with an opportunity to increase sales and reap huge financial rewards from novel vaccines which have not been subjected to costly trials. It would appear that fast-tracking vaccines is going to become more common. Recently the Coalition for Epidemic Preparedness Innovations (“**CEPI**”) and the UK Government recently hosted the Global Pandemic Preparedness Summit to explore how we can respond to the next *“Disease X”,* by making “safe and effective vaccines” within 100 days[24]. The WEF has been preparing for Disease X since 2018 and has included it in its agenda for the 2024 Davos conference[25].

48. Jeremy Farrar was one of the three co-authors of the CEPI concept in 2015. The concept was further developed at the WEF 2016 Davos meeting. CEPI was launched at the 2017 Davos meeting with co-founder Bill Gates, who stated:

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[20] https://documents1.worldbank.org/curated/en/882781602861047266/text/World-COVID-19-Strategic-Preparedness-and-Response-Program-SPRP-using-the-Multiphase-Programmatic-Approach-MPA-Project-Additional-Financing.txt
[21] https://x.com/MurfittTauranga/status/1718292201543983223?s=20
[22] https://www.facebook.com/DrTedros.Official/photos/a.555336211202542/2424952817574196/?type=3&paipv=0&eav=AfbMCXq2qdSw1Ao1l6Bu10sSerkjQAzyRiZITX94JRJZnhppotB3P8lZvoYpITGBT7k&_rdr
[23] https://x.com/MurfittTauranga/status/1715943450015850743?s=20
[24] https://100days.cepi.net/#:~:text=What%20if%20it%20took%20100,effective%20vaccines%20within%20100%20days.
[25] https://x.com/MurfittTauranga/status/1746246754788577714?s=20

"The market is not going to solve this problem because epidemics do not come along very often — and when they do you are not allowed to charge some huge premium price for the tools involved.[26]".

49. Recently, Farrar pioneered the idea of producing a vaccine in 100 days and manufacturing it for an entire nation in 30 days. Given that it normally takes years to develop a licensed vaccine, it is highly questionable whether this can be done safely (consequently the instruments require a liability shield for manufacturers). It is interesting to note that Farrar served as a director of The Wellcome Trust (a funder of GAVI) from 2013 to 2023 but was appointed as the Chief Scientist at WHO in the second quarter of 2023[27] and will have an instrumental role in any future pandemic, such as the proposed Disease X pandemic.

Conclusion

50. New Zealanders must be given the opportunity to understand the full ramifications of the proposed amendments to the IHR given that the proposed amendments to the IHR will galvanise WHO as the singular controlling authority and architect of global health. This will change the relationship between New Zealand citizens and the State by moving away from a democracy and towards an autocratic dictatorship run by unelected and unaccountable members of the WHO.

51. If the instruments are adopted, WHO will have law-making, executive, expert, and censorship roles, which are well-known paths to the usurpation of unrestrained power. This is a serious concern given the vested interest of WHO's private donors who can direct funding according to their priorities, which creates investment opportunities that provide returns far exceeding their financial contributions to WHO. Recently, Croatian MEP Mislav Kolakušić stated:

"It would be healthier and safer for humanity to sign an agreement with the Colombian drug cartel than to sign an agreement with the World Health Organisation[28].

[26] https://en.wikipedia.org/wiki/Coalition_for_Epidemic_Preparedness_Innovations#:~:text=Founding,-Jeremy%20Farrar%2C%20co&text=The%20concept%20for%20CEPI%20was,)%2C%20American%20physician%20Stanley%20A.

[27] https://www.who.int/news/item/13-12-2022-world-health-organization-names-sir-jeremy-farrar-as-chief-scientist-dr-amelia-latu-afuhaamango-tuipulotu-as-chief-nursing-officer

[28] https://x.com/MurfittTauranga/status/1718289928617120241?s=20