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Behind the Mask: Malaria Eradication and Involuntary Sterilization

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Abstract

Driven by the sustainability agenda and development prerogatives, the UN system has devised the 'Global Technical Strategy for Malaria 2016-2030' as an open plan to combat malaria and a hidden program to combat population growth in countries where previous efforts to lower fertility to replacement level have failed. The chemical and pharmacological arsenal used to combat malaria and subvert fertility by chemoprophylaxis and vector control under the direction of the WHO poses great risks to health and even greater risks to society as it is aimed at stabilizing the still growing populations of the Americas, Eastern Mediterranean, Asia Pacific and Africa through involuntary and mass sterilization. This methodology of combatting population growth is enabled by the moral loophole created by the Holy See for secular authorities to subvert fertility only while healing disease, which has debased medicine and public health into handmaidens of genocide, has perverted the integrity of medical authorities and has shattered the credibility of medical research. The lives it will save in the present outside the womb will be exceeded many times over by the lives it will take in the future inside the womb and the imaginary benefits it will bring to child mortality rates will be overshadowed many times over by the real rise in morbidity rates through chronic diseases that a sustained chemical and pharmacological attack on the human reproductive system will inevitably trigger. Unless stopped and replaced with open and legal methods of population control it will inevitably lead to violent conflict.

Keywords Malaria; Involuntary sterilization; Infertility; Insecticides; G6PD deficiency; Chemoprophylaxis; Vector control; Demographic transition; Epidemiologic transition

Background

The hardest lesson learned in the 20th century is that saving life without promoting death leads to unsustainable population growth and that destabilizing the natural balance between life and death inevitably and invariably results in economic and social disaster within two generations since food production and manufacturing capacity simply cannot keep pace with the consumption needs of an exploding number of people.

Increasing population due to advances in sanitation, nutrition and medicine coupled with increasing consumption per capita due to industrialization and the human need for progress and for better living conditions resulted in a bitter struggle for scarce natural resources and ultimately to the colonial depredations of the era of New Imperialism in the second half of the 19th century and in the unspeakable atrocities of the two world wars in the first half of the 20th century.

This hard history lesson underlies the United Nations, which was created to preserve international peace by controlling population growth worldwide (i.e. depopulation) and by facilitating access to raw materials to any and all nations through the open markets irrespective of place of origin and without prejudice to the destination country (i.e. globalization). Since 1945 the world revolves around the depopulation/globalization axis [1].

On the most fundamental level, this international order seeks to satisfy man's basic instincts, to survive and procreate. The program of depopulation tames men's procreative drive by limiting reproductive rights while the program of globalization meets men's material necessities by controlling and distributing global resources. By stabilizing the global population and sharing the planet's resources nation states can remain at peace with one another and human civilization can reestablish harmony with nature.

Our history from 1945 until today is shaped by covert strategies of depopulation and coerced strategies of globalization applied in every nation and on every continent according to the principle of reciprocity through the coordinating agency of a UN system guided by the long-term geopolitical goals of stable populations and universal prosperity and buttressed by the military force of the United States and its allies.

Method

Policies and statistics are contrasted while insecticides and medicines are analyzed to reveal the full scope and hidden objectives of the WHO's Global Technical Strategy for Malaria.

Discussion

The World Health Organization's Global Technical Strategy for Malaria 2016-2030 is the latest covert depopulation strategy devised by the UN system to force the total fertility rates of the last remaining growing countries down to replacement level under the cover of, and while at the same time, combatting malaria.

Accomplishing two goals simultaneously, one openly and the other secretly, is the modus operandi of the international system since the early 1950s when religious authorities gave their secular counterparts permission to subvert fertility so long as they cure a disease at the same time. This duplicitous behavior takes advantage of an ethical loophole provided by the Vatican in its encyclical letter "Humanae Vitae: On the Regulation of Birth", issued by Pope in 1968 but based on an earlier

decision made by Pope in 1953, and expressed in paragraph 15 under the heading "Lawful Therapeutic Means":

On the other hand, the Church does not consider at all illicit the use of those therapeutic means necessary to cure bodily diseases; even if a foreseeable impediment to procreation should result there from-provided such impediment is not directly intended for any motive whatsoever [2].

To deny ulterior motive, the UN system and governments around the world, with the tacit support and implicit collusion of Church leaders, hide their attacks on fertility under the cover of plausible deniability. This cover is sustained by perverting science, falsifying research, abusing medicine, coopting the judiciary and legislative branches of government, controlling the message, censoring the media, corrupting state and international institutions, prostituting the faith, encouraging ignorance, promoting secrecy, compartmentalizing knowledge, violating the rule of law, and circumventing democratic checks and balances.

Between 1960 and the late 1990s malaria was allowed to inflict as many deaths on the developing world as possible to offset its exploding populations. No efforts were made to develop drugs and no investments were made in malaria eradication programs. During the same period, however, malaria was wiped off the map of the developed world through the Global Malaria Eradication Campaign (1955-1969), which freed 37 countries of the disease [3].

By contrast, malaria has continued to be a leading cause of death and morbidity in the developing world and especially in Africa where to date 90% of all malaria deaths still occur.

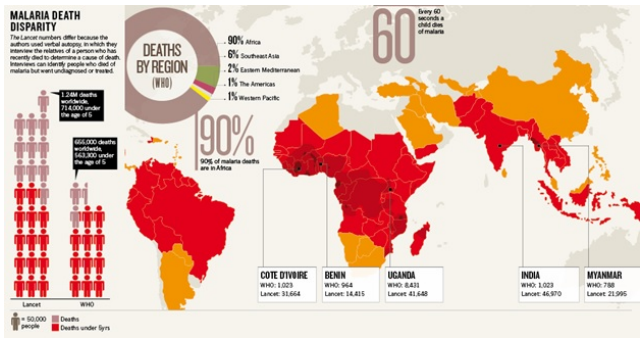

Figure 1: Graph of malaria deaths by region.

Only at the beginning of the 21st century did malaria receive recognition as a global health priority and primarily because it provides the perfect cover for subverting fertility, as it requires preventive and continuous care for entire populations in malaria endemic regions; regions that also happen to have fertility rates far above replacement level and that are responsible for 90% of the global population growth of the past half century.

According to the WHO, malaria intervention programs between 2001 and 2013 reduced global mortality rates by 47% and the global incidence of malaria by 30% saving more than 4 million lives, but the disease is still endemic in 97 countries and territories, placing 3.2 billion people at risk and infecting 200 million people every year of which half a million die, mostly children under five and mostly in Africa [4].

This makes malaria the third leading cause of death for children under five after pneumonia and diarrhea.

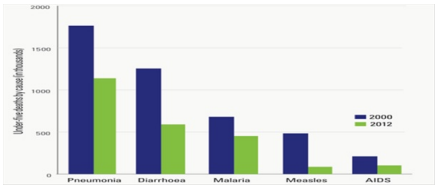

Figure 2: Under five deaths by cause.

The ambitious goal set by the WHO to reduce the global malaria burden by 90% by 2030 is more than justified given the terrible suffering caused by this disease [5]. If accomplished it will contribute greatly to bringing the global child mortality rate below 5%, which will have an extraordinarily positive impact on the 40% of the global population where child mortality rates are still unacceptably high.

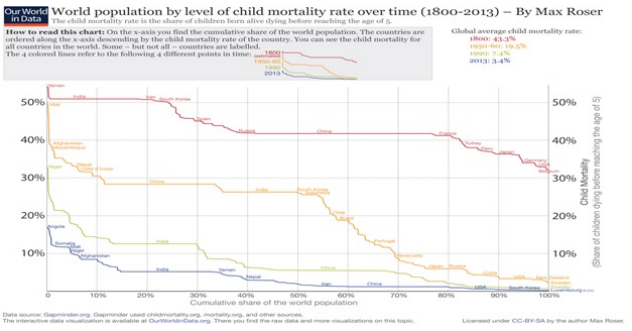

Figure 3: World population by level of child mortality rate over time (1800-2013).

What is not justified is the terrible impact the chemical and pharmacological arsenal used to combat malaria and subvert fertility by chemoprophylaxis and vector control will have on the health of individuals who have never given permission to the authorities to be sterilized, or the devastating impact this immoral and illegal methodology will have on the health of society; both of which are foreseeable.

It is well known but even better hidden that child mortality rates have not decreased but increased since the international community began subverting fertility in 1945 through covert chemical and biological means. This inconvenient reality is hidden by the way child mortality is counted. To have an accurate count lost pregnancies would also have to be considered, but that is not the case. Lost pregnancies are not counted because the UN system has since its inception waged war on fertility in order to halt population growth by preventing the moment of conception. More often than not, however, this war on the human reproductive system does not prevent conception but rather terminates life shortly after conception leading to loss of pregnancy and thus to child death in the womb rather than after birth.

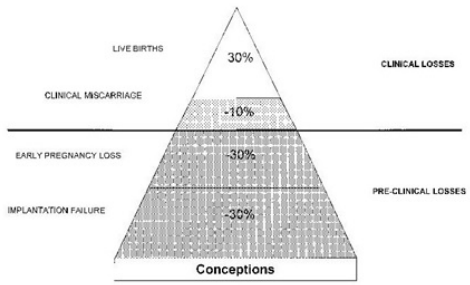

Figure 4: The pregnancy loss iceberg.

Leaving implantation failures aside, since we have no way of determining whether their incidence has increased or decreased over the past seven decades given the lack of statistical data, child death in the womb occurs in 30% of all pregnancies due to unknown or occult early pregnancy loss and in 10% of all pregnancies due to clinical miscarriage according to a study from 2008, which also identifies chromosomal abnormalities in the gametes and embryo as the likely cause of pregnancy loss [6].

For all intents and purposes the lives saved by modern medicine through cures of infectious diseases or their prevention and through better child and maternal care once children are born have been replaced by lives lost due to the covert chemical and biological war on fertility as well as the increasing age of mothers (itself a consequence of economic methods of population control), which are the underlying causes of the chromosomal and hormonal abnormalities that kill children in the womb today; children who are never added to child mortality statistics. Were they to be added it would be plainly evident that we have made no progress whatsoever in saving children's lives and that in fact the true child mortality rates today are higher than those prior to 1945, the only difference being that the majority of children now die in the womb rather than outside of it, as was previously the case due to infectious diseases and poor living conditions.

If we were to add abortions to this dismal equation-and 20% of the total number of pregnancies worldwide end in abortion- then the true child mortality rate today would be substantially higher than it ever was. And if child mortality statistics were to be truly accurate they would have to include a 20% rate of miscarriage, which is the current global estimate for miscarriages according to the Guttmacher Institute [7].

The expansion of involuntary sterilization under the cover of malaria eradication will only increase child mortality inside the womb, irrespective of investments in medical services and improvements in medical science.

What is equally foreseeable is that the goal of eradicating the global malaria burden by 90% by 2030 cannot be possibly realized without the participation of the Democratic Republic of the Congo and Nigeria, the two countries that account for 40% of the estimated mortality due to malaria worldwide. And these two countries do not appear to be participating in the Global Technical Strategy for Malaria 2016-2030. That, of course, is of secondary importance to the UN system and the greater international community whose primary interest is to bring the total fertility rates of all participating countries down to replacement level and not to eradicate malaria.

Incidentally, the WHO refuses to release the list of countries participating in the Global Technical Strategy for Malaria 2016-2030-list that is nowhere to be found and that the author has requested from the WHO only to be ignored. The participating countries in Africa only could be inferred from the website of the Roll Back Malaria Partnership, the precursor to the Global Technical Strategy for Malaria 2016-2030, where links to country roadmaps and 2013 implementation status [8] as well as a list of malaria endemic countries [9] can be found.

The only way of discerning what countries have agreed to participate in the current malaria eradication/mass sterilization program concocted by the WHO is by reading the eight technical consultation reports that took place in 2013 and 2014 [10], when the Global Technical Strategy for Malaria 2016-2030 had not yet been identified as a covert sterilization project and the participating nations did not need to hide.

These reports reveal the following participating nations for each of the six WHO regions:

Africa region

The total number of participating nations for the Africa Region is forty-one plus the province of Zanzibar. They are: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Sao Tome & Principe, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia, Zimbabwe and the island of Zanzibar (a province of Tanzania).

However, from the two technical consultation reports that took place in Africa-the first in Brazzaville, Congo, from 18-19 March 2014 [11] and the second in Harare, Zimbabwe, from 8-9 April 2014 [12]-we discover that of the forty-one nations and one province that participated in the consultations only fifteen nations and one province have actually committed to eliminating malaria and they are: Algeria, Botswana, Cape Verde, Comoros, Gambia, Madagascar, Mauritania, Mali, Namibia, Sao Tome, Senegal, South Africa, Swaziland, Rwanda, Zanzibar, Zimbabwe.

Of these, Algeria stands out as it has no indigenous cases of malaria and zero people living within active foci [13]. Since Algeria is not a malaria endemic country one must ask why is it participating in a malaria eradication program? The answer lies in its total fertility rate, which has slipped up to above replacement level in 2011 and the government needs to bring it back down again.

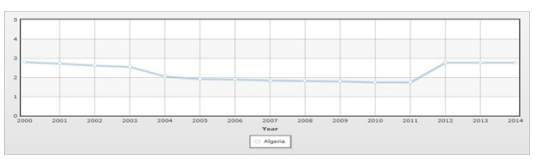

Figure 5: Algeria total fertility rate from 2000 to 2014.

The government lost its ability to subvert fertility when a series of riots and protests erupted on 28 December 2010, forcing it to lift a 19-year-old state of emergency on 24 February 2011 that had been used to force covert methods of depopulation onto the people and had allowed the Algerian government to lower the nation's total fertility rate from 4.5 children per woman in 1990 to just 2 children by 2004.

Americas region

The total number of participating nations for the Americas Region is twenty-two: Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Columbia, Costa Rica, Ecuador, El Salvador, Guatemala, Guyana, French Guyana, Haiti, Honduras, Jamaica, Nicaragua, Mexico, Panama, Paraguay, Peru, and Trinidad and Tobago.

The technical consultation report that took place in Panama City, Panama, on 1-2 April 2014 [14], reveals that only seven of a total of twenty-one countries with endemic malaria in the Americas are in the pre-elimination phase, but fails to identify them. What the report does tell us, however, is that the common regional goal is to eliminate malaria from Central America by 2020 and from South America by 2025 and this implies the participation of all countries in the region.

Eastern mediterranean region

The total number of participating nations for the Eastern Mediterranean Region is fifteen and they are: Egypt, Iraq, Iran, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Palestine (West Bank), Saudi Arabia, Somalia, Sudan, Tunisia, and Yemen.

The technical consultation report that took place in Casablanca, Morocco, on 15-16 April 2014 [15], informs us that Afghanistan, Pakistan, India and Indonesia also participated in the event. Since they are not part of the region their participation can only be explained by the fact that they too are Muslim countries; although in India Muslims are minorities.

Conspicuous is the absence of the Gaza Strip especially since the West Bank is represented. Of course, the Hamas leadership of the Gaza Strip does not participate in the sterilization of its citizens whereas the Fatah leaders of the West Bank do, which is why the latter are the darlings of the international community and the former, are pariahs.

Even more conspicuous is the fact that seven of the fifteen participating nations of this region are not malaria endemic, namely Egypt, Iraq, Libya, Morocco, Palestine, Tunisia and Oman. They are part of the program because they need to use malaria eradication as a convenient cover for subverting fertility to either bring or keep their total fertility rates below replacement level.

South-east-Asia region

The total number of participating nations for the South-East-Asia Region is ten: Bangladesh, Bhutan, North Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, and Thailand.

The report of the technical consultation that took place in New Delhi, India, on 28-29 April 2014 [16], informs us that five countries have already achieved 75% decrease in case incidence, two countries are projected to achieve 75% decrease by 2015 and that Sri Lanka is the most advanced and was certified malaria free by the WHO in 2015. It fails to specify, however, which countries achieved these targets.

Nepal and Bhutan are malaria endemic countries only in the self-serving imagination of UN technocrats who need to use the cover of malaria to sterilize these hard to reach people.

Sticking out like a sore thumb is also the Maldives which is not a malaria endemic country and in fact has never seen malaria. It is however frightfully overpopulated and it needs to continue to use malaria as a cover for combatting fertility, which it began doing in 2007 and within a year decreased its total fertility rate from 5 to 2 children per woman.

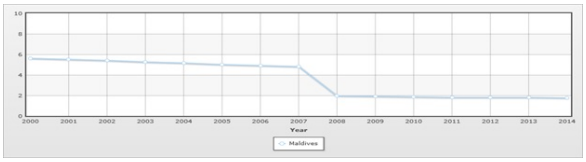

Figure 6: Maldives total fertility rate from 2000 to 2014.

The only country from this region that has broadcast its participation in the Global Technical Strategy for Malaria 2016-2030 is India, which did so with much fanfare on 11 February 2016 [17]. Four days later, the author asked President Mukherjee and Prime Minister Modi to pull out of the program or face the same consequences Brazil has started to face due to an explosion in microcephaly and other congenital malformations caused by the larvicides and insecticides used for Malaria and Dengue vector control [18].

Western pacific

The total number of participating nations for the Western Pacific Region is ten and they are: Cambodia, China, Lao PDR, Malaysia, Papua New Guinea, Philippines, Solomon Islands, Vanuatu and Viet Nam. The Republic of Korea sent apologies for not being able to participate.

According to the technical consultation report that took place in Manila, Philippines, on 10-11 June 2014, "all ten malaria endemic countries of this region have declared malaria elimination as a national goal, the most recent being Papua New Guinea" [19].
Vanuatu and Solomon Islands should not be on this list given that the medical community knows how to eradicate malaria from islands with hypoendemic and mesoendemic malaria since 1991 when a study was done on the island of Aneityum and malaria was fully eliminated within nine weeks, without the use of Artemisinin, and permanently according to malariometric monitoring [20]. Malaria endemicity did not return because malaria transmission and importation can be easily prevented on remote islands.

It was however not in the interest of the depopulation lobby at that time to eliminate malaria once and for all as that would have deprived it of high mortality rates in regions where low fertility rates could not be accomplished, just as it is not in the interest of the depopulation lobby today to eliminate malaria from the face of the earth as that would deprive it of a pretext to inject sterilizing agents across populations as needed in order to depress fertility rates below replacement level and to keep them there in perpetuity.

Europe region

The total number of participating nations for the Europe Region is nine and they are: Armenia, Azerbaijan, Georgia, Greece, Kazakhstan, Kyrgyzstan, the Russian Federation, Tajikistan, and Turkey.

The technical consultation report that took place in Copenhagen, Denmark, on 10-11 June 2014 [21], however fails to explain why Russia, Armenia, Georgia and Kazakhstan, who have never seen malaria, should be part of the program. It also fails to explain why Greece and Tajikistan, who have only had rare and tiny outbreaks, should participate in a malaria eradication program intended for malaria endemic countries.

It does not explain this because none of these countries are as interested in eradicating malaria as they are keen on lowering and/or keeping their total fertility rates below the required replacement level. The malaria eradication program gives them a perfect excuse to subvert the fertility of rural people in remote areas and of indigenous people that pose problems to national cohesion or offend the bigotry and racism of the ethnic majority and their leaders. In other words, it serves the eugenic aspect of the Global Depopulation Policy [22].

To hide this inconvenient truth the report declares that the regional consultation was intended "to seek input from regional experts of Euro."

What the above reports reveal by their omissions is what the UN system and governments around the world want to hide, namely that their primary motivation is to accomplish ambitious and indeed necessary demographic objectives and that the malaria eradication program provides them with the opportunity to commit mass involuntary sterilization without being found. It also provides them with the plausible deniability required by religious leaders to preserve the appearance of morality and by political leaders to preserve the appearance of legality.

The reality, however, is that there is nothing legal or moral about the malaria eradication program and this is illustrated by the dual purpose drugs and pesticides used to combat malaria and cause infertility at the same time.

Chemoprophylaxis and Vector Control

The WHO Guidelines for the Treatment of Malaria were first issued in 2006 and have since been re-issued in 2010, 2013 and most recently in 2015. These guidelines purportedly provide "evidence-based recommendations on the case management of malaria" and "detailed national protocols that take into account local antimalarial drug resistance patterns and health service capacity in the country" [23]. These assertions, however, are untrue.

The WHO Guidelines include prevention through vector control and treatment with antimalarials in a four-pronged approach:

1. Artemisinin-based Combination Therapy (ACT)
2. Indoor Residual Spraying (IRS)
3. Long-Lasting Insecticide-treated Net (LLIN)
4. Integrated Vector Management (IVM)

All four components deliberately use chemical and pharmacological compounds that are known antifertility agents.

Artemisinin-based combination therapy

The first component, artemisinin-based combination therapy (ACT), is the recommended treatment for uncomplicated Plasmodium falciparum malaria, the most virulent form of malaria causing the highest mortality rate and having the greatest prevalence in sub-Saharan Africa where more than 75% of cases are caused by this particular protozoan parasite.

The WHO recommends five different ACTs, all of which contain an artemisinin derivative-such as artemether, artesunate or dihydroartemisinin-in addition to one of the following anti-malarial drugs: lumefantrine, amodiaquine, mefloquine, piperaquine, and sulfadoxine-pyremethamine [24].

No research exists, however, that shows artemisinin to be an effective anti-malarial drug, which is why this assertion is repeated in paper after paper without a citation and why the WHO never recommends artemisinin and its derivatives as monotherapies for malaria. It is also why the WHO strictly forbids clinical trials with the plant. In fact the WHO explicitly discourages artemisinin as malaria monotherapy in all four reiterations of its Guidelines, just as it explicitly discourages people from self-treating with artemisinin, which could be easily obtained by drying the leaves of the wormwood plant, stating the difficulties of obtaining high-content artemisinin from plant leaves and the risks of under-dosing and of recrudescence as reasons for refraining from self-treatment [25].

To justify the use of artemisinin as a front-line malaria treatment drug the WHO and the Malaria Consortium now refer to it as a fast-acting antimalarial drug and to its companion drugs as longer-acting antimalarials that have a different mode of action and that together provide "high efficacy, fast action and the reduced likelihood of resistance developing" [26], but none of these assertions are based on demonstrable science.

What the WHO and the depopulation lobby are trying to hide is that artemisinin is a potent sterilizant and that its inclusion in ACTs as a companion to antimalarial drugs is intended only to subvert fertility for population control purposes.

Artemisinin is isolated from the Artemisia annua plant, whose common name is sweet wormwood; a plant known since antiquity to possess sterilizing qualities. Modern research confirms this and further shows that Artemisia annua is a potent abortifacient (prevents implantation), contraceptive (prevents ovulation and fertilization) and emmenagogue (stimulates uterine flow) whose phytoconstituents with abortifacient and contraceptive activity have been identified and isolated [27].

While no literature exists to demonstrate Artemisinin's efficacy as an antimalarial drug there are innumerable scientific papers which show that Artemisinin and its derivatives cause male infertility and androgenic deficiency, severe anemia and embryo death, embryotoxicity, inflammation of the testicles, and decreases of testosterone levels of up to 37%, in addition to being genotoxic and cytotoxic [28].

Chinese pharmaceutical chemist Youyou was awarded the 2015 Nobel Prize for Medicine for "discovering" Artemisinin [29] not because it is an effective therapy against malaria but because it is an effective fertility suppressant, which is what she was looking for in the first place on behalf of the Chinese government who was in need of a covert method of sterilization for the bourgeoning Chinese populace and that later proved very useful in combating population growth

among troublesome Muslim minorities and among the Tibetan people who could not be subjected to the one-child policy without stirring social unrest.

That Artemisinin was meant from the very beginning to be a sterilizing drug is amply demonstrated by its origin, as it is the product of a secret military project of the People's Republic of China, called Project 523 [30], which started during the Cultural Revolution (a period when scientists and intellectuals were banished not funded) and that was not looking for a cure for malaria, as it is being asserted, since that would not have been classified, but for a way to subvert the human reproductive system.

Any inquiring mind will also not fail to notice the gap between discovery of the drug, which happened in the 1970s, and the time when its discoverer, Youyou, was awarded the Nobel Prize for Medicine for finding Artemisinin. The notion that a scientist should be rewarded with a Nobel Prize forty years after the fact is ridiculous, especially in the absence of any other accomplishments, and can only be explained as a political decision to appease the Chinese government and to reward it for its contributions to the global depopulation agenda. Youyou is the only Chinese scientist to date to be rewarded with a Nobel Prize in Medicine and to obtain such an honor for a discovery for which there are no publications in any other language than Chinese and that she purportedly published under a pseudonym [31].

That the 2015 Nobel Prize for Medicine was entirely a political exercise and not a scientific recognition is further demonstrated by the other co-winners, William and Satoshi, who were rewarded for their discovery of Ivermectin, which is also a sterilizant in disguise that happens to kill parasitic worms, but has been shown to cause "significant reduction in sperm counts and sperm motility" as well as "significant increase in the number of abnormal sperm cells" [32]. It is currently used as an adjunct therapy in patients with uncomplicated falciparum malaria who receive a 2-dose Ivermectin regimen during a standard 3-day Artemisinin combination therapy so their blood serves as vector control [33].

The Nobel Prize for Medicine is further tainted by the lack of credibility of its fifty voting members, all of whom are professors at Karolinska Institutet in Stockholm, Sweden [34], an incubator of the depopulation lobby.

Artemisinin has become ineffective as an antimalarial drug in Asia, where it has been used and abused the longest as a population control method, due to mutations in the *Plasmodium falciparum* K13 propeller gene [35], as well as in arts of Africa and South America [36]. Nevertheless, countries around the world continue to use it in combination therapy and the WHO continues to advise its use as a first-line treatment of uncomplicated *P. falciparum* malaria, for while it is useless in combatting malaria it is useful in combatting fertility. Its high price, be it as a natural extract, a semi-synthetic derivative or a transgenic product is not a consideration given its importance to the depopulation lobby.

A problem that is unrelated to Artemisinin but very much related to malaria therapy is that of G6PD deficiency, an inherited condition with a 15% prevalence rate in the African population.

Individuals who lack the enzyme glucose-6-phosphate dehydrogenase or G6PD, which helps red blood cells function normally, are at risk of developing haemolysis when treated with primaquine. This genetic anomaly is thought to be an immune response to malaria that offers some protection against lethal malaria [37], which is why it is found in Africa at such a high rate, but is almost absent in areas that are not malaria endemic.

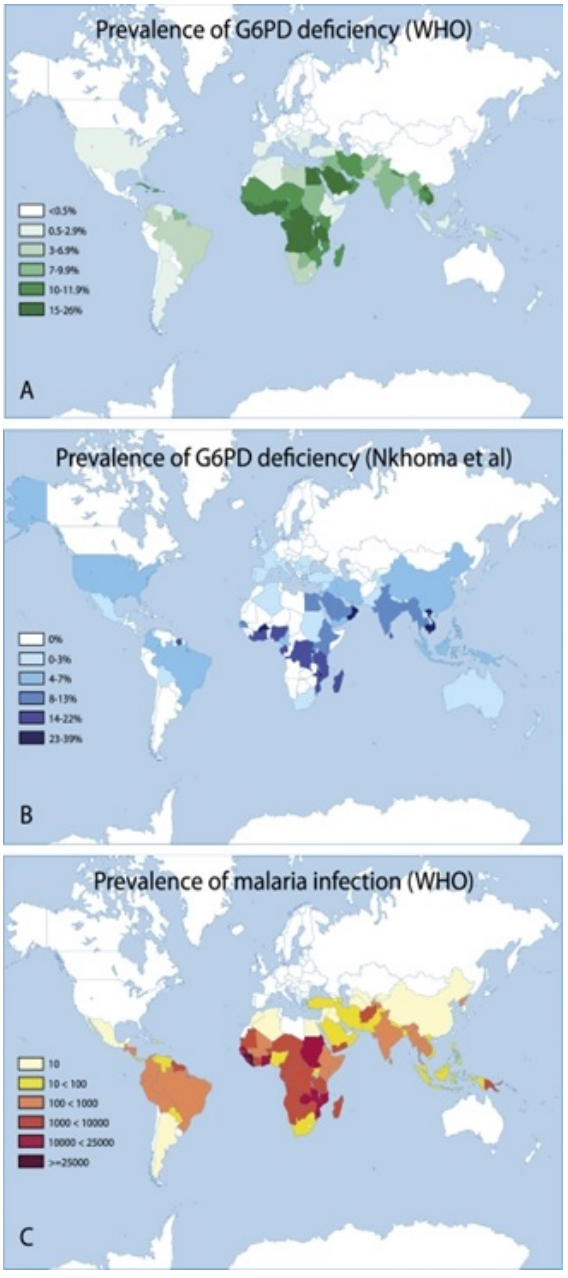

Figure 7: Prevalence of G6PD deficiency and malaria infection

Unless diagnosed prior to treatment-and such diagnosis will not be forthcoming in the cheap and mass immunization programmes of the malaria eradication drive-many people, and especially children, stand to lose their lives once they receive an ACT that contains primaquine.

That the WHO intends to overlook this problem is made painfully evident by the fact that the two reports of the technical consultations that took place in Africa (the first in Brazzaville, Congo, from 18-19 March 2014 and the second in Harare, Zimbabwe, from 8-9 April

2014) fail to even mention G6PD deficiency let alone detail plans on how to address it, whereas the technical consultations reports that took place in Asia and Europe do mention it as a problem that will need to be solved through adequate diagnostic methods, namely a cheap and reliable cytochemical assay that, unfortunately, has yet to be discovered.

Given that Africa has by far the highest incidence of G6PD deficiency this should have been high on the agenda of the aforementioned technical reports. It is not because no cheap cytochemical assay exists and because no money would be provided to test every African prior to mass ACT treatment even if such a test were available.

Mass malaria eradication on the cheap means that many of those who are G6PD deficient will die from the ACT treatment and this, in addition to being an unforgivable crime, will reduce immunity to malaria in the long run, thus setting up the continent for even greater public health disasters further down the road.

The WHO and the UN system, however, are not concerned because death is as valuable as life in the brutal task of population stabilization.

Indoor residual spraying

Indoor residual spraying (IRS) is one of two core vector control interventions, the other being long-lasting insecticidal nets (LLIN). Circa 150 million people or 5% of the global population at risk of malaria is currently subjected to IRS [38].

The purpose of IRS is to reduce the vector's lifespan, density and vector-human contact in areas with an annual parasite incidence (API) of more than 2/1000 so that seasonal annual peaks of malaria transmission are attenuated, epidemics are prevented, and malaria transmission is brought down to a level that can be sustained with near universal use of long-lasting insecticidal nets (LLINs) .

The most common form of IRS is thermal malathion fogging. Malathion is an organophosphate insecticide that is highly contaminating by direct contact or evaporation of solvent vapor [39], is a suspected reproductive toxicant [40] and a known teratogenic agent [41].

Figure 8: Malathion spraying

All other insecticides recommended by the WHO for use in IRS are toxic to reproduction and dangerous to human health: DDT, Fenitrothion, Pirimiphos-metyl, Bendiocarp, Propoxur, Alpha-cypermethrin, Bifenthrin, Cyfluthrin, Deltamethrin, Etofenprox, and Lambda-cyhalothrin.

TABLE 4
WHO-recommended insecticides for IRS against malaria vectors

INSECTICIDE COMPOUNDS & FORMULATIONS[1]	CLASS GROUP[2]	DOSAGE (g a.i./m²)	MODE OF ACTION	DURATION OF EFFECTIVE ACTION (MONTHS)
DDT WP	OC	1–2	Contact	>6
Malathion WP	OP	2	Contact	2–3
Fenitrothion WP	OP	2	Contact & airborne	3–6
Pirimiphos-methyl WP, EC	OP	1–2	Contact & airborne	2–3
Pirimiphos-methyl CS	OP	1	Contact & airborne	4–6
Bendiocarb WP, WP-SB	C	0.1–0.4	Contact & airborne	2–6
Propoxur WP	C	1–2	Contact & airborne	3–6
Alpha-cypermethrin WP, SC	PY	0.02–0.03	Contact	4–6
Alpha-cypermethrin WG-SB	PY	0.02–0.03	Contact	< 4
Bifenthrin WP	PY	0.025–0.050	Contact	3–6
Cyfluthrin WP	PY	0.02–0.05	Contact	3–6
Deltamethrin WP, WG, WG-SB	PY	0.020–0.025	Contact	3–6
Deltamethrin SC-PE	PY	0.020–0.025	Contact	6
Etofenprox WP	PY	0.1–0.3	Contact	3–6
Lambda-cyhalothrin WP, CS	PY	0.02–0.03	Contact	3–6

[1] CS, capsule suspension; EC, emulsifiable concentrate; SC, suspension concentrate; SC-PE, polymer-enhanced suspension concentrate; WG, water-dispersible granule; WG-SB, water-dispersible granules packaged in water-soluble bags; WP, wettable powder; WP-SB = wettable powder in sealed water soluble bags

[2] OC, organochlorines; OP, organophosphates; C, Carbamates; PY, pyrethroids.

Note: WHO recommendations on the use of pesticides in public health are valid ONLY if linked to WHO specifications for their quality control. WHO specifications for public pesticides are available on the WHO website at http://www.who.int/whopes/quality/en/.

Figure 9: WHO-recommended insecticides for IRS against malaria vectors.

DDT has been banned in Europe and North America in the 1980s but it is being used elsewhere despite its known toxicity. DDT's long-term ravages that have only recently come to the fore in the form of delayed pregnancy in daughters of women exposed to DDT thirty years ago [42] and preterm and small babies for mothers with maternal serum concentrations of DDT [43]. That these findings are not included in any assessments of the costs and benefits of vector control with DDT reveals the true purpose of malaria vector control with insecticides known to be toxic to reproduction.

Much the same dismal story we find with all others insecticides used for IRS:

Fenitrothion causes "deleterious effects on the sperm and testes" [44]; pirimiphos-metyl "is detrimental to the reproductive potentials of male rats" [45]; Propoxur causes "menstrual problems, altered sexual behavior, infertility, altered puberty onset, altered length of pregnancy, lactation problems, altered menopause onset and pregnancy outcome" in females as well as "altered sexual behavior, altered fertility and problems with sperm shape or count" in males [46]; Alpha-cypermethrin "affects testes development and function in adults" even at low-dose perinatal exposure [47]; exposure to Biphentrin "may increase the risk of ovulatory dysfunction in females" [48] and has innumerable negative effects on health in general [49]; Cyfluthrin is a suspected reproductive toxicant [50]; Deltamethrin induces "neurotoxicity, hepatotoxicity, nephrotoxicity, reproductive toxicity, genotoxicity and immunotoxicity" [51]; and Lambda-cyhalothrin "may cause sexual dysfunction in male rats" [52].

What is strikingly and embarrassingly obvious is not only that the entire gamut of malaria fighting chemicals is toxic to reproduction but that none of the research demonstrating this comes from western nations where these chemicals are conceived and manufactured and where the sponsors of the Global Depopulation Policy have perverted science and medicine to such an extent as to render any research originating in the West completely dishonest and utterly blind to the true state of affairs.

We have come to a point in history when being a western scientist is no longer a point of pride but one of shame.

The WHO defines and explains IRS as:

"The application of a long-lasting, residual insecticide to potential malaria vector resting surfaces such as internal walls, eaves and ceilings of all houses and structures (including domestic animal shelters) where such vectors might come into contact with the insecticide.

When a vector comes into contact with a sprayed surface, it absorbs a lethal dose of insecticide, thereby reducing its lifespan. This results in a progressive decline in vector density and longevity, especially among older female mosquitoes, and a reduction in overall vectorial capacity, thereby contributing to a reduction in malaria transmission [53].

The operative words here are 'long-lasting' and 'residual' insecticides that are 'lethal' to mosquitoes and that coat the walls and surfaces of human habitations with unknown and unquantifiable results for people's health; results that can only be negative and that will never be acknowledged by the architects of the Global Depopulation Policy because it would jeopardize their primary mission, which is to bring down fertility to replacement level come hell or high water.

The two methods of vector control, indoor residual spraying (IRS) and long-lasting insecticidal nets (LLIN), dovetail and this is how the WHO explains their synergistic and complementary effect:

"One significant difference between the use of IRS and the use of treated mosquito nets is the point at which each intervention works to greatest effect. IRS may provide some small amount of protection to an individual house by repelling and reducing the number of vectors that come into the house. However, the greatest impact of an IRS intervention takes place after feeding, when the anopheline mosquito is more likely to rest on a sprayed surface and pick up a lethal dose of insecticide, thus preventing it from going on to transmit the malaria parasite to others in the vicinity. This means that for IRS to be effective, there must be high coverage (usually > 85%) of all structures that are potential resting places in order to obtain the "mass effect" on the vector population: in other words, being the only sprayed house in the neighbourhood will do little to protect the residents. LLINs, however, inhibit feeding before the mosquito can inoculate the person with sporozoites, and insecticide component of net provide a degree of lethal effect on the vector. This provides both personal protection and, at high coverage rates, a "mass effect" on the vector population. Therefore, being the only house in the neighbourhood with residents sleeping under a treated net will provide some degree of protection, even if the neighbours are not covered" [54].

While this rationale is sound as far as malaria eradication is concerned it is unsound for the well-being of people who are forced to live in an environment where contact with toxic insecticides is inescapable and where chronic insecticide poisoning is considered a worthwhile price to pay by far away technocrats who themselves do not have to pay it, but who nevertheless find it acceptable to impose it on others under false pretenses, falser promises and the falsest premises.

This sorry state of affairs prevails because we live in an international system that irrationally sacrifices entire populations rather than empowering individuals to make rational sacrifices.

Long-lasting insecticidal net

At $10 a piece insecticidal bed nets are a great investment, which is why 89 countries distribute them free of charge and why they constitute more than 40% of overall spending on malaria eradication. As a result, coverage has increased by leaps and bounds since the beginning of the 21st century [55].

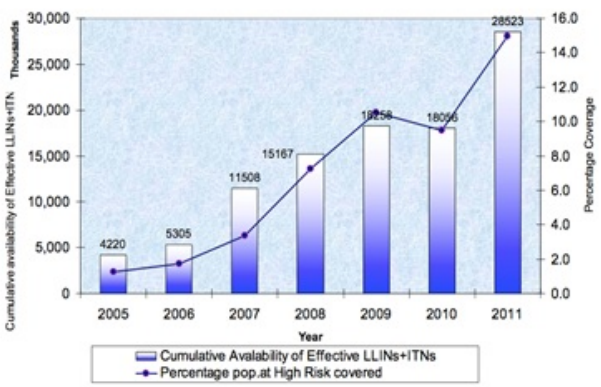

Figure 10: Availability of effective ITNs/LLINs among the population at risk in the SEA Region, 2005-2011.

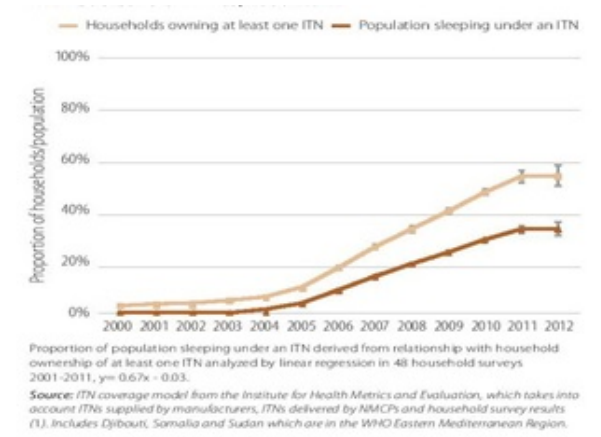

Figure 11: Estimated trend in proportion of households with at least one ITN and proportion of the population sleeping under an ITN in sub-Saharan Africa, 2000-2012.

Bed nets coated with insecticides are recommended by the WHO for vector control of malaria-carrying mosquitoes and indeed play an essential role as a preventive method of malaria control. But that is not why they are freely and continuously distributed in antenatal and immunization services, as the WHO requests, or why the international community is keen on achieving universal coverage, defined as one net for every 1.8 persons at risk. It is also not why the WHO has devised four extraordinarily intrusive survey indicators to monitor use of Insecticide-treated Nets (ITNs) and Long-lasting insecticide-treated nets (LLINs), these being: (a) percentage of household with at least one ITN/LLIN, (b) percentage of population with access to an ITN/LLIN within the household, (c) percentage of population reporting having slept last night under an ITN/LLIN, and (d) percentage of under-five children reporting having slept last night under an ITN/LLIN [56].

The true reason for this generosity and intrusiveness is that the UN system needs to bring the fertility rate of the developing world down to replacement level in advance of industrialization and the high

consumption rates that accompany it. And to do this, the international community needs to ensure that every person in the developing world sleeps under a bed net coated with sterilizing chemicals and that every adult knows how to treat their own bed nets with sterilizing poisons so they remain effective sterilizants [57].

The LLIN is the contraceptive of the developing world. It hovers over every bed and robs every sexual act of the possibility of conception.

Figure 12: African children under an LLIN.

The chemicals used to coat them with ensure the effectiveness of LLINs as contraceptives. The WHO recommends four classes of insecticides for this purpose: pyrethroids, organochlorines, organophosphates and carbamates, but pyrethroids "accounted for the majority of IRS coverage worldwide in 2009 and were used in all LLIN's" [58].

The most common pyrethroid used for LLINs is deltamethrin and its adverse effect on reproductive organs and fertility is well documented in both rats [59] and humans [60]. Tens of millions of insecticidal nets manufactured by Vestergaard, a strategic partner of WHO, are coated with it and hang over beds in all corners of the world.

The second most common pyrethroid for bed nets is cypermethrin and it too is known to cause testicular damage in rats [61] and to decrease fertility in both sexes [62]. Many people in Africa are poisoned with cypermethrin coated bed nets.

The third most common pyrethroid for bed nets is pyriproxyfen, which was recently linked to the increase in microcephaly cases in Brazil [63] and that is also known to cause testicular damage by reducing gonadotropin and testosterone levels [64]. All huts in the UN-sponsored Millennium Villages Project feature a pyriproxyfen-coated bed net due to the generosity of Sumimoto Chemicals, a strategic partner of Monsanto.

To make matters worse, the newest generation of LLINs is now coated with an insecticide synergist called piperonyl butoxide in addition to any of the above pyrethroids so as to enhance the potency of the pesticides by inhibiting the natural defense mechanisms of insects [65], making them even more toxic to humans than just pyrethroid coated nets.

Despite conclusive evidence that all pyrethroids are toxic to reproduction as well as neurotoxic the WHO continues to approve their use in LLINs and ITNs through its pesticides evaluation scheme (WHOPES) [66]. And while mosquitoes are developing resistance to pyrethroids humans are not and increasingly more humans of all ages are being subjected to continuous contact at an increasingly high exposure level with these dangerous insecticides. This violates not only common sense but also the two most fundamental principles of medicine, namely to do no harm and to use precaution.

This violation of fundamental principles of medicine is not by omission or failure of judgement on the part of those who carry out these duplicitous policies, but by a calculated sacrifice of individual health for the wealth of nations and the future of mankind. Human beings are treated with callous disrespect and are cast aside as collateral damage so that nations can escape the poverty trap, international peace can be maintained, and sustainability attained [67].

Integrated vector management

The fourth strategy for malaria control and eradication, Integrated Vector Management (IVM), tackles the disease at source through various means and in conjunction with IRS/LLIN vector-control and ACT treatment.

Such additional methods include: larvivorous fishes in lakes and rivers (fishes such as Guppy and Gambusia are employed in Bhutan, India, Indonesia, Myanmar, Sri Lanka and Thailand), chemical larvicides in drinking water sources (Pyriproxyfen used in India, Indonesia and Brazil), biolarvicides (such as Bacillus thuringiensis and Bacillus sphaericus used in countries such as India and Tanzania), engineering interventions that eliminate mosquito breeding grounds, and repellants for personal use [68].

While a careful analysis of the chemicals and organisms used for IVM is beyond the purpose of this paper, it suffices to say that the chemical larvicide Pyriproxyfen has been identified as the most likely cause for the microcephaly epidemic in Brazil, forcing the authorities to stop adding it to drinking water sources [69].

Larviciding (the regular application of chemical and biological insecticides to breeding sites) is widely used in Africa and Asia in areas where breeding sites are "few, fixed and findable" as a "supplement to ITNs and IRS" in urban areas where population density makes it cost-effective and where they can play an important role in insecticide resistance management.

The four methods of malaria control and eradication conceived by the WHO provide multiple sources of sterilization that continuously surround and assail the citizens of the developing world creating an inescapable toxic environment.

The developing world will find itself a few decades from now in the same demographic dire straits as the developed world which began subverting fertility with chemical toxins that are endocrine disruptors as early as 1945 and now watch helplessly as their populations collapse due to sub-replacement level fertility caused by exploding rates of sterility and impaired fecundity.

Between 1982 and 1995, for instance, a US National Survey of Family Growth from 1998 found that impaired fecundity increased 42% in women 25 and under, 12% in women 25 to 34 years old, and 6% in women 35 to 44 year old, confirming that the damage to the reproductive system is cumulative and affects new age cohorts to a greater degree than each previous age cohort. And the incidences of sterility and impaired fecundity have only gotten worse since, as national indicators and international statistics clearly show and which is why the native populations of all developed countries are rapidly declining.

Much ink and research money is spent on meaningless studies by self-serving scientists who are paid to find that the chemicals used in

the malaria eradication program pose no significant health threats even though a high school student could determine that the criteria of such research cannot possibly offer any comfort to a panicked populace who sees its health and strength degrade from day to day.

The studies on which the safety of the malaria eradication program rests are fraudulent because they are:

1. Limited to one compound at a time whereas in life we are being subjected to multiple contaminants at the same time.
2. Limited to animals or adults but fail to consider that the fetus is infinitely more sensitive to such chemical onslaught.
3. Limited to short periods of time whereas in life we are exposed to such contaminants for decades.
4. Limited to analyzing short-term changes while failing to consider that early exposure can have life-long consequences, some of which are not visible for decades after exposure.
5. Limited to high dose experiments without considering that endocrine disruptors working in tandem potentiate each other's negative effects on human health and can therefore be toxic at very small doses.

While fraudulent research continues to enable the depopulation genocide under the guise of medicine and public health, the same epidemiologic transition from infectious to non-communicable diseases that was triggered in the developed world through covert chemical means via endocrine disruptors that adulterate the food and beverage system is being triggered in the developing world via drugs and insecticides designed to sterilize humans while also killing malaria-carrying mosquitoes.

The Global Technical Strategy for Malaria 2016-2030 is merely the latest cover for attacking the human reproductive system and the largest assault on human fertility yet devised by an international system based on genocide.

The damage done to human health in general and fertility in particular will be directly proportional to the scale and scope of this assault, downgrading the genetic and intellectual endowment of the people of the developing world just as it has been and continues to be done to the people of the developed world. But since this damage is being imposed on poor people and on developing nations that lack the technical and financial capacity to mitigate for this damage through high investments in healthcare, the pain and misery caused to billions in the developing world will be that much greater than the pain and misery inflicted on the developed world.

Equally important, the walls of deception and lies that have kept the Global Depopulation Policy secret and have enabled governments and the UN system to commit genocide in the developed world for the past seven decades unhindered by public resistance have fallen and this spells certain and violent conflict between the vast masses of innocents who are being sickened, sterilized and prematurely killed and the self-serving elites in government, the UN system and the scientific community who drive this genocide.

Only a change of course from covert and involuntary to overt and consensual limits on fertility through a global replacement level fertility law can prevent violent conflict between the 99% and the 1% and stop humanity from self-destruction.

This transition, however, will not occur unless and until the medical community speaks up and stands up in defense of life and does so publicly and firmly in open defiance to the political and economic forces arrayed against life.

Conclusion

The malaria eradication program will shrink the geographic area of malaria but will explode the incidence of chronic disease, lower the quality of life and downgrade the genetic and intellectual endowment of the people of the developing world just as it was done to the people of the developed world, which will eviscerate the trust people have in government and health authorities and will ultimately and inevitably lead to violent conflict.

The lives that will be saved outside the womb in the short run will be exceeded many time over by the lives that will be terminated inside the womb in the long run, malaria will not be eradicated, countless people will die from Primquine-induced haemolysis because their G6PD deficiency will not be identified, herd immunity will be compromised, and the incidence of sterility and impaired fecundity will rise significantly and will be cumulatively worse with every generation leading to population collapse fifty years down the road and not to the steady and smooth decline now envisioned and hoped for.

The population bomb will be defused throughout the developing world and the demographic transition advanced to the final stages, just as it was done in the developed world, but a nuclear political bomb will have been ignited and the epidemiologic transition worsened to such an extent that morbidity and mortality rates will rise to heights never before seen.

Only a change of course from covert and involuntary to overt and consensual limits on fertility enshrined in law and enabled by cheap, safe and universally available contraceptives can prevent political, demographic and economic disaster. And this transition hinges on the willingness of doctors and scientists to speak the truth, to stop collaborating in genocide and to sacrifice their privileges for the wellbeing of mankind.

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