PANDA

PANDEMICS - DATA & ANALYTICS

THE WHO REVIEW AND WHY IT MATTERS TO YOU

JUNE 2022

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INTRODUCTION: YOUR HEALTH MATTERS

Avoiding disease and maintaining health is important to all of us. It allows us to live fuller lives, spend time with our loved ones and do the things we love. Being healthy leads to a better quality of life and overall increased happiness.

Losing sovereignty over your health matters.

Your health is your most valuable asset. You have a responsibility to research, learn, analyse and critically assess information in order to make better decisions for yourself and your loved ones.

We usually rely on expert guidance when making choices related to our health. These experts influence many of our decisions, from what we choose to eat for dinner to what medical interventions we elect to undergo. It is paramount that we ensure the chosen experts have our best interests at heart. It is paramount that we retain the final say in matters related to our health.

Reflection | What do you think the **criteria** should be for **entrusting your health** to an organisation?

THE WHO ACCORD: THE PROMISE OF BETTER HEALTH

The World Health Organization (WHO) has been entrusted by nations to safeguard global health and look after the people's best interests. It is currently leading negotiations on a proposed Global Accord on Pandemic Prevention, Preparedness and Response — an initiative aimed at making the world "**much better prepared** and **better aligned in responding to possible future pandemics."**

Indeed, we should always endeavour to do better, respond better, share knowledge and resources better and coordinate better. We should utilise all available tools to accurately assess threats and devise sound responses, proportionate to the identified threat. We should seek to reduce illness, promote health and improve quality of life for all — to the best of our human ability. We should be compassionate, humane and ethical. Most importantly, we should choose carefully those who represent us in achieving these goals. .

This review attempts to empower you with key information to help you **reassess the WHO's candidacy as an authoritative global public health organisation**. It provides background information on public health and pandemic management principles, to allow you to evaluate the soundness of the WHO-recommended response to Covid-19. It goes on to summarise the assumptions underlying their Covid-19 recommendations, followed by a summary of the recommendations. Finally, it discusses possible influences on the WHO's decisions and direction, and suggests actions you may take to safeguard your health sovereignty.

PART I: FUNDAMENTAL PRINCIPLES

In times of emergency, when uncertainty and fear are rampant, societies function best if they uphold long-standing principles and ethical values, developed over many years through collective wisdom.

PUBLIC HEALTH PRINCIPLES

10 basic principles of public health that should be revived and re-committed to by all nations:

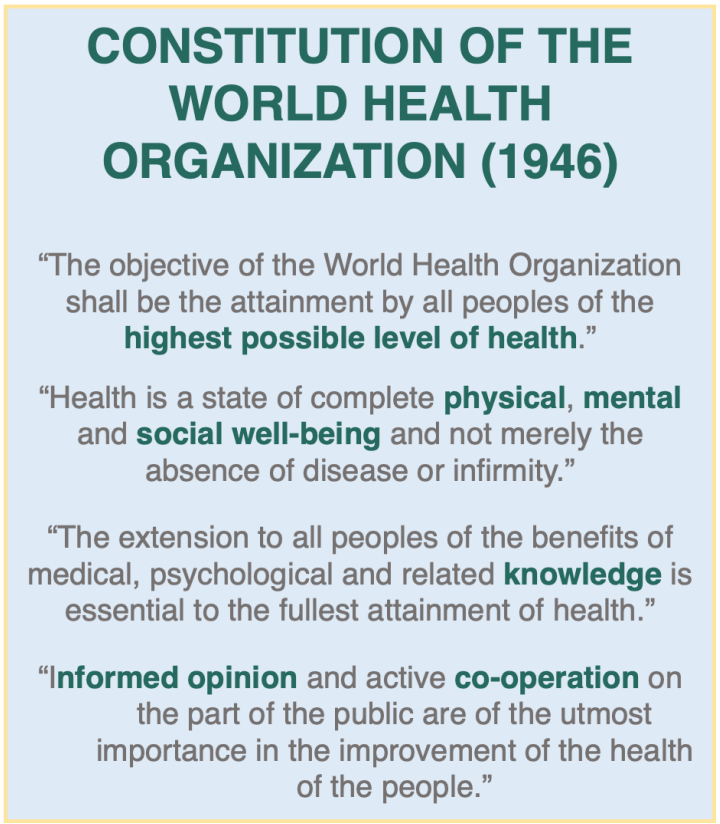
1. Human dignity and personal freedoms should be upheld under all circumstances. Any restrictions on individual freedom, on public health grounds, must be temporary and case-specific, and should be undertaken as a last resort under an exceedingly high burden of proof of their necessity, reasonableness and proportionality.
2. A holistic definition of health includes physical, mental, spiritual and social well-being.
3. Individuals have the right to bodily integrity, i.e. to make free choices regarding their body and to be free of any interference with their body to which they do not consent.
4. Health professionals should only recommend health interventions based on individual needs and only if the benefits outweigh the risks for that person.
5. Health professionals must obtain informed and voluntary consent from individuals before any medical intervention. Inaccurate information, psychological manipulation and any form of coercion render consent invalid.
6. Public health interventions should protect private medical information. Interventions that lead to discrimination and stigmatisation based on personal health care choices are unethical.
7. Public health interventions should take into account biological (pathogen, genetic factors, health status, medical interventions...), as well as social determinants of health, including economic stability and employment, neighbourhood and physical environment, community support and mental wellbeing and access to and quality of education, food and health care.
8. A multi-disciplinary approach should be undertaken to assess the short-, medium- and long-term effects of any public health intervention prior to its implementation.

9. Individuals and communities directly affected by public health interventions should participate in the decision-making process to ensure their fairness, appropriateness and success.
10. Trust in public health is built on transparency and honesty. Policies and recommendations should be based on accurate data — free of conflicts of interest. They must also be subjected to continuous improvement through open scientific debate.

    All decisions related to individual and public health should be guided by these principles in order to improve health and quality of life for all.

THE WHO CONSTITUTION

The WHO was established in 1946 to serve the people and help them achieve "the highest possible level of health".



Source: Constitution of the World Health Organization (1946) [highlights]

THE WHO PANDEMIC PLANS

Prior to the Covid-19 Pandemic, WHO experts analysed the scientific literature and drafted recommendations for pandemic management.

Reflection | Were the **non-pharmaceutical interventions** (NPIs) deployed during the Covid-19 pandemic **in line** with the **2019 WHO pandemic management recommendations**? (Assess below)

Non-pharmaceutical Public Health Measures For Mitigating The Risk And Impact Of Epidemic And Pandemic Influenza World Health Organization (2019)

"Active **contact tracing** is NOT recommended in general because there is no obvious rationale for it in most Member States." (p. 38)

"Home **quarantine** of exposed individuals to reduce transmission is NOT recommended because there is no obvious rationale for this measure, and there would be considerable difficulties in implementing it." (p. 47)

"The EFFECT of reactive **school closure** in reducing influenza transmission varied but was generally LIMITED." (p 50) "In such cases, the adverse effects on the community should be fully considered (e.g. family burden and economic considerations), and the timing and duration should be limited to a period that is judged to be optimal." (p. 52)

"The strength of EVIDENCE on **workplace closure** is very LOW because the identified studies are all simulation studies." (p. 54)

"The EFFECT of measures to avoid **crowding** ["e.g. large meetings, religious pilgrimages, national events and transportation hub locations"] alone in reducing transmission is UNCERTAIN… the quality of evidence of its effectiveness is very low." (p. 57).

"NO scientific EVIDENCE was identified for the effectiveness of **travel advice** against pandemic influenza; however, providing information to travellers is simple, feasible and acceptable." (p. 61)

Entry and exit screening of travellers [e.g., health declarations, visual inspections for symptoms and temperature checks] is "NOT recommended due to the overall ineffectiveness in reducing the introduction of infection and delaying local transmission." "Involuntary screening may have ethical or legal implications." (p. 64)

"Overall, **border closure** is NOT recommended… This is due to the very low quality of evidence, economic consequences, resource implications and ethical implications." (p. 69)

Source: Non-pharmaceutical Public Health Measures For Mitigating The Risk And Impact Of Epidemic And Pandemic Influenza (WHO, 2019)

PART II: MISCELLANEOUS MISUNDERSTANDINGS

There are several underlying assumptions that determined the WHO-recommended response to the Covid-19 pandemic; these led to behaviours at individual and societal level that were unwarranted and detrimental.

LETHALITY

The WHO played a vital role in influencing the public's perception of the threat of SARS-CoV-2 (the virus that causes Covid-19 in some people).

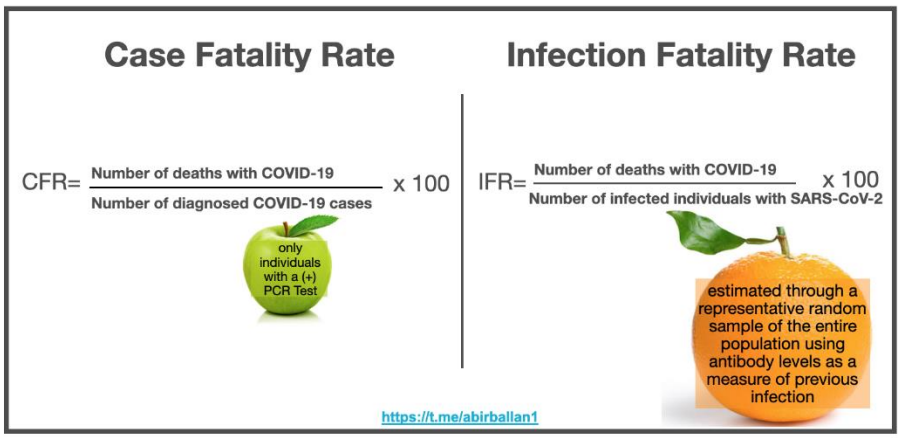
Tedros A. Ghebreyesus, the WHO Director General, started his speech (March 3, 2020) by mentioning Ebola, priming the public to make an association between Ebola (a highly deadly disease) and Covid-19. This is a behavioural science technique — techniques used to modify human behaviour subconsciously — that creates an association between two events in order to transfer the characteristics of one event onto the other.

Reflection | Should behavioural science techniques be used as public health tools?

Ghebreyesus then compared the Case Fatality Rate (CFR) of Covid-19 to the infection fatality rate (IFR) of the Flu.

"Globally, about **3.4%** of **reported Covid-19 cases** have died [these represent the severe case that reached the hospital]. By comparison, seasonal **flu** generally kills far fewer than **1%** of those **infected** [these represent total infections including mild ones]."

TEDROS A. GHEBREYESUS, MARCH 2020



[Note: The definition for a Covid-19 case used during this pandemic is inaccurate. A case should be defined as a person with a (+) PCR Test and clinical symptoms of illness]

Reflection | Does comparing apples with oranges reflect good scientific practice and integrity in public health messaging?

Professor John Ioannidis, professor of medicine and epidemiology at Stanford University, denounced the WHO stating:

"Reported case fatality rates, like the official **3.4%** rate from the **WHO**, cause horror — and **are meaningless**."
JOHN IOANNIDIS, MARCH 2020

"At a very broad, bird's eye view level, worldwide the **IFR of Covid-19** [0.02-0.4%] this season may be in the **same ballpark** as the **IFR of influenza** (0.1%, 0.2% in a bad year)."
JOHN IOANNIDIS, MAY 2020

In February 2021, Ioannidis estimated the global average IFR to be 0.15%. Finally, in July and December 2021, he estimated the age-graduated mortality of Covid-19 as shown in the table below.

Age group	Infection Fatality Rate* (13/07/2021)	Infection Survival rate	Infection Fatality Rate* (23/12/2021)	Infection Survival rate
0-19	0.0027%	100%	0.0013%	100%
20-29	0.014%	99.99%	0.0088%	99.99%
30-39	0.031%	99.97%	0.021%	99.98%
40-49	0.082%	99.92%	0.042%	99.96%
50-59	0.27%	99.73%	0.14%	99.86%
60-69	0.59%	99.41%	0.65%	99.35%
70-90	5.5%	94.5%	4%	96%

* The Median IFR for 14 countries

Source: Infection fatality rate of COVID-19 in community-dwelling populations with emphasis on the elderly: An overview (July 2021) & (December 2021)

This virus is far from being more lethal than previous respiratory viruses and certainly not indiscriminately deadly to everyone. Age and health status played a major role in the outcome of an infection.

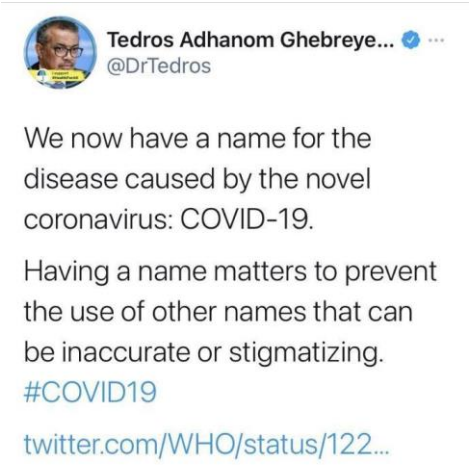
"**As of 19 March 2020**, COVID-19 is no longer considered to be a high consequence infectious disease (HCID) in the UK."

UK GOVERNMENT, 2020

Despite the unfolding evidence of the low lethality of the virus, the WHO did not adjust its recommendations to apply the principle of **proportionality** throughout the pandemic. Any public health policy must be proportionate to the level of threat.

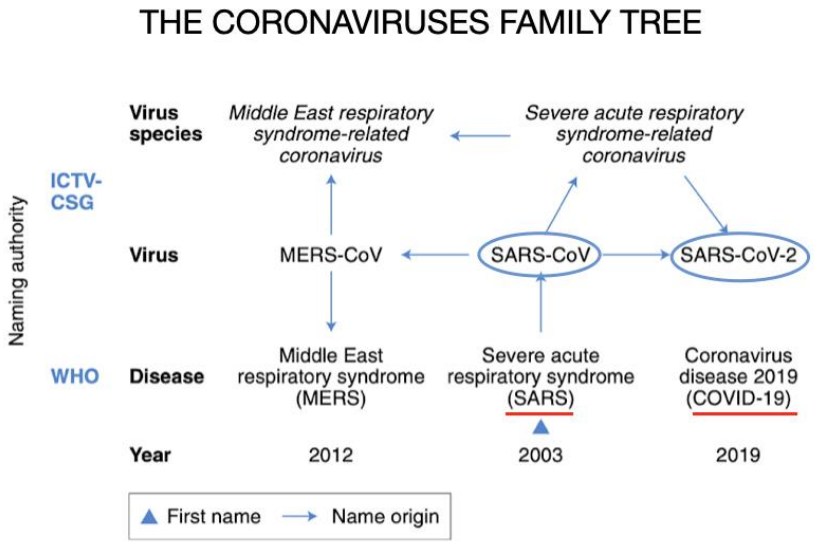
NOVELTY

In March 2020, the WHO declared SARS-CoV-2 as an entirely novel virus.



Source: Tedros A. Ghebreyesus, Twitter, 11/02/2020

SARS-CoV-2 is not entirely novel. It is a new member of the coronavirus family, closely related to the SARS-CoV virus which caused the SARS disease in 2003. In fact, the disease resulting from SARS-CoV-2 should really have been named SARS-2 (instead of Covid-19) for consistency in naming.



Source: The species *Severe acute respiratory syndrome-related coronavirus*: classifying 2019-nCoV and naming it SARS-CoV-2 (2020)

People fear what is novel and unknown. The WHO's public messaging was dominated by scary discussions of not knowing much about this 'novel' virus or how to treat it. Early on in the

pandemic, doctors described 3 phases of the disease: viral replication, inflammation and blood clotting. All these biological processes were common and treatable with existing drugs. A multi-drug, early treatment approach (of antiviral, anti-inflammatory and anticoagulant drugs) was shown to reduce mortality by 75%. Covid-19 is a treatable disease.

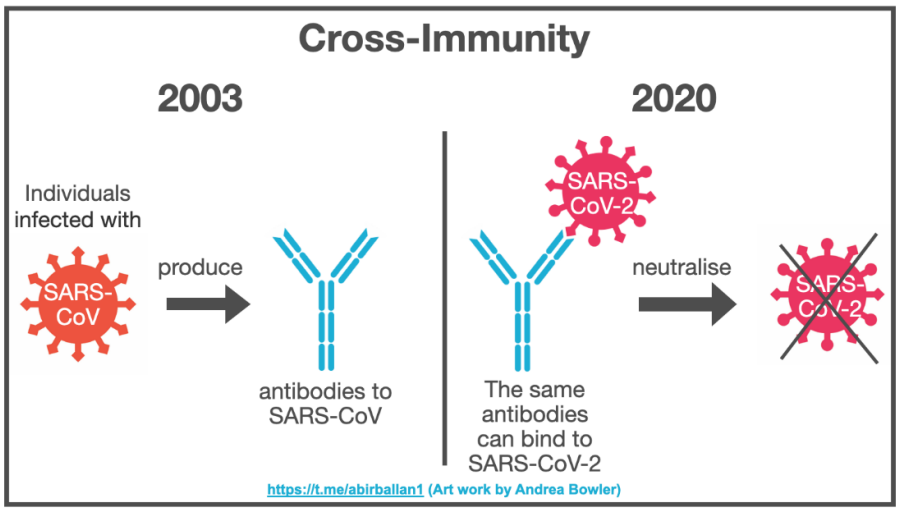
UNIVERSAL SUSCEPTIBILITY

The complete novelty claim paved the way for the WHO to make the complete susceptibility claim.

> "COVID-19 is a **new** virus to which **no one has immunity**."
> TEDROS A. GHEBREYESUS — WHO DIRECTOR GENERAL, MARCH 2020

> "A **majority** of the world's population is **susceptible** to infection from this virus."
> MARIA VAN KERKHOVE — WHO TECHNICAL LEAD, SEPTEMBER 2020

However, the scientific literature pointed to evidence of cross-immunity resulting from exposure to related coronaviruses and providing immunity to SARS-CoV-2.



Cross-immunity: Immunity to one pathogen can provide protection to a closely related pathogen.

> "At least six studies have reported T-cell reactivity against SARS-CoV-2 in 20% to 50% of people with no known exposure to the virus."

“Cross-reactive SARS-CoV-2 peptides revealed pre-existing T-cell responses in 81% of unexposed individuals and validated similarity with common cold coronaviruses.”

"A significant majority of the global population is likely to have SARS-CoV-2 reactive T-cells because of prior exposure to flu and CMV viruses, in addition to common cold-causing coronaviruses."

In short, not everyone is susceptible to becoming ill. Those with cross-immunity may not even develop symptoms at all if infected.

The WHO was aware that a large portion of the population had some form of immunity to the virus and was protected from serious illness. They, unfortunately, opted to spread fear instead of comforting the population with this good news:

“Most people infected with the virus [SARS-CoV-2] will experience mild to moderate respiratory illness and recover without requiring special treatment.”
WORLD HEALTH ORGANIZATION

ASYMPTOMATIC SPREAD

The WHO went back and forth on their position on the role of asymptomatic spread in transmission. On June 8th, 2020, Dr Maria Van Kerkhove, WHO Technical lead, stated:

“From the data we have, it still seems to be **rare** that an asymptomatic person actually transmits onward to a secondary individual.”
MARIA VAN KERKHOVE, JUNE 8, 2020

HEALTH AND SCIENCE

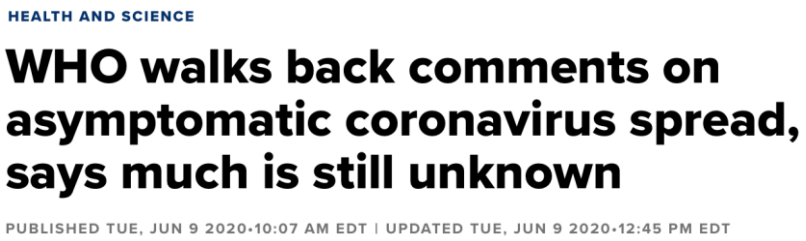
Asymptomatic spread of coronavirus is ‘very rare,’ WHO says

PUBLISHED MON, JUN 8 2020•1:05 PM EDT | UPDATED WED, JUN 10 2020•2:17 PM EDT

Source

The very next day, Van Kerkhove walked back her comment saying:

> “Asymptomatic transmission is a “really complex question” and “we don’t actually have that answer yet”
> MARIA VAN KERKHOVE, JUNE 9, 2020



HEALTH AND SCIENCE

WHO walks back comments on asymptomatic coronavirus spread, says much is still unknown

PUBLISHED TUE, JUN 9 2020•10:07 AM EDT | UPDATED TUE, JUN 9 2020•12:45 PM EDT

Source

A study in May 2020 found that all 455 contacts of an asymptomatic individual did not become infected with SARS-CoV-2 and the researchers concluded that *“the infectivity of some asymptomatic SARS-CoV-2 carriers might be weak.”*.

Another study shows the minimal effect of asymptomatic transmission within the same household. 1000 asymptomatic and pre-symptomatic individuals led to seven new infections, while 1000 symptomatic individuals led to 180 new infections.

Asymptomatic spread was never a major driver of transmission. Pre-symptomatic individuals, those who are infected but not yet showing symptoms, shed much far less virus than symptomatic individuals, which leads to much lower onward transmission on their part. Completely asymptomatic individuals, those who never develop symptoms, are essentially immune and not infectious.

MODE OF TRANSMISSION

Initially, the WHO claimed that SARS-CoV-2 is transmitted mainly via large droplets and fomites [by touching surfaces] and is not airborne.

Source: WHO, Twitter, 28/03/2020

However, SARS-CoV-2 is airborne, similar to the flu and other coronaviruses. In high-viral load settings, such as hospitals (Ref, Ref) and care homes where there are severely sick patients, transmission can occur regardless of mask wearing and social distancing. On the other hand, in low-viral load settings, such as schools (Ref, Ref) and shopping centres where the presence of symptomatic patients is less likely, transmission is much lower than in the previous settings. Transmission is almost nil outdoors.

Source: Dismantling myths on the airborne transmission of severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) (2021)

Furthermore, a systematic review of 64 studies — commissioned by the WHO and conducted by scientists from the Centre for Evidence-Based Medicine at Oxford University — concluded that:

> "There is **no evidence** of viral infectivity or transmissibility via **fomites** to date but no studies to date have been found to be methodologically robust and of high enough quality to even adequately address the question."
> ONAKPOYA ET AL., 2021

Eventually, in July 2021, the WHO admitted that the virus was airborne.

> "**Airborne transmission** is defined as the spread of an infectious agent caused by the dissemination of droplet nuclei (aerosols) that remain infectious when suspended in air over long distances and time."
> WHO, 2021

Despite this admission, the WHO continued to push ineffective measures such as masks, social distancing and avoiding touching surfaces throughout the Covid-19 pandemic.

Source: How to protect yourself from Covid-19, WHO, 2020

PART III: UNMEASURED MEASURES

The WHO-recommended response to Covid-19 was largely followed by most countries. Very few had the courage to stand alone and follow well-established public health measures. The impact of the WHO's influence on local governance has far-reaching consequences.

LOCKDOWNS

At the beginning of the pandemic, the WHO promoted the Chinese model and recommended it as a one-size-fits-all solution for the world with the ultimate aim of stopping the spread of the virus.

"China's uncompromising and rigorous use of non-pharmaceutical measures to contain transmission of the COVID-19 virus in multiple settings provides **vital lessons for the global response**."

"This truly all-of-Government and all-of-society approach that has been taken in China has averted or at least delayed hundreds of thousands of COVID-19 cases in the country."

WHO REPORT OF THE CHINA JOINT MISSION ON CORONAVIRUS DISEASE 2019
HEADED BY DR BRUCE AYLWARD OF WHO AND DR WANNIAN LIANG OF THE PEOPLE'S REPUBLIC OF CHINA

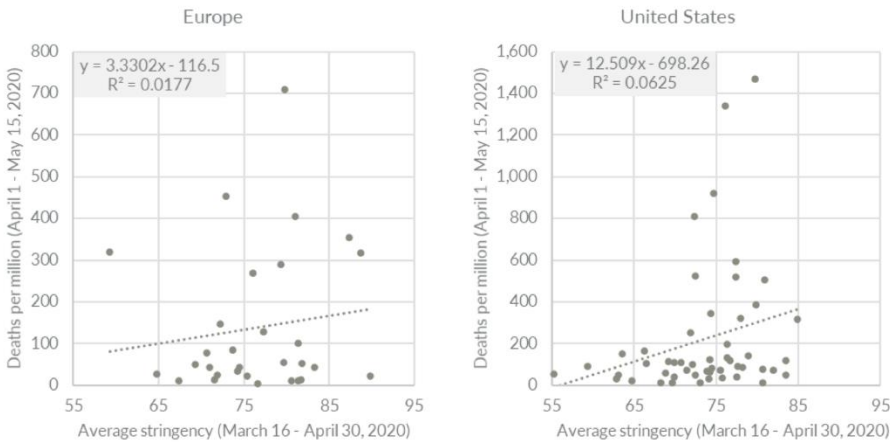
The Chinese model included the following elements: lockdown, social distancing, testing and contact tracing, isolation of asymptomatic individuals, compulsory mask wearing, temperature checks, travel restrictions and border quarantines.

Reflection | Why did the WHO promote this approach, which completely disregards **existing pandemic plans**, the mode of **transmission** of the virus, the **immunity**, **health status and age** of different population groups, country-specific circumstances — such as **healthcare system** capacity and health resource — as well as the evident **health** and **societal** harm that would ensue?

The verdict is out. Lockdowns — a term **never** used in previous pandemic plans — do not save lives. They destroy lives and livelihoods.

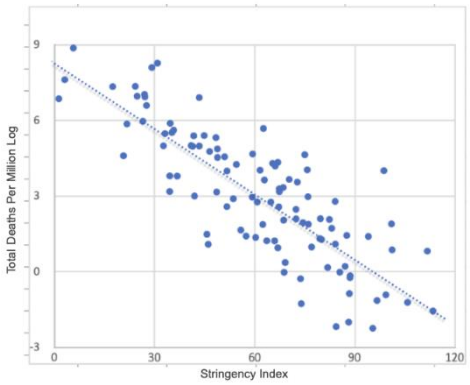
A systematic review and meta-analysis (2022) of lockdown stringency index studies, shelter-in-place order (SIPO) studies, and specific NPI (non-pharmaceutical interventions) studies found "**lockdowns have had little to no effect on COVID-19 mortality**". On the other hand, "they have imposed enormous economic and social costs where they have been adopted. In consequence, lockdown policies are ill-founded and should be rejected as a pandemic policy instrument."

The below scatter plot shows no correlation between the stringency of Covid-19 measures and deaths with Covid-19.



Source: A Literature Review And Meta-Analysis Of The Effects Of Lockdowns On Covid-19 Mortality (2022), Johns Hopkins University

If there was an effect of the stringency of the measures on deaths, the graph would look as follows:



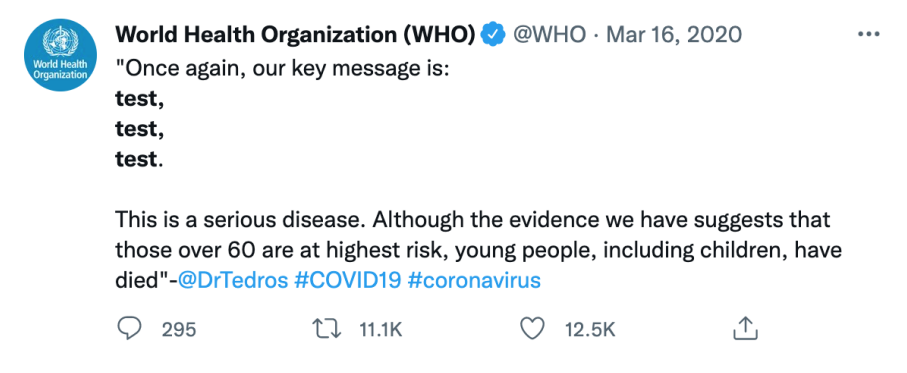
This graph represents a negative correlation between two variables. The more one variable increases, the more the other decreases.

"Whole-population isolation is not medically ideal and will lead to less effective elimination of the infection threat. Population immunity...can only be achieved by letting people who are not at risk...get exposed to it."

DR. SCOTT ATLAS — SENIOR FELLOW IN HEALTH CARE POLICY AT THE HOOVER INSTITUTION, STANFORD UNIVERSITY

TEST, TEST, TEST AND CONTACT TRACE

The WHO recommended testing and contact tracing for Covid-19 to curb transmission of the virus.



Source: WHO, Twitter, 16/03/2020

[Notice the wording "Young people, including children have died". Does the WHO specify here the percentage of children and young people who have died as a result of Covid compared to other diseases? The IFR for Covid in children is 0.0013%. More children die from diarrhoea than from Covid.]

> "**We don't even talk about containment** for seasonal flu — it's just not possible. But it is possible for Covid-19. We don't do contact tracing for seasonal flu — but countries should do it for Covid-19 because it will prevent infections and save lives. Containment is possible."
>
> TEDROS A. GHEBREYESUS — WHO DIRECTOR GENERAL, MARCH 2020

Reflection | Why is **containment** NOT **possible** for the **flu** but possible for **Covid-19**?

- Influenza and SARS-CoV-2 are both highly infectious respiratory viruses which share the same mode of transmission, mainly airborne (individuals inhaling virus-loaded aerosols suspended in the air indoors)
- Both viruses have a similar lethality.
- For both viruses, an infected person who hasn't developed symptoms yet (pre-symptomatic) may infect others.
- With infectious respiratory viruses, the majority of cases go undetected. So contact tracing a small portion of the population is a waste of resources. This was confirmed by studies that measured antibodies to SARS-CoV-2 in representative samples of populations in different locations. As early as April 2020, it was clear that SARS-CoV-2 was widespread across the world and reported cases did not reflect the magnitude of the spread.
- The PCR test involves false-positive and false-negative results, making this tool an unreliable method of determining infectiousness.

Source: WHO, Twitter, 24/06/2020

Contact tracing is very helpful in the case of a highly deadly disease that spreads by physical contact, such as Ebola. A symptomatic case, in this instance, can be isolated to prevent further physical contact with other individuals and stop the spread. This is not the case for Covid-19.

"Most of the hope placed on contact tracing efforts to control the [Covid-19] epidemic is ultimately **futile**"

PROF. JAY BHATTACHARYA — PROFESSOR OF MEDICINE AT STANFORD UNIVERSITY

It is important to note here the WHO's recommendation on the PCR test cycle threshold (Ct). The Ct is the number of times the genetic material in a sample is doubled before viral pieces — dead or alive — are detected.

The WHO recommended a high Ct of 45, well above what is needed to detect a live virus (Ref, Ref, Ref). PCR tests are very unreliable in determining infectiousness, especially at high Ct (e.g., up to 97% of positive tests are false at Ct of 35) and may remain positive for up to three months following infection when the individual is no longer infectious.

Steps	Time	Temperature	Cycles	Detection Format
Reverse Transcription	10 min	55°C	1	COVID-19 = FAM (465-510) Internal Extraction Control (IEC) = VIC / HEX / Yellow555 (533-580)
Initial Denaturation (Taq Activation)	2 min	95°C	1	
Denaturation	10 sec.	95°C	45	
Annealing and Extension	60 sec.	60°C*		

Source: Coronavirus (COVID-19)- genesig® Real-Time PCR assay (April 2020) (Wayback machine was used to retrieve a deleted WHO page)

Contrary to established medical practice, the WHO also defined a case based on a positive PCR test, regardless of symptoms. Usually, a diagnosis is based on a clinical presentation (signs and symptoms) with a laboratory diagnostic test only used to rule out other diagnoses or confirm a diagnosis, if this informs the treatment of high-risk individuals.

Confirmed COVID-19 case

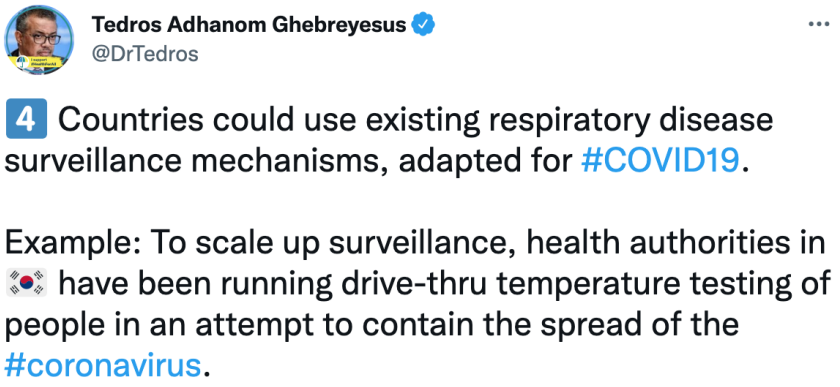
A person with **laboratory confirmation of COVID-19 infection**, irrespective of clinical signs and symptoms.

Source: WHO COVID-19: Case Definitions (August 2020)

These guidelines contributed to the distortion of the data on cases and deaths and the exaggerated attribution of death to Covid-19. Indicators to assess or track an outbreak and inform public health policy should be based on voluntary, representative sample testing rather than mass testing.

TEMPERATURE CHECKS

The WHO promoted countries that employed temperature checks.



Source: Tedros A. Ghebreyesus, Twitter, 08/03/2020

Temperature screening is not a reliable measure to control transmission as many infectious people can be easily missed.

- Not all infected people display a high-body temperature.
- Individuals who are infected but not yet displaying symptoms would not be detected.
- A person with a fever can take an antipyretic medication prior to crossing a checkpoint to mask the fever temporarily.

> "It is possible that some travellers with fever might opt to take antipyretics to reduce their symptoms before travel, to avoid detection of their fever by thermal scanners or thermometers."
> WHO, 2019, P. 63

- Certain temperature screening methods lack sensitivity.

Entry and exit screening doesn't reduce transmission, but it normalises a surveillance state and makes free movement conditional upon health prerequisites.

MASKS

In June 2020, the WHO recommended mask wearing to the general public without reference to the 'evolving' evidence.

Source: WHO, Twitter, 05/06/2020

Ironically, also on 5 June 2020, the WHO published an Interim Guidance — Advice on the use of masks in the context of COVID-19:

> "At present, there is **no direct evidence** (from studies on COVID-19 and in healthy people in the community) **on the effectiveness of universal masking** of healthy people in the community to prevent infection with respiratory viruses, including COVID-19."
> WHO, JUNE 2020

> "The pooled results of [67] randomised trials **did not show a clear reduction** in respiratory viral infection with the use of medical/surgical masks during seasonal influenza."
> JEFFERSON ET AL., 2020

> "We **did not observe association** between mask mandates or use and reduced Covid-19 spread in US states."
> GUERRA & GUERRA, 2021

Beyond the simple logic of virus size (~0.1 microns) versus the mask pore size (~19 microns), obvious leakage and poor handling of masks by the general public, there is ample evidence demonstrating that masks are ineffective at reducing community spread and cause a range of ill effects (malaise, increased CO2 inhalation, contamination, reduced cardiopulmonary function...). Furthermore, a false sense of security resulting from a false belief in mask effectiveness may lead an infectious individual to wear a mask and mix with high-risk people, putting them at serious risk of potential infection and illness.

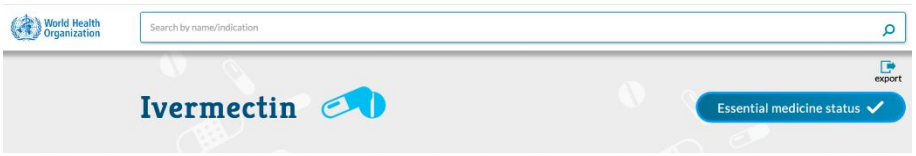
Reflection | How do masks protect **you** or **others** if the virus can pass through them?

TREATMENT

The WHO disregarded emerging evidence on potentially effective early treatments for Covid-19 and actively recommended against their use. For instance, it advised against the use of ivermectin to treat patients and limited its use to clinical trials despite promising evidence for its effectiveness and safety in treating Covid-19.

Source: WHO, March 2021

Ivermectin is listed on the WHO Model List Of Essential Medicines — 21st List (2019). This list contains "the most efficacious, safe and cost–effective medicines for priority conditions". More than four billion doses have been given worldwide since 1987.



Source: WHO List of essential medicine

A real-time meta-analysis of 84 studies suggests that ivermectin may contribute to the treatment of Covid-19.

"Meta-analysis of 15 trials found ivermectin reduced risk of death compared with no ivermectin... Low-certainty evidence found ivermectin prophylaxis reduced Covid-19 infection by an average 86%... Moderate-

certainty evidence finds that large reductions in Covid-19 deaths are possible using ivermectin. Using ivermectin early in the clinical course may reduce numbers progressing to severe disease. The apparent safety and low cost suggest that ivermectin is likely to have a significant impact on the SARS-CoV-2 pandemic globally."

"Meta-analyses based on 18 randomized controlled treatment trials of ivermectin in COVID-19 have found large, statistically significant reductions in mortality, time to clinical recovery, and time to viral clearance."

"Meta-analysis of 15 trials found ivermectin reduced risk of death compared with no ivermectin"

Reflection | How many **lives** could have been **saved** had the WHO not suppressed the use of **life-saving drugs**?

MASS VACCINATION

COVAX is a global collaboration aimed at the 'equitable' distribution of vaccines to the entire world.

No one is safe,
until everyone is safe

COVAX

CEPI Gavi unicef World Health Organization

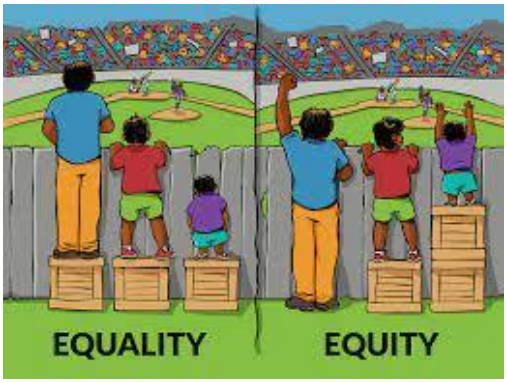
Source: COVAX partners

Reflection | Does this mean the vaccine **doesn't protect YOU** unless **I** take it **TOO**? But the WHO asserts in December 2020: "Vaccinated people are protected from getting the disease in question."

Under the mantra of 'vaccine equity', the WHO promoted indiscriminate vaccination of the entire world's population — a one-size-fits-all approach — completely disregarding several key considerations:

- personal risk from Covid-19 based on health status, age, immunity level;
- risk of exposure to the virus;
- risks associated with the Covid-19 vaccines;
- availability of safe and effective treatments for Covid-19;
- natural immunity as the safest route to acquiring robust and long lasting immunity for low-risk individuals;
- the Covid-19 vaccines' failure to stop infection (Ref, Ref, Ref, Ref, Ref) and transmission (Ref, Ref, Ref, Ref) and the negative efficacy of boosters to new variants, i.e. the increased chance the vaccinated have of catching the virus compared to unvaccinated individuals;
- bioethical standards that reject the coercion of individuals into accepting unnecessary personal risk in order to protect others, denying them their right to informed and voluntary consent.

Reflection | Does **health equity** mean equal distribution of a pharmaceutical product regardless of individual need, or achieving **optimal health** for everyone based on **individual need**?

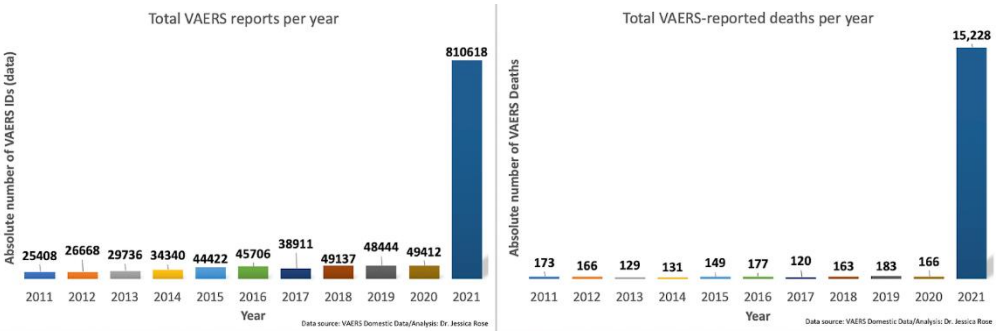


Source

The WHO regularly boasts about the safety of the Covid-19 vaccines.

Source: WHO, Twitter, 11/05/2022

Unfortunately, the data from the US vaccine adverse events reporting system (VAERS) reflects a clear, strong signal, with more reported adverse events (many of which are serious) following the administration of the Covid-19 vaccines when compared to all other vaccines combined. This signal warrants halting the vaccination programme to investigate any potential risks inherent in these novel gene therapeutics.



Source: Dr Jessica Rose, Total reported adverse events and death counts for the past decade for all vaccines combined as of 24/06/2022

As of June 6th, 2022, the WHO website shows 3,861,047 reports of side effects following the Covid-19 vaccines which have been in use since December 2021.

Source: VigiAccess.org, Covid-19 Vaccines, WHO, accessed on 06/06/2022

For comparison, the WHO website shows 285,058 reports of side effects for the Influenza vaccine which have been in use since 1942.

Source: VigiAccess.org, Influenza vaccines, WHO, accessed on 06/06/2022

This is not the first time that the WHO has endorsed a vaccine that was known to be harmful. During the H1N1 2009 pandemic, the WHO endorsed the use of the Pandemrix vaccine, despite several studies (Ref, Ref, Ref, Ref, Ref) linking it to a risk of developing narcolepsy as well as other adverse events before it was quickly discontinued.

Reflection | Is it possible that the **WHO** is **fallible**?

VACCINE PASSPORTS

The WHO initially declared its opposition to vaccine passports.

"**Proof of COVID-19 vaccination should not be required** as a condition of entry to or exit from a country."

"International travellers should not be considered by default as suspected COVID-19 cases or contacts or as a priority group for testing."
WHO INTERIM GUIDANCE, JULY 2021

Soon enough, on 23rd of February 2022, the WHO signed a contract with T-Systems, a subsidiary of Deutsche Telekom, for the development of a software solution for the global electronic verification of coronavirus vaccination certificates — a tool to ensure mass vaccination, the digitization of health information and compliance.

Source (February, 2022)

Under this system, individuals have to subscribe to an infinite booster schedule in order to keep on accessing societal 'privileges', such as education, work, leisure and travel, establishing a regime of discrimination based on private medical information.

Source: WHO, Twitter, 31/05/2022

Reflection | How are **vaccine passports** similar to the **DOJO** reward system in schools, the **Kudos** employee recognition system at work and the **social credit systems** in society?

MEASURES THAT MAKE A DIFFERENCE

Meanwhile, simple, standard measures that could have made a difference in reducing deaths with Covid-19 were completely disregarded by the WHO.

1. Indoor ventilation and proper isolation of Covid wards in hospitals and care homes to reduce iatrogenic airborne transmission;
2. Health campaigns to improve risk factors for death with Covid: chronic diseases, obesity, anxiety and Vit D deficiency;
3. Early treatment for high-risk individuals (shown to reduce deaths with Covid by 75%);

4. The development of natural immunity in the low-risk population (safe and durable);
5. Testing the high-risk population for prior Covid infection to avoid unnecessary vaccination.

PART IV: THE WHO AND THE INTERESTS OF THE PEOPLE

It is crucial to evaluate what guides the WHO's decisions on scientific matters. Two scientific concepts will be explored here as examples: the criteria for declaring a pandemic and the definition of herd immunity.

Both of these concepts influence when the WHO declares the beginning and the end of a pandemic. These criteria provide the foundation for the flourishing of pandemic-related industries.

PANDEMICS UNDEFINED

The original description of a pandemic on the WHO's website included a criterion for severity.

An influenza pandemic

An influenza pandemic occurs when a new influenza virus appears against which the human population has no immunity, resulting in several, simultaneous epidemics worldwide with enormous numbers of deaths and illness.

Source: WHO Pandemic Preparedness, 2003

On May 4, 2009, about one month before the H1N1 pandemic was declared, the WHO changed its description of a pandemic. The severity indicator was eliminated, under the pretext of requiring more 'objective' criteria to declare a pandemic. According to Marie-Paul Kieny, WHO Assistant Director General and a member of the WHO Swine-flu working group (also an ex-pharma employee) — the most reliable measure of severity (number of deaths) was not an 'objective' criterion. (Trust WHO "Documentary", Lilian Frank, 24:03)

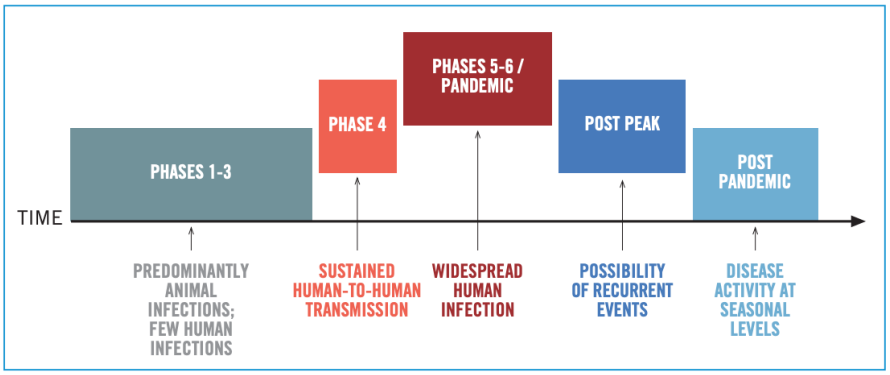
The new pandemic description was reduced to the following:

"Influenza pandemics occur when a new influenza A virus emerges to which the population has little or no immunity."
WHO NPI DOCUMENT, P.6, 2019

Reflection | If the disease is **mild**, is it worth declaring a pandemic and risking destabilising the population by **spreading fear**?

This loose description of a pandemic allows the WHO to declare pandemics arbitrarily. In fact, the H1N1 pandemic was declared based on the 6 phases below, all of which relate to disease spread, without taking into account pathogen lethality, population immunity and disease severity. The H1N1 pandemic would not have qualified as a pandemic under the 2003 definition.

FIGURE 3
PANDEMIC INFLUENZA PHASES (2009)



Source: Pandemic Influenza Preparedness and Response — A WHO guidance Document (WHO, 2009, p. 24)

> "What would and would not be declared a pandemic depends on a host of **arbitrary** factors such as who is doing the declaring and the criteria applied to make such a declaration."
>
> DR PETER DOSHI — ASSOCIATE PROFESSOR OF PHARMACEUTICAL HEALTH SERVICES RESEARCH IN THE SCHOOL OF PHARMACY AND ASSOCIATE EDITOR AT THE BMJ

Peter Doshi notes that most government officials and scientists charged with decision-making about pandemics are part of working groups funded by pharmaceutical companies, rendering their neutrality questionable.

In fact, according to the International Health Regulation (IHR) 2005, the WHO Director General was charged with declaring a public health emergency of international concern (PHEIC) following consultation with the Emergency Committee. So far, not all criteria set out in article 1 of the IHR (p.9) for declaring a PHEIC have been met for previously declared pandemics, confirming the lack of consistency in declaring pandemics.

Defining pandemics arbitrarily is particularly detrimental when combined with an overreliance on theoretical modelling of pandemic outcomes. Modelling predictions are as good as the assumptions they are based on. Models are not hard science. Modelling studies from the Imperial College London, Uppsala University and the Institute for Health Metrics and Evaluation were based on inaccurate assumptions concerning the level of population immunity, the lethality of the pathogen, the nature of spread, levels of exposure, local healthcare capacity and voluntary human behaviour adjustment, and therefore resulted in predictions of pandemic outcomes that were completely wrong and lead to an incorrect declaration of the Covid-19 pandemic.

Reflection | How **arbitrary** can the declaration of a **public health emergency of international concern be**?

HERD IMMUNITY REIMAGINED

The WHO's initial position on herd immunity included both vaccination and natural immunity and described immune individuals as shields protecting others.

"Herd immunity is the indirect protection from an infectious disease that happens when a population is immune either through **vaccination** or **immunity developed through previous infection**. This means that even people who haven't been infected, or in whom an infection hasn't triggered an immune response, they are protected because people around them who are immune can act as buffers between them and an infected person."
WHO, JUNE 2020

In November 2020, the WHO changed its definition to exclude natural immunity and focused on vaccination as the only route to reaching herd immunity and protecting the vulnerable.

"'Herd immunity' exists when a high **percentage of the population is vaccinated**, making it difficult for infectious diseases to spread, because there are not many people who can be

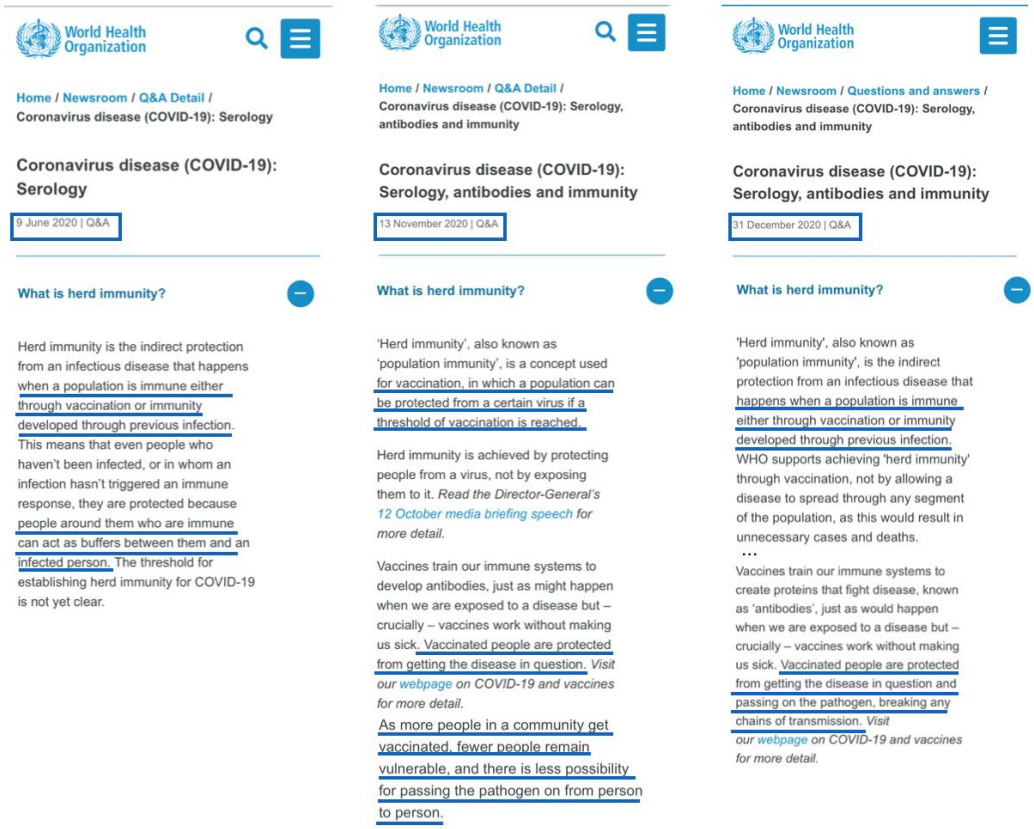
infected.” “As more people in a community get vaccinated, fewer people remain vulnerable, and there is less possibility for passing the pathogen on from person to person.”
WHO, NOVEMBER 2020

Following a big uproar in the scientific community, the WHO reinstated natural immunity, in December 2020, as a contributing factor to herd immunity, while strongly supporting vaccination.

'Herd immunity', also known as 'population immunity', is the indirect protection from an infectious disease that happens when a population is immune **either through vaccination or immunity developed through previous infection**. WHO supports achieving 'herd immunity' through vaccination, not by allowing a disease to spread through any segment of the population, as this would result in unnecessary cases and deaths." “Vaccinated people are protected from getting the disease in question and passing on the pathogen, breaking any chains of transmission.”
WHO, DECEMBER 2020

This definition further assumes that all vaccines are sterilising, meaning they protect from infection and transmission. This is not the case for all vaccines, and particularly not the case for the Covid-19 vaccines.

Denying the contribution of natural immunity was an unscientific act that goes against all long-lasting immunological principles.



World Health Organization

Home / Newsroom / Q&A Detail / Coronavirus disease (COVID-19): Serology

Coronavirus disease (COVID-19): Serology

9 June 2020 | Q&A

What is herd immunity?

Herd immunity is the indirect protection from an infectious disease that happens when a population is immune either through vaccination or immunity developed through previous infection. This means that even people who haven't been infected, or in whom an infection hasn't triggered an immune response, they are protected because people around them who are immune can act as buffers between them and an infected person. The threshold for establishing herd immunity for COVID-19 is not yet clear.

World Health Organization

Home / Newsroom / Q&A Detail / Coronavirus disease (COVID-19): Serology, antibodies and immunity

Coronavirus disease (COVID-19): Serology, antibodies and immunity

13 November 2020 | Q&A

What is herd immunity?

'Herd immunity', also known as 'population immunity', is a concept used for vaccination, in which a population can be protected from a certain virus if a threshold of vaccination is reached.

Herd immunity is achieved by protecting people from a virus, not by exposing them to it. *Read the Director-General's 12 October media briefing speech for more detail.*

Vaccines train our immune systems to develop antibodies, just as might happen when we are exposed to a disease but – crucially – vaccines work without making us sick. Vaccinated people are protected from getting the disease in question. *Visit our webpage on COVID-19 and vaccines for more detail.*

As more people in a community get vaccinated, fewer people remain vulnerable, and there is less possibility for passing the pathogen on from person to person.

World Health Organization

Home / Newsroom / Questions and answers / Coronavirus disease (COVID-19): Serology, antibodies and immunity

Coronavirus disease (COVID-19): Serology, antibodies and immunity

31 December 2020 | Q&A

What is herd immunity?

'Herd immunity', also known as 'population immunity', is the indirect protection from an infectious disease that happens when a population is immune either through vaccination or immunity developed through previous infection. WHO supports achieving 'herd immunity' through vaccination, not by allowing a disease to spread through any segment of the population, as this would result in unnecessary cases and deaths.

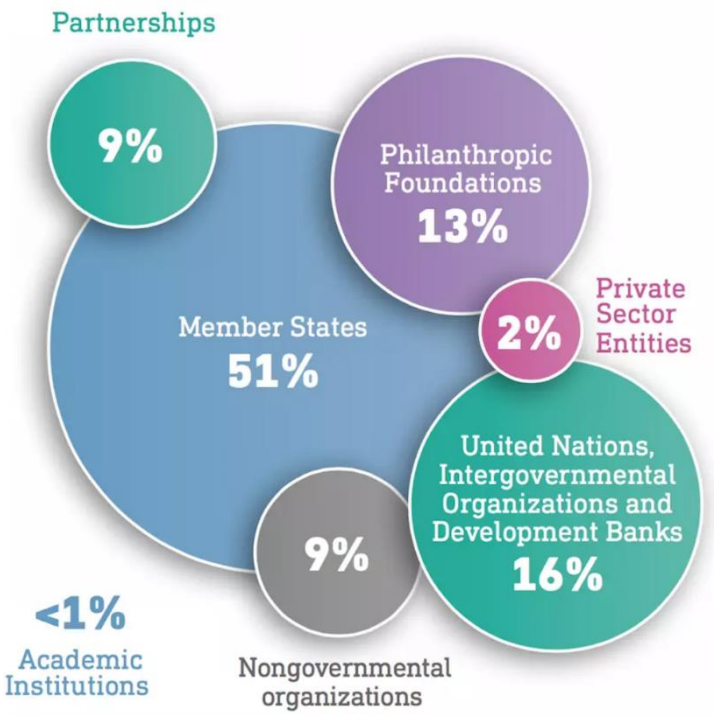
...

Vaccines train our immune systems to create proteins that fight disease, known as 'antibodies', just as would happen when we are exposed to a disease but – crucially – vaccines work without making us sick. Vaccinated people are protected from getting the disease in question and passing on the pathogen, breaking any chains of transmission. *Visit our webpage on COVID-19 and vaccines for more detail.*

Source: Coronavirus disease (Covid-19): Serology, antibodies and immunity, WHO, 9 June 2020, 13 November 2020, 31 December 2020

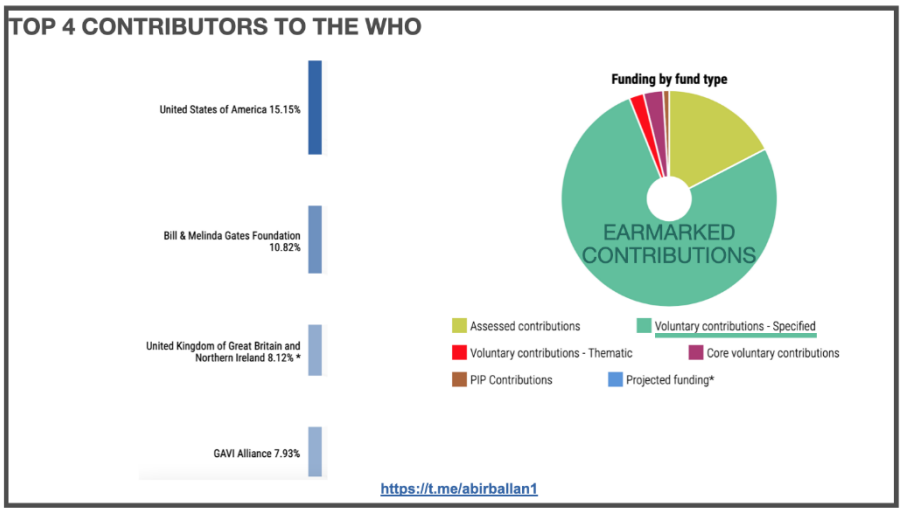
UN$CIENTIFIC GUIDANCE

The WHO is funded by fees paid by Member States as well as voluntary contributions from Member States and donors such as the Bill and Melinda Gates Foundation (BMGF), GAVI — the Vaccine Alliance, UN agencies, the World Bank and Rotary International, among others.



Source: How is the World Health Organization funded? — Revenue in 2018 by Source (WEF, 2020)

At least 20% of contributions come from sources linked to corporate interests and 88% of voluntary contributions are earmarked for specific projects, largely serving those corporate interests.



Source: WHO Contributors (WHO, 2019)

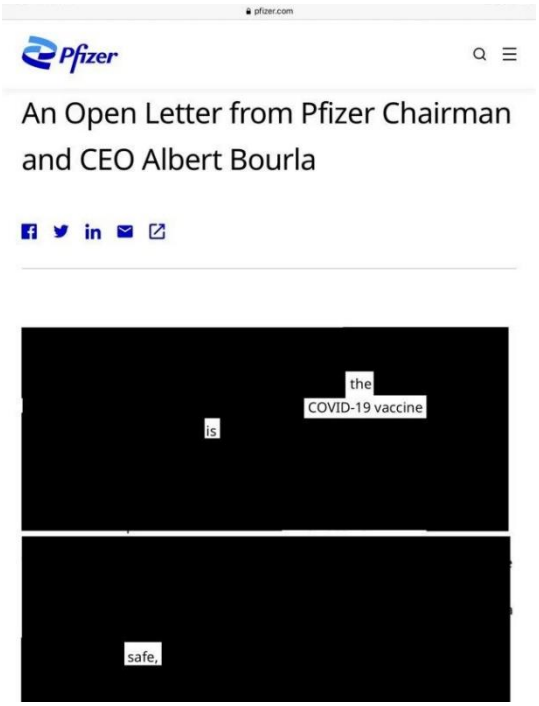
Interestingly, GAVI is also funded by the BMGF, which has donated USD 4.1 billion to date.

Source: GAVI- The Vaccine Alliance

Source: WHO website

Reflection | Are you still sure the **WHO** is '**dedicated** to the **well-being of people** and **guided by science**'?

Private investors in healthcare products have a far-reaching influence on global health. Meanwhile, they profit from an unholy matrimony between pharmaceutical companies that obfuscate data in order to sell their products, government officials who have become product marketers, and the WHO that drives narratives to support the sales of these products. It's a win-win affair for the former and a lose-lose formula for the people.



Source unknown: Humorous meme [Video of MEP Cristian Terhes showing the redacted Pizer contracts.(2:52)]

Sadly, profitable philanthropy is a lucrative business that requires an entire bureaucracy behind it to sustain it. Bill Gates is building a GERM — Global Response and Mobilisation Team — which will be managed by the WHO to ensure that the world is ready for future, possibly incorrectly declared 'pandemics'.

Source

CONCLUSION: RECLAIMING YOUR HEALTH SOVEREIGNTY

Now that you have reviewed the WHO's track record...

Reflection | What can you do to participate in decisions that directly impact **your health** and **that of your loved ones**?

Each one of us has a responsibility to raise concerns about the trustworthiness of the WHO with our governments and:

1. Demand clarity on the internal checks and balances in place to manage any conflicts of interest within the WHO;
2. Demand that the WHO eliminates industry funding and earmarked projects;
3. Ensure that the WHO acts in a technical advisory capacity without any power over sovereign nations;
4. Ensure that the WHO develops strict international guidelines on biosurveillance to protect the privacy of personal health information.
5. Limit the WHO to an administrative and coordinating role between Member States to enhance collaboration, knowledge sharing and scientific debate

If we, the people, decide there is a need for a supranational organisation such as the World Health Organization, tasked with achieving 'the highest possible level of health' for all people, then this organisation must represent the people, have the best interests of the people at heart and empower the people. It's our responsibility to explore alternatives at a local level and select routes better suited to achieve such an ambitious goal.

Many thanks to Dr Jonathan Engler, Emma McArthur, Dr David Bell, Heike Brunner, Heidi Short, Sinead Stringer, Chris Gordon and David Charalambous for their valuable review and feedback.

ABOUT THE AUTHOR

Abir Ballan has a Masters in Public Health, a graduate degree in special needs education and a BA in psychology. She is a children's author with 27 published books. She has been an advocate for the inclusion of children with learning difficulties in mainstream schools. Abir is a former member of the Executive Committee at PANDA~Pandemics Data & Analytics. She helped build the organisational structure and led several projects that placed PANDA on the international map. She is particularly committed to promoting the health and wellbeing of children and young people. Twitter (suspended), LinkedIn (suspended), Substack, Telegram