THE WORLD HEALTH ORGANIZATION

SHSMUN'21

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Introduction to Committee:

The World Health Organization (WHO) was founded in 1948 with the main aim of working for better health for everyone, everywhere. The WHO coordinates with fellow UN agencies, governments, donors, NGOs, and the private sector. Headquartered in Geneva, it has 141 offices spanning across six regions and employs about 8,000 doctors, scientists, epidemiologists, managers, and administrators. It has grown from 55 members in 1948 to 194 members today, and the WHO's scope and influence gives it a relevant position in the international community. The WHO's initial priorities were malaria, tuberculosis, venereal disease, and other communicable diseases, plus women's and children's health, nutrition, and sanitation; nevertheless, the focus axis has expanded its horizons to include other issues. As delegates to the World Health Organization, you have an opportunity to discuss the topics at hand and to work collectively on designing viable solutions through the process of negotiation and compromise.

Topic #1: Evaluating Ethics in Cases of Maximization of Hospital Resources

History of the Topic

Bearing in mind the COVID-19 pandemic, it has become clear that a majority of hospitals across the globe are ill-prepared, with severely limited resources, in the face of pandemics/large spreads of disease. Hence, there are ethical considerations that must be taken when dealing with the issue of maximized hospital resources. Without a doubt, ethical aspects of hospital management need more attention and scrutiny than they have received up till now. Topics such as cloning, research on human stem cells, or preimplantation diagnosis have a much more immediate appeal than "cost efficiency", "workflow management", "clinical pathways", "process orientation", and "total quality management", but these technical terms actually have major moral implications. Management decisions are in fact riddled with ethical questions and have a significant impact on patients, staff members, and the community being served. How to allocate available funds to departments, what portfolio of clinical services to offer, or how to assure a reliably high quality of services are matters that do indeed deserve ethical reflection and analysis. They need to be addressed directly and concretely, and not only by way of more general and abstract discussion on health care systems or access to health. Given that there are no clear upper limits to the demand and supply of medical goods, it is necessary to use some rational criteria for resource allocation. In this decision-making process, evidence based medicine (EBM) plays an increasingly important role as a tool for rationalizing as well as rationing health care resources. Health care institutions must also give special consideration to the needs and medical problems of vulnerable groups, whether their vulnerability results from a specific lack of autonomy (as in the case of the very young, the elderly, or psychiatric patients), or from social marginalization, as in the case of poor or inadequately insured people. Hospital managers can exercise influence aimed at promoting ethical health care over a wide range of organizational features. Although medical ethics mainly deals with conflicts between the patients and their health care providers, it is clear to us that the features which frame the institutional setting, such as the hospital, in which such conflicts take place, are of considerable importance as well as finding appropriate solutions. The emergence and formulation of common and consensual codes of conduct in many hospitals today can be interpreted as a sign of a general growing consciousness of moral conflicts in medicine. The tasks and responsibilities of hospital management contain many urgent ethical questions and problems— for example, who will decide in the future what is medically necessary and what a society can afford to pay? Even more today than in the past, achieving the goals of equitable access, responsible cost containment, and effective quality assurance will require ethical decision making—as is the case with the patient-physician relationship. It might be of help if established ethical codes, like the American Health Association's, explicitly acknowledged and addressed ethical challenges, the increasing use of EBM, and decisions made for explicit or implicit economic purposes as opposed to ethical ones.

Involvement of Countries

The World Health Organization declared the outbreak a Public Health Emergency of International Concern on 30 January 2020, and a pandemic on 11 March. Increasing capacity and adapting healthcare for the needs of COVID-19 patients is described by the WHO as a fundamental outbreak response measure. The European Center for Disease Control and the European regional office of the WHO have issued guidelines for hospitals and primary health care servers to shift resources at multiple levels; the following are the endorsements for action that countries could take:

- Focusing laboratory services towards COVID-19 testing.

- Cancelling elective procedures whenever possible.

- Separating and isolating COVID-19 positive patients.

- Increasing intensive care capabilities by training personnel and increasing the number of available ventilators and beds.
- Providing non-emergency healthcare services virtually to maintain physical distancing and to protect both patients and clinicians in some areas.
- 3D printing healthcare material such as nasal swabs and ventilator parts due to capacity limitations.

At the height of the COVID-19 outbreak, the number of patients that required ventilator support outnumbered the available intensive care unit (ICU) beds. In most countries, general beds were rapidly converted to ICU beds, and general hospitals were converted to critical care hospitals; additional physicians and nurses trained in critical care medicine were transferred to the most affected areas. In other countries, such as the Republic of Ghana, ICU beds and personnel trained in critical care are limited to tertiary hospitals, and accordingly, the mortality associated with COVID-19 is likely to exceed the reported case fatality rate of 2.3%. A huge issue lies in whether low- and middle-income countries (LMICs) can fund the cost of additional critical care units from their limited healthcare budgets.

Based on the WHO's core components, the infection prevention and control (IPC) minimum requirements are standards that should be in place at both local and national health facility levels to provide minimum protection and safety to patients, healthcare workers, and visitors. The minimum requirements constitute the initial starting point for building the IPC's core components in a stepwise manner based on the local conditions. The COVID-19 outbreak has again demonstrated the importance of basic IPC measures and the importance of having these minimum requirements in place.

The disruption of supply chains and depletion of stock (such as medical supplies and equipment) in both high- and low-resource settings has catapulted IPC core component 8 (built environment, materials, and equipment for IPC) to daily front-page headlines in the popular press and social media. Panic buying and irrational use of personal protective equipment (PPE) have led to inadequate supplies of N95 respirators, and these shortages will have potentially devastating consequences for multidrug-resistant/extreme drug-resistant tuberculosis management in LMICs. To prevent shortages of essential PPE for the COVID-19 response, governments should give clear

guidance on the use of PPE and act now to secure adequate supplies and stocks in case the outbreak spreads to these countries. Regional production of medical supplies should be considered for all continents to reduce the risks of shortages of PPE at crucial times.

Furthermore, triage and the implementation of minimum WHO IPC requirements should be initiated as part of COVID-19 preparedness in the existing health care facility.

Finally, in the special case of totally overwhelmed hospitals, such as in the advent of COVID19, many ethic boards/triage guidelines were created in order to determine who gets treated with the limited resources available. In New York State, the guidelines on who should be offered ventilator support exclude anyone with "underlying disease or medical conditions that may hinder recovery." In Alabama, ventilator use was even further restricted from "with intellectual disability, complex neurological problems, dementia, severe or profound mental retardation, individuals with motor neuron disease, glioblastoma multiforme, and children with severe neurological problems." The New England Journal of Medicine, in collaboration with doctors from around the world, published a set of ethical guidelines on how to ration resources which cautioned against a "first come, first served" criteria and instead favored young, severely ill patients who had high chances of recovery.

There is yet to be a consensus on the best way to make the heart-wrenching decision of which patients should live or die in the case of maximized resources, especially when considering all the angles the decision encompasses: the legality of it all, the ethics, the effect on the community, and the effect it may have on medical personnel's mental health. That is why it is of the utmost importance to come to a unified and global consensus on the matter both to deal with the current crisis at hand and to prepare for the future.

Possible Outcomes

After the COVID-19 pandemic, many countries faced problems in hospitals with PPE and medical supplies. Thus, hospitals should increase their medical supplies with aid from the government and the WHO. Moreover, hospital patients should be separated based on their health. For example, infectious-disease afflicted patients may be moved to other, less crowded hospitals to avoid further disease spreading. Furthermore, symptomatic people must be treated whereas asymptomatic people must be moved into solitary confinement, and monitored, in order to contain the disease. Social distancing is a habit that all citizens of this world should practice while responding to an unknown disease/virus. Finally, in order to make the most considered decisions, health care professionals may collaborate with ethical/moral professionals in order to come up with favorable solutions.

Questions to Consider

- How should hospitals decide who to treat (and who not to treat) if resources are severely limited?

- Should those in better health be prioritized as they have better chances of surviving, or should it be those in worse health as their cases are more critical?

- How can these decisions be kept as objective as possible? Is the best medical decision always the best overall decision?

- Who should be making these decisions? Medical professionals or those who have studied ethics and philosophy?

- Does your country have any established laws in regards to the topic?

- Has your country taken any actions in relation to the topic?

- What are these actions?

Topic #2: Re-examining International Health Standards and Regulations

Introduction to Topic

It is the World Health Organization's aim to educate and save the world from dangerous diseases and viruses, as well as to promote general health. Accordingly, as new diseases disperse and health risks emerge, urgent and calculated responses are often made through consultation of the aforementioned IHR, which helps legalize and structuralize the WHO's aim.

An example can be found in the spring of 2009 when an outbreak of the H1N1 (Influenza A) virus occurred. At the time, injecting people with seasonal flu vaccines was thought to be the best solution. However, this turned out to be ineffective and caused fear, stress, and uncertainty for the global population, and scientific and medical communities. However, through international collaboration and urgent response, a vaccine- the monovalent (H1N1) pdm09 vaccine- was developed and released in small quantities by early November. Later, in late November, more vaccines were released following the peak of the illness during the second wave in the United States.

Due to increasing awareness and education concerning illnesses and public health, populations are increasingly prepared for medical emergencies and crises. Still, there is a great amount of uncertainty and unknowns. Currently, experts are seeking and testing vaccinations and medications to end the highly infectious COVID-19 pandemic.

While the search for and testing of vaccines occurs, prevention is key. Personal Protective Equipment (PPE) is of utmost importance during this worldwide pandemic in order to prevent the disease from exponentially spreading, as well as to protect physicians, hospital staff, and essential workers throughout their workday. Countries, perhaps now more than ever, have understood the need to stock up on such equipment as much as possible in order to avoid shortages in times of emergency. For example, the USA had a significant shortage of PPE as it relied on importing from other countries instead of producing its own, and it is highly likely this shortage led to a quicker spread of disease.

COVID-19 has changed the way people live and the way they think, specifically in terms of social situations and activities. According to a global tourism expert, UniSA's Professor Marianna Sigala, tourists are unsure about travel, especially since many countries are under lockdown, and tourism businesses are on the verge of bankruptcy. This extends to domestic and everyday activities, like going to the movies, eating at restaurants, or meeting at public places. This newfound caution and interest concerning public hygiene should be addressed by governments through legislature as the world struggles to find how it will move forward.

History of the Topic

While disease outbreaks and other acute public health risks are often unpredictable and require a range of responses, the International Health Regulations (2005) (IHR) provide an overarching legal framework that defines countries' rights and obligations in handling public health events and emergencies that have the potential to cross borders.

The IHR is an instrument of international law that is legally binding on 196 countries, including the 194 WHO Member States. The IHR grew out of the response to deadly epidemics that once overran Europe. They create rights and obligations for countries, including the requirement to report public health events. The Regulations also outline the criteria to determine whether or not a particular event constitutes a "public health emergency of international concern".

At the same time, the IHR requires countries to designate a National IHR Focal Point for communications with the WHO, to establish and maintain core capacities for surveillance and response, including at designated points of entry. Additional provisions address the areas of international travel and transport such as the health documents required for international traffic.
Finally, the IHR introduces important safeguards to protect the rights of travelers and other persons in relation to the treatment of personal data, informed consent, and non-discrimination in the application of health measures under the Regulations.

Involvement of Countries

The following are how countries are dealing with the Covid-19 pandemic and how they are changing their standards in order to adapt, as of the time of writing:

Australia:

Only Australian citizens are allowed into the country after being quarantined in a hotel under the government's supervision for 14 days. By that, Australia is maintaining massive success over the pandemic. Life is going back to normal in some states like New South Wales. The key to Australia's success over the pandemic is due to the closure of the border between each state.

Jordan:

Jordan's borders remain closed and commercial flights to and from the country remain suspended. Non-Jordanians cannot enter Jordan without special permission from the Jordanian authorities. If citizens have approval, they will need to undertake 14 days of quarantine in a government facility. Some National Defense Law restrictions remain in place and may change depending on the cases per day. Life in Jordan is going back to normal in order to support the economy; however, many precautions have been taken.

Cyprus:

Commercial flights have resumed, and seaports have reopened. If citizens travel from a Category A or B country, they will be permitted to enter Cyprus, subject to conditions depending on which country that citizen is coming from. If citizens have been to any other country in the preceding 14 days, they will not be allowed to enter, unless they have the right to live and work in Cyprus. Crossings between Cyprus Government controlled south, and Turkish-Cypriot administered north are only allowed for permanent legal residents with a negative COVID-19 test within 72 hours. Some crossing points between the north and the south remain closed. Wearing a mask outside during the day in North Cyprus is compulsory. Life in Cyprus is back to normal as all citizens are going to public places.

Italy:

All citizens in Italy are now permitted to maneuver around. Citizens no longer require a selfdeclaration form to travel within Italy, unless regional authorities decide otherwise. In all public spaces, citizens must follow one-meter social distancing protocols. The use of face coverings or protective masks is mandatory in enclosed public spaces. Life in Italy is slowly going back to normal as all precautions are being taken.

As seen above, many countries are slowly going back to normal in order to support the economy, but almost all still have strict precautions in place. Furthermore, as the possibility of a second, and maybe third, wave looms, changes in policy cannot be considered permanent as future lockdowns are possible.

Possible Outcomes

People always talk about new vaccines being developed or how the FDA approves a company to legalize a vaccine. However, what people always ask about when it comes to vaccines is the duration that it takes for it to be developed. Vaccines typically take around 10 to 15 years to be developed. This lengthy time for vaccine development forces Vaccine companies to work on other vaccines to find a fast solution during a pandemic. During the Ebola outbreak in West Africa, there was a keen interest in repurposing already approved drugs, such as interferon-beta 1a, to treat patients. Interferon-beta 1a works by modifying the immune system. It was tested during the outbreak in a single-arm proof of concept pilot study to study its safety and effectiveness against Ebola. This method of repurposing already existing drugs is an excellent way to find a new vaccine in a short period, but it may not always work, or be time and cost-efficient. Taking all of this into consideration, using already existing drugs for different purposes is not the ideal solution during a pandemic. Research should more be focused on predicting diseases and major viruses before they become global, and properly preventing them if they do.

For example, Italian scientists had identified from the sewage sample analysis that the Covid-19 virus had existed in the northern part of Italy in December 2019. What is promising from this sample is that it could help scientists understand how the virus functions and mutates, which would help in finding a vaccine. Another major issue in implementing safe vaccines during times of crisis is distribution and funding. Until a vaccine is produced, people need safety kits but not all countries are equipped adequately with enough PPEs and testing kits; this creates a problem of equality of access. For instance, in the UK, the Department of Health and Social Care (DHSC) has confirmed that over 1.48 billion PPEs have been delivered to the health and social care services in the kingdom. However, right across the pond, the USA was facing significant problems in the PPEs supply. In May 2020, it was found in a poll by the Washington Post that many front-line healthcare workers still do not have enough PPEs to keep them safe from infection. Around two-thirds of workers did not have enough masks in early May. More than four in 10 reported shortages of surgical masks, which are even less protective, and about a third said they were running low on hand sanitizer. About 70 percent of workers had to wear the same mask for more than a day. This poses the question of why factories are not being able to manufacture and deliver on time, and why hospital resources were not sufficient to begin with, especially in a country that has the means to afford it.

In terms of economy, Corona has dealt a huge blow. In 2018 tourism brought 782 billion euros and provided almost 14.5 million jobs. Tourism is not an essential factor for the European nations alone; in KSA, for example, tourism accounts 9.0% of the economy, while more than a tenth of China's economy is a result of tourism. Nevertheless, all of these numbers drop and also disappear during pandemics, which forces many countries to face financial and economic issues, with many of their citizens not able to work. Furthermore, with citizens under lockdown, almost all businesses, especially those who were unable to virtualize their services, were severely and detrimentally affected. Hence, there should be a method or strategy in place to maintain health and prevent outbreaks during emergencies while also protecting the economy.

An aspect that should be studied post-pandemic is whether countries that have not yet should start moving to free healthcare. For most industrialized/developed countries, a form of

universal/healthcare is provided, but in some countries, like the US, there is a more privatized form of health care. Citizens pay for private-sector medical insurance, which covers most medical bills, but what about those medical bills not paid by the insurance companies, or those who cannot afford insurance? Are citizens supposed to suffer because they cannot pay these bills even though they pay their taxes? And if these citizens who cannot afford healthcare suffer from contagious diseases that must be treated so they do not spread, how will their treatment be paid for? Countries that provide free healthcare are far from perfect as well. Many citizens report long waiting hours and substandard treatment. How should the provision of healthcare as a whole be reconsidered? Reforms in the healthcare system to provide equality of access to all citizens, improve treatments, and better vaccine developments and research should be a priority for all countries.

As this pandemic continues, countries must re-examine their public health and hygiene protocol and legislature, as well as how heavily they enforce them. Should these laws only be taken seriously in times of emergency and pandemic? Or should they become the new normal in order to prevent future catastrophes? How may countries better prepare themselves for the future, bearing the lessons Covid-19 has taught in mind? Should masks in public become the new normal? Will huge, close conglomerations of people, such as concerts, clubs, and large events, ever be allowed again? How will countries ensure they have sufficient medical resources going forward in order to avoid the problems they ran into with the Covid-19 pandemic? These are all questions which countries, the IHR, and the WHO delegates must ponder over in order to come up with more permanent solutions that look past the Covid-19 emergency and prepare for the future.

Questions To consider

1. Is your country willing to change health standards in response to major changes/emergencies/medical breakthroughs? How have past actions proven this?
2. What new health standards did your country take during the Covid-19 pandemic?

3. Is your country planning on expanding its quantities of medical equipment and resources?
    4. Is there a universal healthcare system in place in your country, or does it operate out of the private sector?

5. How is your country managing the costs of the virus, specifically if poverty is high?

    (Consider the virus spreading in a country where poverty is very high.)

6. Is your country locally producing PPE? If not, is it securing a reasonable amount for its citizens?

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