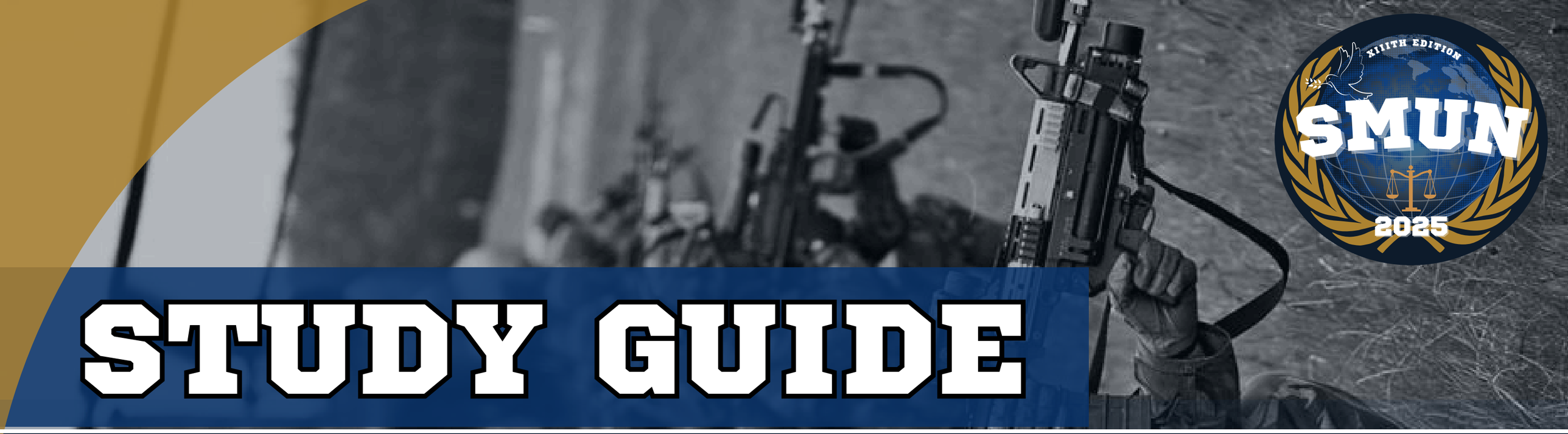

STUDY GUIDE

WHO

WORLD HEALTH ORGANISATION



SMUN 2025

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Introduction to the Agenda

The World Health Organization (WHO) is the United Nations specialized agency for global public health, founded in 1948 with a mandate to promote health, make the world safe, and protect the vulnerable. It is the apex policy-making authority on global health, which sets international standards, coordinates responses to health emergencies, conducts research, and offers technical and financial assistance to nations. The WHO is directed by the World Health Assembly (WHA), composed of representatives from all of its 194 Member States.

The WHO mandate also encompasses disease prevention, pandemic preparedness, immunization campaigns, health education, and coordination of emergency preparedness. It tracks global health trends, provides advice to governments, and offers infrastructure for universal coverage of health. It acts on the principle that health is a fundamental right of all human beings from birth, as enshrined in its Constitution and reaffirmed in international human rights conventions.

Introduction to the Agenda

The vaccine apartheid issue runs counter to the very spirit of WHO's mandate. During the pandemic, WHO spearheaded the Access to COVID-19 Tools Accelerator (ACT-A) and co-facilitated COVAX and promoted equal access to vaccines and therapeutics.

Wealthy nations, however, bought the majority of the first doses under bilateral agreements, while poor nations followed in line. The WHO 20% equitable allocation scheme was ignored, and the global response showed deep-seated inequalities.

WHO Director-General Dr. Tedros Adhanom Ghebreyesus labeled this disparity in May 2021 as "vaccine apartheid" a term which reflects the profound moral and systemic health failures of global health. The overwhelming majority of nations of the Global South had none of their own manufacturing capability, access to supply lines, or negotiating leverage.

This agenda calls on delegates not only to consider the errors of the COVID-19 response, but also to consider the long-standing global health inequities in vaccine access, ranging from intellectual property systems and supply chains to health financing and production in the regions. Delegates need to consider how the WHO needs to be reimagined to make vaccines and life-saving medicines global public goods in order to create more equity in future health crises.

Global Disparities in Vaccine Access

Access to life-saving vaccines is disproportionately unequal across the world, more so between low- and high-income nations. The COVID-19 pandemic unraveled these disproportions, yet the issue is far more widespread than that, reaching from COVID-19 vaccines to HIV/AIDS, HPV, malaria, tuberculosis, and more.

In COVID-19, 1% of one or more doses had been received in low-income countries compared to over 50% in high-income countries. Regionally, Africa had the least coverage (2%) and Europe and the Americas over 35%. Inequality in vaccination rises with increasing doses, poorest in booster and highest in Africa and Asia/Oceania.

These are structural and endemic inequalities:
HPV vaccines, which are required to avert the cancer of the cervix, remain inaccessible in the Global South as over 90% of cervical cancer deaths are taking place there.

HIV medications reached Africa nearly ten years after they were introduced in the West.

The rollout of the new licensed malaria vaccine is hampered by limited finance and infrastructure.

Global Disparities in Vaccine Access

It is also interrupted by shortages in infrastructure: Most low-income nations do not have ultra-cold storage for mRNA vaccines and face last-mile delivery issues, particularly to rural or displaced communities.

Refugees, stateless individuals, and Indigenous peoples are systematically left out of national immunization plans.

Furthermore, the bulk of the vaccines are manufactured in the Global North, U.S., EU, China, and India, and Africa only produces 1% of what it consumes. WHO's suggestion of regional mRNA production hubs is already in process but in the opposite direction.

In the meantime, vaccine hoarding, backroom agreements, and intellectual property walls by the drug companies prevented equal access and local manufacturing. Pfizer and Moderna were accused of putting profits before people and against technology transfer to low- and middle-income countries.

Ultimately, these inequalities delayed the international response, spawning new strains such as Omicron and putting economic strain on already stressed parts of the globe. Vaccines are not only a matter of public health, but one of equity, justice, and resilience across the globe.

TRIPS Waiver and Intellectual Property Debate

The WTO Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement has been globally criticized for obstructing access to pandemic lifesaving health technologies.

In October 2020, India and South Africa initiated a temporary TRIPS waiver on COVID-19 vaccines, treatments, and diagnostic tools and called on all nations to waive IP rights to help facilitate faster, lower-cost production, most crucially in LMICs.

The proposal centered on how IP limitations reduce the capacity of global manufacturing, especially for the Global South. The developing countries preferred the waiver, but the high-income countries such as the US, EU, and Japan opposed it. The critics argued that IP protections safeguarded the pharmaceutical monopolies at the expense of limiting world health equality.

Outcome of TRIPS Waiver Negotiations (2022–2023): Following months of talks, a limited waiver was cleared at the WTO 12th Ministerial Conference in June 2022 but only for COVID-19 vaccines and not for therapeutics or diagnostics. The deal was criticized by global health activists as too little, too late, a political watering-down of an initially ambitious proposal.

TRIPS Waiver and Intellectual Property Debate

Current Debate – Beyond COVID-19:

There is growing pressure at the international level to expand TRIPS waivers to cover monkeypox, cancer drugs, insulin, and emerging pandemic threats. The worry is that IP rules will again strangle equitable access when the next health emergency strikes.

CTAP against IP Монополіes

The COVID-19 Technology Access Pool (C-TAP) invoking voluntary license and sharing of knowledge also drew limited response. Such inaction proved that voluntary action is not enough in such a crisis backing demands for binding multilateral action on IP reform.

Role of International Organizations

Global immunization is being increasingly challenged by misinformation, budget cuts, population growth, and humanitarian emergencies.

On World Immunization Week (24–30 April), WHO, UNICEF, and Gavi sounded the alarm that vaccine-preventable illnesses like measles and diphtheria are on the rise and poised to claim millions of lives. Even though vaccines have already saved over 150 million lives in the first half-century, recent funding cuts and inequalities jeopardize the gains.

WHO

Actions: Directed the global coordinated development and response to the vaccine; created the COVID-19 Technology Access Pool (C-TAP) to aid in voluntary sharing of vaccine technology; made recommendations on vaccine safety and efficacy.

Weaknesses: Did not have authority to enforce equitable distribution of the vaccines, resulting in uneven outcomes between nations; C-TAP fell short; fell behind with early pandemic actions, especially travel warnings.

Role of International Organizations

Gavi

Actions: Develop COVAX with WHO and partners to deliver fair access to COVID-19 vaccines, especially to low- and middle-income countries (LMICs).

Weaknesses: Underfunding, Vaccine supply and delivery delays, as well as export and vaccine nationalism in high-income countries impacted COVAX.

UNICEF

Activities: Facilitated vaccine delivery and supply, including children and youth; facilitated immunization infrastructure and community activities.
Weaknesses: Faced challenges with fair and timely access to vaccines; pandemic interfered with regular immunization as well as other health services.

WTO Actions: Assisted in negotiating intellectual property and trade deals on COVID-19 vaccines.
Weaknesses: Did not gain approval for the TRIPS waiver to ease patent limitations; faulted for slow response and inability to support developing countries.

Role of International Organizations

COVAX: Promises and Reality

COVAX committed to delivering 2 billion doses of vaccine by end-2021 but only managed to deliver below 50% of its target. It got to more than 100 countries rapidly but faced supply reductions and logistical issues. Wealthy nations advanced their populations with booster doses while 98% of individuals in poor nations were unvaccinated.

Donations of vaccines to COVAX were usually late, inadequate, or close to expiration, disrupting immunization campaigns.
The scheme was derailed by pharma profit margins, vaccine nationalism, and bureaucratic governments that stunted transparency and accountability.

Broader Issues and Challenges to Reform Power Imbalances: Donor and pharma interests, not recipient country interests, are being represented in such global health partnerships as COVAX. Greater Global South engagement and decision-making are needed to equitable governance.

Equity vs. Charity: Excessive vaccine dose release was charity on donor terms, not equity. Earmarked, delayed, or near-expiration contributions contributed to undermining fairness and effectiveness.

Pharmaceutical companies and profit motives

Pharmaceutical corporations have immense power to shape global health outcomes through price regulation, patents, licenses, and technology. Although their innovation during COVID-19 is essential, their profiteering came at the cost of equity of access in the overwhelming majority of instances.

Even after being granted billions of public dollars, governments and public institutions, and corporations such as Pfizer and Moderna still had sole IP rights and charged whatever prices they wanted. For instance, Moderna's vaccine was jointly developed with the U.S. NIH but was kept in private monopoly control.

Pfizer, BioNTech, Moderna, and Sinovac collectively generated over $50 billion in COVID-specific sales alone in 2021. A WHO-commissioned study put vaccine-related revenues at $75 billion in 2021–22, and this shows the way vaccines were not viewed as public health goods but as private goods.

Intellectual property (IP) laws, while encouraging innovation, also limited worldwide access to vaccines. While 10 billion doses were manufactured through 2021, just 4% of the population in low-income countries was fully vaccinated. Most able Global South producers were prohibited from producing generics because of patent protections.

Pharmaceutical companies and profit motives

Even efforts by shareholders to push companies such as Pfizer toward the prospect of tech transfer to LMICs were dismissed. Consequently, efforts such as COVAX were left waiting on the sidelines, avoiding premature stockpiling, obscurity, and profiteering measures.

Secret vaccine deals were also maintained with redacted delivery terms, prices, and reducing transparency and public accountability (MSF, BMJ, and STAT).

These issues are symptomatic of wider issues outside COVID-19:
Three companies control over 90% of the global insulin market, and diabetes care is an expensive luxury in most of the world.

Cancer medications such as Trastuzumab are still inaccessible in LMICs, years since they entered the market.

Finally, the pandemic revealed how profit-oriented pharma business models for health perpetuate health inequities, not merely in crisis management but also in access to life-saving medicines globally.

Vaccine Hoarding and Waste

The COVID-19 pandemic showed the extent to which vaccine hoarding and mismanagement by wealthy nations worsened access worldwide. The majority of nations pre-ordered far more than they needed, advance purchase agreements, leaving LMIC in the lurch. While LMIC waited, doses expired and went unused in wealthier nations.

An estimated 1 billion doses were wasted by 2023, the WHO says, with Nigeria, Malawi, and South Sudan destroying massive quantities of expired vaccines each.

Along with equity, excess production and absence of coordination led to the immense production of vaccine-related waste in the form of:
Non-biodegradable plastic (packaging, syringes, vials),

Used PPE, expired vaccines, (medical waste)
Environmental degradation, i.e., thimerosal spillage, plastic pollution, and CO_2 emissions arising from ultra-cold storage and transportation.

Vaccine Hoarding and Waste

A dramatic instance is 1.56 billion surgical masks discarded into oceans and formed thousands of tons of plastic waste in the seas.

All these tactics damaged public health and inflicted environmental damage.

In future pandemics such as monkeypox, Ebola, or influenza, you need equitable distribution and global stockpiling with coordination so as not to make the same errors.

Export bans, vaccine nationalism, and late donations should give way to solidarity, openness, and green waste management.

Ethical and Human Rights Concerns

The COVID-19 vaccine distribution also uncovered egregious human rights violations, especially the right to health, non-discrimination, and equality. "Vaccine apartheid" best describes the moral failure of global systems wherein wealthy nations controlled vaccine manufacturing and distribution, leaving poor countries significantly disadvantaged.

South Asian and African countries received vaccines months after their Western peers, promoting inequality in global distribution. The Universal Declaration of Human Rights (UDHR) and the legally binding International Covenant on Economic, Social and Cultural Rights (ICESCR) enjoin the right to the highest attainable standard of health, including access to medicines and vaccines (UN Committee on ESCR General Comment No. 14).

The covenants also enjoin justice, equity, and international solidarity, rights violated by vaccine nationalism.

Ethical and Human Rights Concerns

Vaccine inequality disproportionately hit vulnerable groups like refugees, Indigenous peoples, and displaced persons, further entrenching systemic discrimination. There was a need for transparency and accountability, but most of the vaccine purchasing was opaque in contracts restricting public scrutiny.

Morally grounded public health systems, based on the principles of justice, beneficence, and non-maleficence, guide fair vaccine allocation, as summarized in WHO's Fair Allocation Framework.

Legal action and civil society mobilization have continued to seek redress for the violation of rights. Lastly, equal access to vaccines also complements the Sustainable Development Goals (SDGs), including SDG 3 (Good Health and Well-being) and SDG 10 (Reduced Inequalities), which further establish that vaccine equity is not just a human rights requirement, but the cornerstone of global solidarity.

Impact on Global Health and Economy

Vaccination is the most cost-effective public health measure with long-term economic and health benefits. Vaccination improves individual health, encourages long-term economic growth, and protects against the cost of disease outbreaks.

Through prevention of disease, vaccines save healthcare expenses, hospitalization, and lost workdays due to illness. For example, the flu alone causes around 6 million lost workdays annually in the UK. Vaccines also contribute to improved school attendance and child development, leading to a healthier, improved, more productive population.

At a macroeconomic level, the ROI is simply enormous. For 94 of the poorest nations in the world, each $1 invested in vaccines will generate an estimated $16 in direct health and productivity benefits. If indirect benefits like increased life expectancy and disability reduction are included, this ROI can be as high as $44 for each dollar.

Public health interventions generally yield £14 for each £1 invested in the UK, but vaccine interventions yield an even higher ROI of some £34 for each £1 invested.

Impact on Global Health and Economy

Organizations like Gavi, the Vaccine Alliance, donors, and pharmaceutical companies have made vaccines available and affordable in the developing world. The NHS top ten vaccines alone will generate more than £6.6 billion of social value annually.

Vaccines are also essential to the maintenance of global industries such as tourism and travel by reducing disease transmission risk. High levels of vaccination coverage generate herd immunity, which protects susceptible groups that cannot be vaccinated, including infants, the elderly, and the immunocompromised.

However, recent reductions in funding for vaccine initiatives, for example, by big donors like the UN and UK, undermine long-term sustainability of initiatives. Active investment in vaccine R&D also needs to be boosted.

WHO Full Vaccine Value Assessments and other models emphasize that vaccines are not just health interventions, but also global public goods, at the forefront of economic resilience and pandemic preparedness.

In short, immunization is not just a health concern, but also an economic one. Vaccine equity and stable financing need to take priority in order to safeguard the world's health as well as the economy.

FUTURE IMPLICATIONS

The 75-year-old WHO is under pressure to modernize its structure, processes, financing, and mindset. Historic delays in outbreak responses such as Ebola (2014) and COVID-19 have highlighted its shortcomings that have been aggravated by long-term underfunding (only $6 billion for 2022-2023) and declining credibility in vulnerable populations. Genuine engagement with civil society and youth is critical to effective, inclusive global health governance.

Some of the emerging health issues include increasing humanitarian emergencies, with more than 300 million individuals in need in 2024, the majority being women of reproductive age and the ongoing burden of epidemic infectious diseases like malaria, TB, HIV/AIDS, hepatitis, and neglected tropical diseases.

To respond to these, the committee would need to factor in current international action towards the creation of a WHO-facilitated pandemic treaty designed to enhance international coordination, openness, equitable access, and quick response to future pandemics. Sustainable funding and governance reform are key to enabling WHO's decisive action.

FUTURE IMPLICATIONS

Developing regional production capacity, particularly in the Global South, through technology transfer and capacity development, will diminish dependence on rich countries and ensure access to vaccines and drugs.

Incorporating the "One Health" concept, where it is understood that human, animal, and environmental health are interconnected, will be essential to avert subsequent zoonotic diseases.
Improved real-time data exchange, monitoring, and digital health technologies are also central to accelerated detection and response to outbreaks, making the global community more prepared and resilient.

Questions a resolution must answer

How can WHO’s structure and funding be reformed to enable faster and more effective responses to global health emergencies?

What key commitments should a global pandemic treaty include to ensure transparency, equitable access, and coordinated international action?

How can WHO better involve civil society, youth, and vulnerable communities in its decision-making processes?

What strategies can promote regional manufacturing capacity and technology transfer to reduce dependence on a few producers?

How can global solidarity be strengthened to prevent vaccine hoarding, wastage, and ensure equitable distribution during pandemics?

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