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Committee: *World Health Organization*
Topic: *Multilateral partnerships with healthcare systems towards global recovery from COVID-19*
Title: *Revolutionising global cooperation to foster resilience and recovery*
Sponsors: *French Republic, People's Republic of China, State of Israel, Kingdom of Thailand,*
Signatories: *Canada, Federal Republic of Somalia, Federal Republic of Germany, Malaysia, Republic of Austria, Republic of Colombia, Republic of Finland, Republic of Korea, Republic of Malta, Republic of Panama, Republic of the Philippines, Republic of Poland, Republic of South Africa, Republic of Sudan, Republic of Timor-Leste, Republic of Tunisia, Republic of Turkey, Russian Federation, Swiss Federation*

The World Health Organization,

Stressing the fact that global recovery from the COVID-19 pandemic is multi-faceted, thus demanding multi-sectoral, multilateral cooperation and collaboration,

Appreciative of the leadership provided by the WHO in shaping the international agenda for effective response plans

Recalling the *World Health Assembly Resolution 74/270* on global solidarity and international cooperation to ensure the production and provision of medicine, vaccine, and medical equipment to combat the COVID- 19 pandemic and the *73rd World Health Assembly A73/CONF./1 Rev.1 COVID-19 response* foundational document in preventing, responding, and more importantly, recovering from the pandemic,

Noting the problems common in Least Developed Countries (LDCs) in the inequitable distribution and availability of various resources essential in dealing with the consequences of the COVID-19 pandemic,

Welcoming the expertise and knowledge possessed by certain Member-States who have successfully subverted the onslaught of the pandemic by upholding and enacting the highest attainable standard of health, which is a fundamental principle of the World Health Organization,

Hereby resolves,

1. ***Requests*** the Director-General, alongside other necessary UN bodies, to provide guidance and oversight in multi-disciplinary partnerships through the One Health High-Level Expert Commission body (HLEC) under the WHO, inclusive of, but not limited to the following stakeholders, goals, and mechanisms:
    a. Stakeholders in exploring partnerships under the existing body may include:
        i. Member-States in pandemic initiatives such as the PREZODE Project;
        ii. Local Health Ministries;
        iii. Health Policy Analysts;
        iv. Non-governmental organizations specialising in healthcare development and zoonoses;
        v. WHO-FAO-OIE tripartite; and
    b. Goals of these partnerships are recommended to include:
        i. The exchange of best practices from countries that have made substantial recovery efforts;
        ii. Enhance the research capacity and resource management capacities of current initiatives;
        iii. Strengthening cooperation between regional CDCs (ie. ECDC) and health ministries/department;
    c. Mechanisms in the development of these partnerships may include:
        i. The provision of guidance and insight from health policy analysts on discrepancies within the current health policy and response of Member-States;
        ii. The insights provided by the WHO-FAO-OIE, as they may aid and empower partnerships within the HLEC using its current advisory role;
        iii. Bringing forward the concerns of local health ministries in order to create recommendations that address such;

2. ***Urges*** and hopes that Member-States, through an economic lens in healthcare and guidelines developed by the Economic and Social Council (ECOSOC), to prioritize the efficient allocation of monetary resources in addressing and continuing recovery efforts amidst the COVID-19 pandemic within their respective countries, which may be accomplished through methods such as, but not limited to:
    a. Reform and restructuring budgetary allocation of government funds towards their respective health ministries for:
        i. The safeguarding of financial and social security of essential workers such as medical professionals;

ii. The refinement of research and development amongst health experts for medicines and vaccines; and
iii. The acquisition of capital resources, as well as laboratory and medical facilities, essential medical equipment, and various sterilization/containment materials;

b. Subsidizing both public and private health sectors in order to advance research and development within the scope of the One Health approach, which may be achieved through methods such as, but not limited to:
   i. Foreign aid;
   ii. Cash grants; and
   iii. Loan guarantees;

c. Minimizing and cautiously managing expenditures on an ad hoc basis, based on the previous sub-clauses, which do not directly contribute to upholding the social and economic wellbeing of civil society for as long as the pandemic remains such as, but not limited to:
   i. Public relations expenses;
   ii. Tourism; and
   iii. Beautification projects;

3. ***<u>Recommends</u>*** that the outcomes of the prior clause be brought to fruition through foreign healthcare development programs wherein Member-States who have been successful in pandemic response and recovery can provide aid and guidance in other Member-States, namely LDCs, in aspects inclusive of:

a. Developing and employing efficient contact tracing technology and infrastructure options of Member-States with innovative technological advancements in the context of the pandemic, namely those developed by the European Union and ASEAN, which:
   i. Can be done through Public-Private Partnerships between national governments and/or local government units and foreign IT-ICT sectors;
   ii. May include telecommunication technology already developed through the EU CDC-African CDC partnership;
   iii. May include epidemiological surveillance network technology developed by MDCs and other such Member-States;

b. Healthcare procedures essential in the COVID-19 pandemic through methods such as:
   i. Medical tourism of local medical practitioners from Member-States that seek to improve recovery efforts in Member-States with highly-developed healthcare systems so that observations can be made and substantial health policymaking can be adopted
   ii. Exchange of medical experts specialising in zoonoses and epidemiology, which may serve as an extended partnership;

c. Addressing the needs of LDCs in tackling the issue of insufficient housing and/or infrastructure through:
    i. Sending infrastructural professionals to collaborate and contribute to local ministries in the development of infrastructure in these Member-States for the purpose of educating on the efficient construction of medical-related infrastructures;
    ii. Guiding local infrastructural professionals in the construction of these medical-related infrastructures in areas recognized as hotspots by the local ministry/departments of health;

4. ***Encourages*** active observation of areas previously labelled as COVID-19 hotspots for the purpose of improving the response time of LGUs and safeguarding civil society through improved health protocols, which utilizes:
    a. National ministries of health to research upon the geographical locations (e.g. municipalities, villages, cities, etc.) which have responded to the COVID-19 pandemic at a subpar level to identify:
        i. Specific needs for capacity building;
        ii. Possible modified stipulations for community quarantines;
        iii. Rural areas in need of COVID-19 testing and/or technological integration of contact tracing;
    b. Local Government Units (LGU) to mobilize community-focused evaluation with regards to health (e.g. infection control, availability of sanitary services, etc.) by using initiatives such as but are not limited to:
        i. Primary healthcare program mobilization wherein community nurses and midwives are deployed to collect data, health records, and other socio-economic areas of lagging in certain villages where capacity building can take place;
        ii. Health data collection from specialized healthcare facilities (e.g. dialysis centres, rabies bites centres, etc.) to inspect any recurring diseases that may be amplified by the lack of facilities, equipment, and training;
    c. Collated data that references communicable diseases and how they may be able to move throughout each nation through factors such as but not limited to:
        i. Disaster-risk preparedness;
        ii. Socio-economic status;
        iii. Environmental sanitation;
        iv. Demography;
        v. Human development level;

5. ***Invites*** Member-States to adopt anti-conspiracy theory, anti-misinformation, and anti-disinformation measures within the Global Medicine and Vaccine Action Plan and the Regional Medicine and Vaccine Action Plan, and the mandate of the United Nations Education, Science, and Culture Organization (UNESCO) and the International Telecommunications Union (ITU) in developing a misinformation combat strategy that should, at minimum, include:
    a. The goal of tackling vaccine hesitancy and public mistrust;
    b. Identification procedures of conspiracies made;
    c. Containment procedures of conspiracies made, which hopes to include targeted misinformation campaigns or removal of harmful;
    d. Collaborate with UNESCO and the ITU to produce procedure guidelines in (i) and (ii) and determining recommended responses; and
    e. Procedures for implementation of recommended responses by Member-States;
    f. Develop procedures and pathways for its integration in the media;

6. ***Decides*** to remain actively seized on the matter.