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World Health Organization

Background Guide



General Assembly

Committee Topic: Preparing for Future Pandemics: Strengthening Global Health Security

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Letter from the Chair

Welcome to the World Health Organization committee. The COVID-19 pandemic stood as a defining stress test for the entirety of global health governance. It exposed critical failures in preparedness, equity, and coordination. Scientific collaboration did achieve unprecedented speed in vaccine development. But, on the other hand, millions of preventable deaths revealed deep structural weaknesses that lie in global health security.

As delegates, you are tasked with confronting the reality of our present, that pandemics are no longer rare events. Climate change, globalization, antimicrobial resistance, and increased zoonotic spillover have led to a heightened risk of future outbreaks. The challenge this committee is faced with is not whether another pandemic will occur, but whether the international community will be prepared when it does.

Committee Background

The World Health Organization (WHO) was established in 1948 as the United Nations' specialized agency for global health and today includes 194 Member States. Its mandate is to promote the highest attainable standard of health by coordinating international health efforts, setting standards, and supporting countries through disease surveillance, emergency response,

and technical guidance. Each year, WHO monitors thousands of outbreaks worldwide and coordinates responses to major crises such as Ebola and COVID-19.

One of WHO's most important legal tools is the International Health Regulations (2005), a binding agreement among 196 countries requiring them to develop systems to detect, report, and respond to public health emergencies. However, enforcement is weak. Before COVID-19, fewer than one-third of countries met the core preparedness requirements, contributing to delayed reporting and uneven response. WHO depends largely on voluntary political cooperation and funding, which limits its ability to ensure full compliance.

Topic Background

The COVID-19 pandemic caused over 7 million officially recorded deaths worldwide and an estimated \$14 trillion in global economic losses. This severely affected every region. The United States, Brazil, and India recorded some of the highest total death tolls, while countries in Western Europe experienced repeated health-system overloads. In parts of Latin America and South Asia, hospitals collapsed under oxygen shortages and limited ICU capacity. Many African countries faced severe constraints in testing and reporting, which revealed weaknesses in global disease surveillance, hospital surge capacity, supply chains, and international coordination. During peak waves, nations such as Italy, India, and Peru reported ICU occupancy rates exceeding 90%, and cities in China, Spain, and the U.S. experienced critical shortages of PPE, ventilators, and medical oxygen.

Vaccine inequality became the most visible global failure. By mid-2021, over 60% of people in high-income countries, including the U.S., Canada, and much of Western Europe, had received at least one vaccine dose, compared to under 2% in low-income countries, most of them

in Sub-Saharan Africa. While wealthy nations pre-purchased billions of doses, countries such as Haiti, South Sudan, and the Democratic Republic of the Congo struggled to vaccinate even healthcare workers. The WHO-backed COVAX program, which aimed to deliver 2 billion doses by the end of 2021, fell far short because of funding gaps, export bans (notably from India during its 2021 surge), and manufacturing limits. These regional disparities allowed sustained transmission, driving the emergence of variants such as Delta (first identified in India) and Omicron (first reported in Southern Africa), prolonging the pandemic and increasing global mortality.

Recent Developments

In response to COVID-19, WHO Member States initiated negotiations for Pandemic Prevention, Preparedness, and Response Treaty. It aimed to strengthen global cooperation, improve early warning systems, ensure equitable access to medical countermeasures, and to establish clearer obligations for transparency.

Alongside this, advances in genomic surveillance and data-sharing platforms have improved variant detection, even though access remains uneven. Despite lessons learned, most countries remain underprepared, with a lack of adequate financing, trained personnel, and rapid response capacity.

Bloc Positions

- I. **Global Solidarity and Equity:** This bloc supports binding international commitments, pooled procurement, and technology transfer to ensure fair access to vaccines and treatments. Countries such as India, South Africa, Brazil, and Kenya often align with this view, arguing that pandemic response must strengthen manufacturing in the Global South. They support tools like patent waivers, compulsory licensing, and WHO-led technology transfer hubs to prevent supply hoarding and unequal access.
- II. **Sovereignty and National Control:** This bloc emphasizes voluntary cooperation and strong national authority over health decisions. It commonly includes countries like the United States, Russia, and the United Kingdom, which are concerned about binding rules interfering with domestic law, emergency powers, and intellectual property systems. They support coordination, but oppose enforcement mechanisms that override national sovereignty.
- III. **Market-Driven Innovation:** This bloc prioritizes private-sector leadership, strong patent protections, and financial incentives for research and development. Countries such as Germany, Switzerland, Japan, and South Korea often support this approach, pointing to public-private partnerships and advance market commitments as key to rapid vaccine development. Their main concern is that weakening IP rights could slow innovation and investment.

Questions to Consider

1. Given the weaknesses exposed during COVID-19, what concrete changes to the International Health Regulations would improve compliance without transferring decision-making power away from states?
2. If a Pandemic Treaty includes binding enforcement, what form should it take (sanctions, inspections, conditional funding), and who would have the authority to trigger it?
3. Since mechanisms like COVAX failed to meet distribution targets, what structural financing model (mandatory contributions, global health security fund, private-sector levies) could guarantee sustained preparedness funding?
4. Should intellectual property protections be temporarily suspended during global health emergencies, and if so, what safeguards would ensure quality control and continued innovation?

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