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United Nations Simulation Conference

World Health Organization

Background Guide

Letter from the Chairs

To World Health Organization,

Greetings delegates, we welcome you to the World Health Organization and sincerely hope this background guide helps you with your impending mountain of research. Whether or not you actually read this document, we'd like you to know that the dais of the WHO would welcome you in with open arms.
Whether you're here to add an extra row to your MUN CV or to debate or to expand your social circle, we hope you have a fun, enriching experience at the WHO of the United Nation Stimulation Conference.

As delegates it is your duty to represent your country's best interests, while at the same time, bring forth a considerable degree of compromise as any promising delegate would. Keep in mind the radical consequences of any decision you may choose to make, converting viable ideas into realistic, practical solutions. Remember delegates, the UN works on the cooperation and goodwill of its 193 member states. This is exactly what we are expecting from each one of you. The best delegates are those who can bring the World Health Organization together and this can only be done through compromise and strong negotiating skills, so work together with other delegates and bring your best diplomacy skills to the table! We look forward to hosting each one of you and hope to nourish the diplomats in you.

To all the delegates who have committed themselves to this conference, we sincerely hope that we meet all your expectations and help you thrive at the art of repertoire. Wishing you all the best for the upcoming conference.

Warm Regards
Omnya Mohamed & Ganga Raj
President & Vice-President

Introduction to Committee

The World Health Organization (WHO) began its constitution on 7 April 1948, which is now celebrated annually as World Health Day. Its primary function in the framework of the United Nations is to guide and coordinate global health. Health infrastructure, long-term well-being, non-transmissible and communicable disease preparedness, control and response services, and business services are key areas of work.

Worldwide, the WHO is working to improve health, protect the world, and help those who are vulnerable. Their aim is to ensure universal health coverage for one billion more people, to protect one billion more people from health crises, and to give one billion more people a better quality of health and well-being.

For universal health coverage, they:

- focus on primary health care to improve access to quality essential services
- work towards sustainable financing and financial protection
- improve access to essential medicines and health products
- train the health workforce and advise on labor policies
- support people's participation in national health policies
- improve monitoring, data, and information.

For health emergencies, they:

- prepare for emergencies by identifying, mitigating, and managing risks
- prevent emergencies and support the development of tools necessary during outbreaks
- detect and respond to acute health emergencies
- support delivery of essential health services in fragile settings.

For health and well-being they:

- address social determinants
- promote intersectoral approaches for health
- prioritize health in all policies and healthy settings.

“Addressing the mental health situation in urban and metropolitan areas”

Mental health is an integral and essential component of health. The WHO constitution states: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." An important indication of this definition is that mental health is more than just the absence of mental disorders or disabilities. Multiple social, psychological, and biological factors determine the level of mental health of a person at any point in time. For example, violence and persistent socio-economic pressures are recognized as risks to mental health.

An unsettling cause can be sexual violence. Poor mental health is also associated with rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, physical ill-health, and human rights violations. An environment that respects and protects basic civil, political, socio-economic, and cultural rights is fundamental to mental health. Without the security and freedom provided by these rights, it is difficult to maintain a high level of mental health. Life in the city can be exhausting. City residents face higher rates of crime, pollution, social isolation, and other environmental stressors than those living in rural areas. For years studies have associated the risk of developing schizophrenia to urban environments but researchers are only beginning to understand why this association exists.

Researches revealed that growing up in the city nearly doubled the likelihood of psychotic symptoms at age 12 and that exposure to crime along with low social cohesion (that is, a lack of closeness and supportiveness between neighbors) were the biggest risk factors. Scientists need to combine the hereditary and environmental factors to understand how city life impacts mental health. The science confirms that efforts to reduce the negative impact of urban living should focus on disadvantaged neighborhoods, where the cycle of poor mental health may persist across generations.

Key terms

Mental Health- The WHO constitution states: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities.

Community care- The policy of transferring responsibility for people in need from large, often isolated, state institutions to their relatives and local welfare agencies.

Deinstitutionalization- Deinstitutionalisation is the process of replacing long-stay psychiatric hospitals with less isolated community mental health services for those diagnosed with a mental disorder or developmental disability.

Psychiatry- Psychiatry is the medical specialty devoted to the diagnosis, prevention, and treatment of mental disorders. These include various maladaptations related to mood, behavior, cognition, and perceptions.

Stereotypes- They are clusters of ideas regarding the characteristics of a particular group of people.

Stigma- Stigma is when someone views you in a negative way because you have a distinguishing characteristic or personal trait that's thought to be, or actually is, a disadvantage (a negative stereotype). Unfortunately, negative attitudes and beliefs toward people who have a mental health condition are common.

History

Ancient theories about mental illness were often the result of beliefs that supernatural causes, such as possession or a vengeful god, were behind the strange symptoms.

Hippocrates and two other prominent Greek thinkers, Galen and Socrates, each developed the idea of there being four essential elements to the human body: blood, bile, black bile, and phlegm. The unique characteristics of human beings could be attributed to the individual balances of these “humor.” When the humor was out of balance, mental illness was the result.

In the Middle Ages, demonology and superstition gained renewed importance in the explanation of abnormal behavior. Demonology was related to a belief that people with mental problems were evil and there are numerous instances of ‘witch-hunts’ during this period. During this period The patient’s family was responsible for custody and care of the patient. In Europe, however, the family having custody of mentally ill patients was seen as a source of shame and humiliation. Many families resorted to hiding their loved ones in cellars, sometimes caging them,

delegating them to servants' care, or simply abandoning them, leaving their mentally unhealthy flesh and blood on the streets as beggars.

However, there were some options for treatment beyond the limitations of family custody or care. These include putting up the mentally unhealthy in workhouses, a public institution where the poorest people in a church parish were given basic room and board in return for work. Others were checked into general hospitals, but they were often abandoned and ignored. Patients were encouraged to repent of their sins and throw themselves at God's mercy, but such methods had little success. However, the treatment offered by facilities run by clergy and nuns was markedly more humane than the alternative methods of the time.

But it was in Paris, in 1792, where one of the most important reforms in the treatment of mental health took place. The Science Museum calls Pinel "the founder of moral treatment,". Pinel developed a hypothesis that mentally unhealthy patients needed care and kindness for their conditions to improve. Moral treatment was highly effective but it died out in the declining years of the 19th century. Critics argued that the method did not treat patients but made them dependent on their doctors and the asylum staff for comfort.

The term mental hygiene has a long history in the United States. After the Civil War, which increased concern about the effects of unsanitary conditions, Dr. J. B. Gray, an eminent psychiatrist, envisioned community-based mental hygiene that would operate through education, social culture, religion, and involvement in national life.

At the turn of the nineteenth century, within the scientific community, mental deviations, i.e., extreme variations, were conceived as having a biological basis, primarily genetic, representing mutations that were unsuccessful adaptations for survival in the environments in which they appeared. This view provided little hope for the recovery of the mentally deviant. The origin of the mental hygiene movement can also be attributed to the work of Clifford Beers in the USA. In 1908 he published "A mind that found itself" a book based on his personal experience of admissions to three mental hospitals. The book had a great repercussion and in the same year, a Mental Hygiene Society was established in Connecticut. The term "mental hygiene" had been suggested to Beers by Adolf Meyer and enjoyed a quick popularity thanks to the creation in 1909 of the National Commission of Mental Hygiene.

When the National Committee was organized, in 1909, its chief concern was to humanize the care of the insane: to eradicate the abuses, brutalities, and neglect from which the mentally sick have traditionally suffered. It was at a later stage that the Committee enlarged its program to include the "milder forms of mental disability" and a greater concern with preventive work. The rationale behind this shift was the belief that "mental disorders frequently have their beginnings

in childhood and youth and that preventive measures are most effective in early life", and that environmental conditions and modes of living produce mental ill-health.

The seventeenth and eighteenth centuries were known as the Age of Reason and Enlightenment. The discrediting of mental asylums on humanitarian grounds led to a process of reducing the number of chronic patients in state mental hospitals, the downsizing and closing of some hospitals, and the development of community mental health services as alternatives. However, deinstitutionalization is not merely the administrative discharge of patients. It was often mistakenly believed that alternative forms of community treatment would be more cost-effective than the increasingly expensive custodial care of chronic inpatients.

Both realities speak to the complexities of treating mental illnesses. Where incantations and brain surgery have fallen short, drug therapy and counseling have picked up the treatment baton for the 21st century, helping millions of people achieve health and recovery. However, this evolution has come at a price, with many thousands falling prey to addiction and falling through the cracks of the modern healthcare system and another challenge being the underfunding of the health sector in many countries and the stigma of mental health that still is prevalent in today's modern world. The challenges indicate that proper treatment for mental health will not be easy or straightforward, but the evolution and advancements suggest that the improvements of today are infinitely better than anything that has come before.

Timeline

Event	Year	Relevance
Establishment of the WFMH	1948	The founding of one of the first international NGOs with the intention of assisting in tackling mental health
Establishment of Department of Mental Health and Substance Abuse (MSD)	1953	The acknowledgment and a step toward dealing the closely related substance abuse and mental disorders
Un calls for improvement of mental health care	1991	The Start of over a decade of progress for dealing with mental health
First Celebration of world mental health day	1992	One of the first global public acknowledgements of mental health issues
International workshop held between nations for mental health at Harvard University	2000	Started a large effort to deal with the burden of mental disorders as well as the economic and social side of the issue

World health report: *"Mental health: New Understanding, New Hope"*	2001	Laid out the framework for future research and development as well as bringing the topic of mental health to international awareness
Resources of the mental health sector developed media strategies through reaching out to national medias	2004-05	The start of a proper medical mental health sector and press engagement by outreaching media sources
Helplines begin to be properly established across most countries that didn't already have them	(around) 2010	Yet another large step for the promotion of mental health and reducing burdens of mental health. It marked the first time in which people could get in contact with professionals for help if they didn't want to deal with the stigma of mental health
Investing in Mental health - WHO	2013	A publication based around explaining the over costs and gains of mental health that assisted in better spreading knowledge of damages that can be done by mental illness and what can be done to prevent those damages
Plethora of online media resources released to public containing not only statistical information but also information on how to get help	2013-2015	Internet resources became more accessible allowing people to gain necessary information regarding mental disorders. Not only would it allow them to identify issues in their life that may have relevance with inducing mental health but it would perhaps provide them with an opportunity to seek treatment from a professional .
Human rights council resolution on mental health and human rights	29 June 2016	Acknowledgment and action from the human rights council to try and link mental health with human rights. Doing this properly and successfully would most likely lead to drastic improvements form a majority of 1st and 2nd world countries

Statistics

Disorder	Share of the global population with a disorder (2017)	Number of people with the disorder (2017)	Share of males: females with a disorder (2017)
Any mental health disorder	10.7%	792 million	9.3% males 11.9% females
Depression	3.4% [2-6%]	264 million	2.7% males 4.1% females
Anxiety disorders	3.8% [2.5-7%]	284 million	2.8% males 4.7% females
Alcohol use disorder	1.4% [0.5-5%]	107 million	2% males 0.8% females
Drug use disorder (excluding alcohol)	0.9% [0.4-3.5%]	71 million	1.3% males 0.6% females

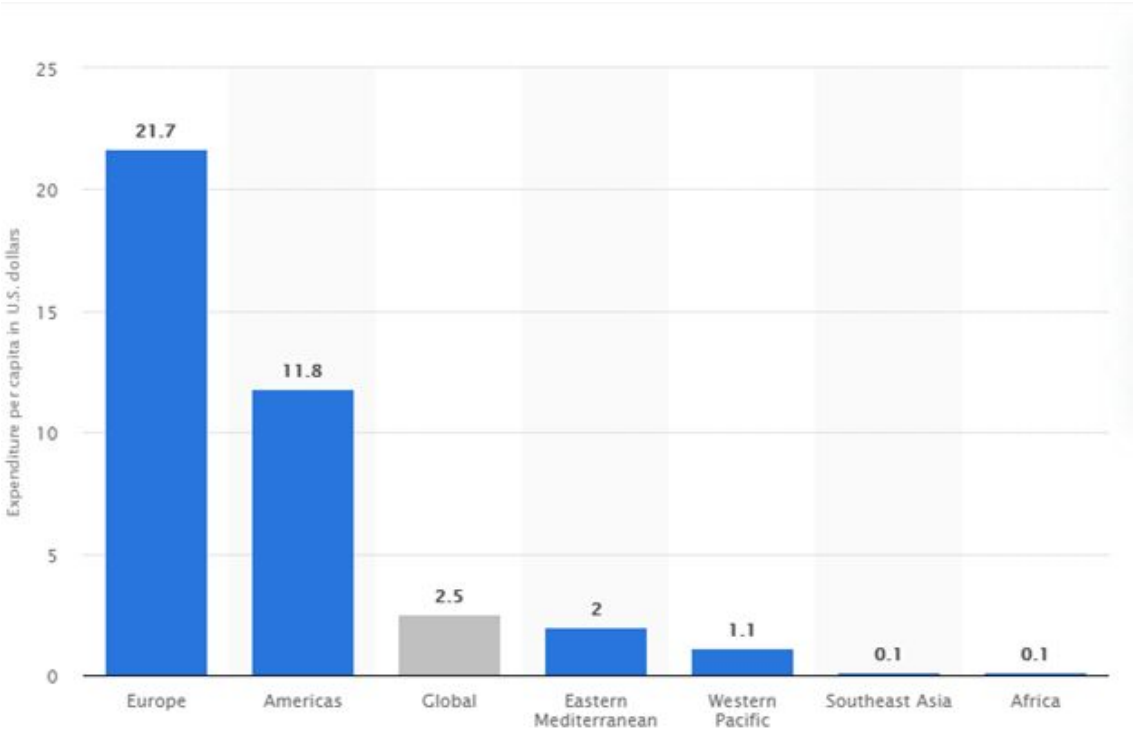
As per this 2017 studies, it is estimated that one in every 10 people experience a mental health disorder at least once in their lifetime. Fast forward to 2020 that pretty much put a pause to our day to day lives.

Key issues

Improving mental health is one of the biggest challenges facing every country in the world, where mental health problems affect at least one in four people at some time in their lives. Although much is known about what works in mental health care and treatment, and how to prevent mental disorders and promote well-being, many people receive little or no treatment or support. Too often, prejudice and stigma hamper the development of mental health policies, and these are reflected in the lack of respect for the human rights of mentally ill people, the low status of the services provided and the lack of support given to work for mental health.

The latest edition of the Mental Health Atlas provides us with yet more evidence that scale-up of resources for mental health is not happening quickly enough. In low-income countries, the rate of mental health workers can be as low as 2 per 100 000 population, compared with more than 70 in high-income countries. This is in stark contrast with needs, given that 1 in every 10 people is estimated to need mental health care at any one time. Less than half of the 139 countries that have instituted mental health policies and plans have these aligned with human rights conventions which stress the importance of the transition from psychiatric institutions to community-based services. And all too often, when mental health plans are made, they are not supported by adequate human and financial resources.

Despite the transition in a number of high-income countries towards psychiatric wards in general hospitals and the provision of community-based residential care places, there remain far too few facilities for community-based mental health care throughout the world. Levels of public expenditure on mental health are very low in low- and middle-income countries. The majority of spending is going to mental hospitals, which serve a small proportion of those who need care. In addition, more than two-thirds of countries report that the care and treatment of persons with severe mental disorders is not included in national health insurance or reimbursement schemes.



Government expenditure on mental health per capita worldwide in 2017

WHO estimates that a little under 800 000 people die by suicide each year. Despite a slight increase in the number of countries reporting having a national suicide prevention strategy since the Mental Health Atlas 2014, only a third of upper-middle and high-income countries reported having such as strategy, with just 10% of low- and lower-middle-income countries with a strategy. Institutional care still dominates in most parts of the world.

Major parties involved

Europe

According to the World Health Organization (WHO), mental health illnesses account for nearly 20% of disease in Europe, affecting one in four people. 27% of the adult population in Norway, Switzerland, and Finland have experienced a mental health illness in the last year, including anxiety, depression, and eating disorders.

"Many of them are deprived of their most basic rights, have little control over their lives and face abuses such as excessive use of seclusion, restraint, and forced treatment. Although there are some positive changes happening in some European countries, the findings of our report highlight some outdated and questionable practices in mental health systems across Europe" explains Nigel Henderson, President of Mental Health Europe.

North America

In America, 1 in 5 adults has a mental health condition. That's over 40 million Americans; more than the populations of New York and Florida combined. Moreover, in the past decade, youth mental health is worsening. Even with severe depression, 80% of youth are left with no or insufficient treatment. Most Americans still lack access to care. 56% of American adults with a mental illness did not receive treatment. In states with the lowest workforce, there's only 1 mental health professional per 1,000 individuals. Moreover, there are over 57,000 people with mental health conditions in prison and jail in those states alone. In Canada, between 15% and 25% of the population experience at least one mental health problem or illness before they turn 19.

Latin America

The average health expenditure (as a percentage of GDP) of Latin American countries is 6.7%, but there is high variability in both the expenditure and per capita income in each country. Access to health services, training, and distribution of human resources in mental health, inequalities in health, financing mental health systems are few of the major challenges that need to be tackled in these nations.

Asia-Pacific

Across Asia-Pacific, anything from 4% (Singapore) to 20% (Vietnam, Thailand, New Zealand, Australia) of the adult population experiences a diagnosable mental illness in any given year. There are indications too that in some countries – such as China, India, Japan, Korea, Thailand, and Malaysia – prevalence rates have increased.

Few of these conditions are adequately addressed in many Asia-Pacific countries, although, in the last few years, there have been concerted efforts in Asia-Pacific countries to raise the profile of mental health, establish legal and policy frameworks for more comprehensive, coordinated disease management, expand investment in infrastructure and human resources, and reduce stigmatization.

Africa

Mental health is highly stigmatized and there are not enough mental health facilities or resources for the people. The average number of psychiatrists is 0.05/100,000 population. There is a strong correlation between different mental illnesses and the socioeconomic status of patients. Furthermore, healthcare expenses are high, making them inaccessible to various African countries and also endure tribal wars and terrorist groups.

Most African countries have insufficient resources, owing to them spending less than 1% of their budget on mental health. Currently, only 3.3% of **Nigeria's** total health budget goes towards mental health, which leaves the public system chronically under-funded. Additionally, mental health is not a popular subject; therefore, there are few higher education facilities teaching about it. The stigma around it prevents graduates from enrolling in mental health-related programs.

Middle-East

It is reported that the Middle East and North African countries have the highest levels of mental disorders. Though, for the most part, mental disorder rates stay fairly similar around the world, there are, of course, deviations and differences. Why then, out of the entire world, does the Middle East have the highest rates of mental disorders?

For the same reasons that numerous medical conditions are inflated issues, mental disorders in the Middle East carry strong stigmas socially and culturally. Between stigmas and a lack of medical aid, diagnosis, assistance, and mental improvement are hard to come by in the Middle East. To many, having a mental disorder is shameful to one's self and family. On top of that, Western medicine and healing are often looked down upon in such cultures where traditional, religious healers are preferred.

Past attempts to solve the issue

On 12–15 January 2005, delegations from the 52 Member States in the WHO European Region gathered in Helsinki, Finland for the first WHO European Ministerial Conference on Mental Health, organized by the WHO Regional Office for Europe and hosted by the Finnish Ministry of Social Affairs and Health. Ministers and other high-level decision-makers met to make decisions about future policies on mental health across the Region. The delegations also included medical and technical experts and representatives of service users' groups. The ministers agreed on a Mental Health Declaration and Action Plan for Europe (2013-2020), which will drive policy on mental health in the Region for at least the next five years.

The WHO Mental Health Gap Action Programme (mhGAP) aims at scaling up services for mental, neurological, and substance use disorders for countries especially with low- and middle-income. The program asserts that with proper care, psychosocial assistance and medication, tens of millions could be treated for depression, schizophrenia, and epilepsy, prevented from suicide, and begin to lead normal lives even where resources are scarce. The four major objectives of the action plan are to:

1. Strengthen effective leadership and governance for mental health.
2. Provide comprehensive, integrated, and responsive mental health and social care services in community-based settings.
3. Implement strategies for promotion and prevention in mental health.
4. Strengthen information systems, evidence, and research for mental health.

Each of the four objectives is accompanied by one or two specific targets, which provide the basis for measurable collective action and achievement by member states towards global goals. A set of core indicators relating to these targets as well as other actions have been developed and are being collected via the Mental Health Atlas project on a periodic basis.

The WHO Mental Health Forum 2019 has also provided an opportunity for diverse stakeholders to discuss progress on WHO's Mental Health Action Plan in countries. The theme this year was "Enhancing Country Action on Mental Health," reflecting the vision of WHO's Thirteenth General Programme of Work, 2019-2023.

Focusing questions

1. Levels of public expenditure on mental health are very low in low- and middle-income countries, what can be done to increase investment in the mental health sector of these countries?
2. What can local communities do to support this cause?
3. What can the country's governments do to improve their countries in terms of mental health?
4. Influenced by the orthodox view that the health of young people has never been better, many people make the mistake of assuming that emotional distress and damaging behaviors are common in young people, this is "normal", and to intervene would be unnecessary, what can be done to spread the seriousness of this cause?
5. How to promote early intervention and sustained holistic care most effectively and safely?

Recommended Readings

Prevention of Mental Disorders:
https://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf

Promoting Mental Health
https://www.who.int/mental_health/evidence/en/promoting_mhh.pdf

World Health Report
https://www.who.int/whr/2001/en/whr01_en.pdf

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https://www.who.int/mental_health/who_urges_investment/en/
https://ourworldindata.org/mental-health

"Developing an international framework to deal with future pandemics"

A pandemic is an epidemic of an infectious disease that affects a large number of people in a wide region , for example several continents or globally. There is no pandemic of a widespread endemic illness with a stable number of people infected.
A variety of disease pandemics, including smallpox and tuberculosis, have occurred in human history. The Black Death (also called the Pestilence), where an estimated 75–200 million people died in the 14th century, is the most lethal pandemic in documented history. The term "influenza pandemic" was not yet used but was used for later pandemics including Spanish influenza in 1918. COVID-19 and HIV / AIDS are the pandemics at present.

Impacts of Pandemics

- Pandemics can cause significant, widespread increases in morbidity and mortality and have disproportionately higher incidences of mortality in LMICs.
- Pandemics can cause economic damage through multiple channels, including short-term fiscal shocks and long-term negative shocks to economic growth.
- Individual behavioral changes, such as fear-induced aversion to workplaces and other public gathering places, are the primary cause of negative shocks to economic growth during the pandemic.
- Some pandemic mitigation measures may cause significant social and economic disruption.
- Pandemics can increase political stress and tension in countries with weak institutions and legacies of political instability. In these contexts, measures to respond to outbreaks, such as quarantine, have provoked violence and tension between states and citizens.

One of the defining aspects of the global pandemic is its fundamental uncertainty. Both common sense and experimental evidence show that almost all people are reluctant to face uncertainty in their lives. One important principle that government policy should follow is not to add further uncertainty in these difficult times. A pre-established, forward-looking policy framework must be in place that commits to providing a safety net for vulnerable people. This should be widely publicized in such a way that the people most affected know what their entitlements are and how to access them.

Thus the goal of the delegates is to come up with a framework that will prove to be effective in controlling and eliminating pandemics in the future, especially for those predicted to become a challenge like Antibiotic Resistance.

Keywords

Pandemic: A pandemic is defined as "an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people". The classical definition includes nothing about population immunity, virology or disease severity.

Framework: It is a basic structure underlying a system, concept, or text. It guides policies and provides a proper base for future activities.

Forward-looking: It refers to something that favours innovation and development. It is progressive and plans for the future.

Influenza Pandemic: It refers to an epidemic of an influenza virus that spreads across a large region and infects a large proportion of the population.

Morbidity: It is the rate of disease in a population.It also refers to your level of health and well-being.

Mortality: It is the number of deaths in a certain group of people in a certain period of time.

IHR: International Health Regulations

Timeline

Event	Year	Additional Notes
The black death	1350	The second large outbreak of the bubonic plague was responsible for the death of one-thirds of the world population. It spread throughout Europe rapidly.
Great plague of London	1665	The bubonic plague led to the deaths of 20 percent of London's population. Hundreds of thousands of cats and dogs were slaughtered as the possible cause of the disease
First Cholera Pandemic	1817	This originated in Russia, where one million people died. Spreading through feces-infected water and food, the

		bacterium was passed onto India, Spain, Africa, Indonesia, China, Japan, Italy, Germany and America, due to the reach of the British empire where it killed 150,000 people.
The Third Plague Pandemic	1855	Starting in China and moving to India, the bubonic plague claimed 15 million victims. The plague is considered a factor in the Panthay rebellion and the Taiping rebellion. India faced the most casualties, and the epidemic was used as an excuse for repressive policies that sparked a revolt against the British.
Russian Flu	1889	The first significant flu pandemic started in Siberia and Kazakhstan, where it moved into the rest of Europe. By the following year, it had crossed the ocean into North America and Africa. By the end of 1890, 360,000 had died.
Spanish Flu	1918	The 1918 flu was first observed in Europe, the United States and parts of Asia before swiftly spreading around the world. At the time, there were no effective drugs or vaccines to treat this killer flu strain.
Asian flu	1957	Starting in Hong Kong and spreading throughout China and then into the United States, the Asian flu became widespread in England where, over six months, 14,000 people died. A second wave followed in early 1958, causing an estimated total of about 1.1 million deaths globally. A vaccine was developed, effectively containing the pandemic
HIV/AIDS	1981	AIDS was first observed in American homosexual communities but is believed to have developed from a chimpanzee virus from West Africa in the 1920s. Treatments have been developed to slow the progress of the disease, but

		35 million people worldwide have died of AIDS since its discovery, and a cure is yet to be found.
SARS	2003	Severe Acute Respiratory Syndrome is believed to have possibly started with bats, spread to cats and then to humans. It infected 8,096 people, with 774 deaths. Quarantine efforts proved effective and by July, the virus was contained and hasn't reappeared since. China was criticized for trying to suppress information about the virus at the beginning of the outbreak.
Swine flu pandemic		The 2009 swine flu pandemic was the second of two pandemics involving the H1N1 influenza virus. It lasted 19 months.
COVID-19	2019	On March 11, 2020, the World Health Organization announced that the COVID-19 virus was officially a pandemic after barreling through 114 countries in three months and infecting over 118,000 people. Currently, the death toll has crossed one million.

Major Concerns

Improper global healthcare systems:

The impact on developing countries is considerably higher in a pandemic. It is challenging for LMIC countries to better their healthcare systems to a standard of high-income countries. This originates from lack of acceptable clinical care, unsanitary lodging conditions and dense populations, etc. LMIC's cannot implement fundamental IHR requirements without significant financial support from the international community as well as assistance in setting up a medical infrastructure, training of health workers, and provision of technology to fasten the diagnosis and

reporting process. Though most developing countries have national hospitals, their limited healthcare budget is spent on managing these without expenditure on preventive measures or epidemic preparedness.

Global medical resource shortage:

A pandemic invariably calls for an urgent and vast supply of medical resources, this includes disposable medical masks, PPE suits, syringes, IVF bags, ventilators, sanitation supplies etc. Recently, it has become evident that even the wealthiest countries have been crippled due to lack of adequate medical resources, to the extent that the export of said resources had been barred by countries like South Korea, Kenya, Russia and Germany. Reservation of resources for health workers and patients is a priority for any country to overcome this pandemic, however even basic medical supplies are commodities in low-income countries. Existing supply chains are insufficient to meet demand as the number of cases increase.

Saturated and overwhelmed medical facilities:

Any hospital has a maximum patient capacity beyond which it cannot provide its services. It has limited ventilators, hospital beds, etc. In medical crisis situations, we often witness every medical facility overflowing with people to be treated, a demand which often cannot be coped with. When the swine-flu and influenza outbreaks first occurred, hospitals all over countries like the USA and Italy were overwhelmed with a massive influx of infected patients. We see this trend continue with the ongoing pandemic too, where hospitals worldwide are struggling to care for not only covid-19 infected patients, but patients with other ailments as well. Infected patients are being denied care. Health workers have also been found to be infected from the patients that they were treating, putting their lives at risk and further decreasing available human resources in healthcare facilities.

Non-compliance of public mitigative measures:

Though countries have implemented strict measures in place to curb the spread of the pandemic to the best of their abilities by methods like lockdown, quarantine and have also imposed social responsibility such as the practice of social distancing, making face masks compulsory, banning large public gatherings, etc there are still a significant amount of people that violate these basic requirements worldwide by hosting large gatherings, violating WHO guidelines and non-essential travel. This is especially relevant to the United States of America, Rome, United Kingdom, Australia and Spain where huge masses are protesting wearing masks.

Challenges to pharmaceutical interventions:

Unlike the influenza virus which has an existing worldwide infrastructure to deal with it, we have limited information on the rapidly evolving coronaviruses strain that have been infecting patients since 2003, making the vaccine development process even more difficult. Although there have been extremely promising results in the process, even if there were fully safe vaccines ready-to-go, the issue of fair distribution and delivery of vaccines to hospitals all over the countries arises. This is especially a concern for LMIC's wherein it poses a logistical challenge.

Major Parties Involved

China: The covid-19 pandemic originated from the Wuhan district in China. The Chinese government was heavily criticized for withholding critical information for many days about the initial outbreak, the first death in the country, and the rapid increase in cases.

United States of America: The USA, prior to the outbreak of the COVID-19 pandemic was ranked at the top along with the UK for preparedness of pandemic. However, now it is the country with the greatest number of cases surpassing 7 million. The USA has also issued a formal notice to withdraw from the WHO amidst a global pandemic.

United Kingdom: Another one of the hardest-hit countries from the pandemic, The UK is in this position due to the delay in emergency response and strict mitigative measures despite having an action plan ready to be implemented before the pandemic began.

India: Due to its poor public and health infrastructure, vast demographic and the allowing of inter-state travel in spite of a nationwide lockdown, India has surpassed Brazil, and stands just below USA with the second most number of cases surpassing 6 million.

Past efforts to address this issue

Compulsory Vaccination

When the swine flu pandemic subsided, "universal" flu vaccination in the U.S. was voted upon to include all people over six months of age. This played a role in curbing the spread of the disease/

Restrictions on movement

A common method to stop the further spread of a pandemic in the past as well as the present is to postpone non-essential transnational travel. Moreover, in most places, travelling within the country as well had been restricted. Schools as well as workplaces had been shut down in multiple areas.

Quarantine

Some countries initiated quarantines of foreign visitors suspected of having or being in contact with others who may have been infected. During the COVID-19 pandemic, most countries have made a fortnight of quarantine compulsory.

Mandatory Disease Testing

Testing has been made mandatory for all international passengers flying into a country as well as for those rejoining public spaces like schools, offices.etc

Food safety

The swine flu pandemic was derived originally from a strain which lived in pigs. Due to this, many countries banned the sale of pork. Azerbaijan imposed a ban on the importation of animal husbandry products from the entire Americas. The Indonesian government also halted the importation of pigs and initiated the examination of 9 million pigs in Indonesia

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