World Health Organization

Topic: Guaranteeing quality medical care in countries with an extreme lack of medical training, resources, and knowledge.
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I. Committee Background

The World Health Organization (WHO) is responsible for all health-related issues tackled by the United Nations (UN). The organization was inaugurated on April 7, 1948, a date that came to be known as World Health Day. The decision-making body for the WHO is the Health Assembly, which mainly determines the organization's policies and appoints the director-general. The Health Assembly usually convenes in the UN headquarters in Geneva each year in May. The Health Assembly also instructs the Executive Board regarding "matters upon which further action, study, investigation or report may be required" (*Information and rules … procedure*, 2021). The Executive Board consists of thirty-four technically qualified experts in the field of public health elected for three-year terms. Generally, the purpose of the Executive Board is to facilitate the work of the Health Assembly. The WHO also relies heavily on its Secretariat, a body consisting of around eight hundred people stationed across the globe in the institution's headquarters and in the organization's regional offices.

The primary goals of the WHO include improving equity in health, reducing health risks, promoting healthy lifestyles and settings, and responding to the underlying determinants of health (*What we do*, n.d.). Resolutions passed by the WHO are non-binding and must be approved by the Health Assembly and the Executive Board. The meeting in which resolutions are approved occurs annually in January. In this conference, resolutions proposed by the WHO are then approved by the Executive Board and passed on to the Health Assembly. In addition, there is a shorter meeting in May to address the details of these resolutions and put them into effect.

II. Introduction

Description and Definition of the Topic

According to the World Health Organization (WHO), quality medical care is "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes" (WHO, n.d). In other words, its primary goal is to grant individuals and populations an opportunity to access high-quality medical services to improve their health concerns. Guaranteeing proper resources and health initiatives can prevent serious illnesses or deaths that result from inadequate care. If not, "poor quality health services [can hold] back progress on improving health in countries at all income levels," (World Bank, 2018). Individuals from

countries with low rates of medical care are more likely to be put at risk due to the lack of medical awareness, such as the inability to access explicit and precise health education. More specifically, they have a higher chance of being affected by receiving “inaccurate diagnoses, medication errors, unsafe clinical facilities, [and] unnecessary treatments [by] providers who lack adequate training and expertise” (World Bank, 2018).

Unfortunately, this scantiness primarily affects regions in developing countries that remain vulnerable due to the lack of proper healthcare. A recent report by The Lancet Global Health Commission on High-Quality Health Systems found that “5.7 million people die in low and middle-income countries every year from poor quality healthcare, compared with the 2.9 million who die from lack of access to care” (World Economic Forum, n.d).

The Problem

As the world's population grows and the demand for medical resources increases, the need for medical services also rises. Developing countries are already at critical crossroads in healthcare delivery, requiring new approaches towards building more medical training and knowledge in the field. In addition, inaccurate diagnoses, medication errors, inappropriate or unnecessary treatments, unsafe clinical facilities and practices, and the lack of proper training are prevalent in multiple countries.

Consequently, around the world, nearly 14% of patients are harmed by treatments they receive during their stay at a hospital. Meanwhile, in some countries, only 35% of patients get the correct diagnosis (Goldschmidt, 2019). These types of error rates constantly risk patients' lives; medical care, which should bring solutions for citizens' health, is, in many cases, creating more problems worldwide.

A collaborative report from WHO and the World Bank found that at least half of the world's population cannot acquire essential health services. Dr. Tedros Adhanom Ghebreyesus, the Director-General of WHO, stated that “it is completely unacceptable that half the world still lacks coverage for the most essential health services” (WHO, 2017). This is a challenge even in relatively wealthier regions such as East Asia, Latin America, and Europe, where an increasing amount of people spend at least 10% of their household income on insufficient healthcare. In other words, citizens are limited to frail health services and have no choice but to pay for them in order to at least have some medical services, though inadequate.

Currently, there is an ongoing healthcare shortage around the world. A 2016 study published by Human Resources for Health showed that the world will need 80 million health workers by 2030. However, the supply of healthcare professionals is expected to reach only 65 million, leaving a shortage of about 15 million workers worldwide. This scarcity will primarily affect developing countries, where financing healthcare is a more significant challenge. Additionally, although the primary standard for health professionals is 23 skilled workers for every 10,000 people, 83 countries still do not meet this requirement (WHO, 2020). Developed

countries like Japan and the United States reportedly depend on services from foreign healthcare providers to meet the needs of their citizens; therefore, many workers migrate from their developing countries to these countries, which leads to a scarcity of healthcare providers in developing countries (Racoma, 2019). In addition, doctors and nurses trained abroad choose to work or migrate to other countries rather than serve their compatriots because they can offer better salaries, housing, and resources (Racoma, 2019). Foreign doctors in the United States usually come from Pakistan, India, and Ethiopia, which are countries that approximately have a single doctor for every 1,000 people (Racoma, 2019). This rate of workers in regard to patients has become increasingly concerning, since it leaves thousands of patients without personal healthcare or proper services in these developing countries.

The distinction between the high-income and developing countries is majorly caused by the financial disparity between these nations. The developed countries are able to support more money being spent on their health care and support better salaries for medical workers. Moreover, corruption can significantly influence the trajectory of a quality medical care system in such developing countries. This form of manipulation also "represents an abuse of trust and intentional violation of duty, and results in negative impacts on population health outcomes, especially for the poor and the disadvantaged" (Naher et al., 2020). Over the last few years, the emerging COVID-19 crisis has shown the world how quality and affordable medical care is essential for citizens in each country. Ensuring access to high-quality healthcare is crucial, not only because it improves a person's quality of life, but also because it increases economic output. Failing to treat sick people puts a toll on citizens and places additional financial strains on families and healthcare systems, amounting to trillions of dollars annually (UN News, 2018). Thus, handling this matter thoroughly is vital to safeguard citizens' lives and their rights to proper medical attention.

III. History of the Topic

Chronological History of the Topic

International or global healthcare can be traced back to the mid-19th century. During this time, establishing an effective healthcare system was not intended to solve international relations but to secure colonial power for European empires throughout Africa and Asia. Some discussions involved research on disease transmission and negotiation of procedures to manage epidemics across borders, demonstrating the first strategies to help and maintain the strength of respective colonies (Brazelton, 2022). However, the implementation of healthcare within these colonies was in the hands of European powers and, consequently, Christian churches, since they sponsored health care; they believed that healing bodies may convert one's soul to their religion. These types of missionary medicines were not restricted to the country of origin. Sometimes, they even supported the occasional health-related project, "which further helped in the

development and research of western medicine within these colonies" (Hardiman, 2006). Towards the end of the 19th century, the development of tropical medicine projects in African and Asian colonies played a significant role in their medicinal studies. Protection against unknown diseases had to be studied thoroughly to promote medical advancement within such lands. Colonized peoples from these terroritories, such as people from the British Raj in India, participated in these projects but were denied education about western medicine, further dividing the empirical countries from their colonies (Das, 2019).

By the turn of the 19th century, the First International Conference of American States was held in Washington D.C. from January 20th to April 27th, 1890. This prompted a significant impulse for Pan-Americanism as well as the establishment of a committee focused on establishing and maintaining health regulations in trade between various countries represented at the conference (PAHO, 2021). Moreover, a series of Latin American sanitary conferences led to the establishment of the Pan-American Sanitary Bureau in 1902. This bureau responded to the yellow fever epidemic that had struck Brazil in 1870. The Pan American Sanitary Bureau would receive data from members relative to sanitary conditions, aid provided to member states, and the promotion of sanitation. In addition, the Bureau would further interactions and cooperation in the development of western medicine and guarantee quality health care and education in member states.

The 20th century brought forward different international health organizations. During an international sanitary conference in 1903, a health office was proposed to help combat the rising pandemics. The proposal was "favorably received" (WHO, 1967). Thus, in 1907, the Office International D'Hygiene Publique (OIHP) was founded. The organization was not allowed to do field work but was effective in spreading information about common diseases and how to treat them effectively. It also implemented rules for quarantining in trade ships to reduce the spread of plague and cholera, as well as to administer health conferences. The OIHP's epidemiological data was implemented into the World Health Organization when it was created (*Twenty years in South-East Asia,* 1967).

Moreover, The League of Nations Health Organization (LNHO) was established after World War I (WWI). The LNHO's primary purpose was lessening the post-war epidemics' impact and was funded by the assembly at the League of Nations. One virus that the LNHO combated over the years was typhus, a fever-like disease that spread over eastern Europe from 1919 to 1920. This disease was increasingly brutal to treat because "commonly used treatments [were] less effective and risks [increased] the complications and hospitalizations" (WHO, 2017). The LHNO also aided citizens during the Influenza pandemic, estimated to have killed 15 million people worldwide. Many countries had the necessary plans of action to combat the disease; however, developing countries did not have enough resources to implement them fully. They had weak health infrastructures and systems, poor housing conditions, and a high population density. When World War II started in 1939 in Europe, the health industry halted; while advances were made for soldiers on the battlefield, the lack of healthcare of regular citizens left

individuals without doctors and medical necessities. After the war, the League of Nations, and therefore LHHNO, disbanded, but it left a legacy of medical experience and showcased the importance of epidemic regulation (WHO, 1967).

Healthcare was not included in the United Nations charter, so in 1947, the Economic and Social Council (ECOSOC) created a declaration to include it. The following year, ECOSOC gathered 16 nations and nine representatives from different health programs to create the World Health Organization (WHO). In eighteen days, the representatives created a constitution; the proposals contained treatment for international diseases, as seen in other organizations, and included proposals on physical and mental health (WHO, 1967). Over the years, they worked on multiple projects, including the smallpox eradication program in 1958 and the Expanded Programme on Immunization: an initiative to vaccinate all children worldwide against diphtheria, pertussis, tetanus, measles, poliomyelitis, and tuberculosis. WHO continues to provide all United Nations members with essential healthcare services and resources.

Historical Case Studies

Health disparities during South Africa's Apartheid (1948)

In 1948, the South African government imposed Apartheid, an institutionalised segregation system individuals based on race (Cullen, 2020). During Apartheid, South African authorities displaced hundreds of people; one of the effects of such system was the disparity in health services. There were decreased funds for medical resources for non-white individuals; thus, poverty-related diseases began impacting communities of color. In addition, maternal, infant, and child mortality rates were also higher in these societies. In black communities such as Bantustans, the doctor-to-patient ratio of 1 to 15,000 was much greater than in white colonies, which were reportedly 1 to 1,700.

Furthermore, from 1980 to 1990, the percentage of doctors working in the private sector increased from forty percent to sixty percent. By the time Apartheid ended in the early 1900s, the percentage was seventy-five percent, making it harder for non-white and impoverished people to afford quality healthcare. The health disparities caused by Apartheid can still be seen today, since "the burden of disease quadrupled due to an increase in diseases of poverty, non-communicable diseases, HIV/AIDs, tuberculosis, and increased violence and injury", however, progress had been made. The 1996 South African constitution was more inclusive and fought discrimination and segregation in the country, as it acknowledged the right to healthcare for all citizens.

Most recently, Cyril Ramaphosa, the current South African president, implemented the 'Presidential Health Compact' in 2019. This is a five-year roadmap for health systems strengthening reforms in the country. Ramaphosa wants every citizen to have healthcare regardless of their ability to pay (Cullen, 2020). This demonstrates how South Africa is taking the necessary steps in its progress to eliminate its health disparities. Although Apartheid is

widely regarded as an inappropriate system, the country is extensively working to lessen the impacts of past governmental systems.

The Manyatta Project

Throughout history, nomadic populations throughout Sub-Saharan Africa have constantly been subjected to a lack of healthcare, as reaching these groups may provide challenges not only to the countries themselves but to international health organizations as well. In these nomadic groups, such as the Maasai, "major causes of mortality and morbidity seem to be preventable infectious diseases," which was the case in Kenya at the end of the 20th century. (Sheik-Mohammed, 1999). Health disparities between villages and nomads within the country were alarming. Individuals from villages had full immunization coverage, whereas nomadic people had none, leading to higher mortality rates caused by preventable diseases (Imperato, 1975). Although nomadic individuals in Kenya were conscious of their healthcare situation, these groups took little action because affiliation with any government organization did not appeal to their nomadic ideology.

As such, in 1992, the Kenyan government and the Expanded Programme of Immunization developed a new strategy to solve the nomadic situation: the Manyatta project. Manyatta refers to a village housing created with local materials where patients can stay and receive medical treatment. Through this new housing technique, staff members could reach nomadic individuals and teach them about health and prescription drug use, leading to successful outcomes. As a result, immunization coverage reached "40% for tuberculosis in children aged under one year, 54% for third-dose of diphtheria-pertussis-tetanus (DPT3), [and] immunization, 35% for children protected against tetanus" (Aliou, 1992). The Manyatta approach demonstrates how international and national healthcare involvement is successful when a community's situations are addressed and priorities are met.

The South Sudan Crisis

Throughout the second Sudanese Civil War and since the 2011 Declaration of Independence from Sudan, South Sudan has experienced high levels of violence, bloodshed, and instability, especially against health workers (WHO, n.d). Moreover, South Sudan faced a massive medical crisis due to poor access to quality healthcare and weak essential services, providing only a limited number of health workers. According to UNICEF, the country was considered one of "the worst health indicators in the world" (UNICEF, n.d). In 2021, the Safeguarding Health in Conflict Coalition (SHCC), a collection of international non-governmental organizations (NGOs) aiming to protect health workers "identified 29 incidents of violence against or obstruction of health care in the country"; in these situations, numerous South Sudanese humanitarian workers were murdered (ReliefWeb, 2022). However, South Sudan was already struggling with several disease outbreaks. The country was also facing floods, population displacements, and a severe shortage of food, which left the nation with

"approximately 4 million displaced and homeless and over 7 million people that are in need of humanitarian assistance". The amount of people involved in these disasters paired with the low number of medical assistance severely affected the way individuals could access proper medical aid. Moreover, the medical workers kept getting infected by these outbreaks in the country because of the lack of proper resources (World Health Organization, n.d).

Thus, the World Health Organization has taken action to ensure quality healthcare in South Sudan. WHO is aiding the South Sudanese Ministry of Health to raise awareness about the conflict, promote support and research for health, and conduct vaccination campaigns for the citizens. For example, "South Sudan received 2160 doses of the Ebola vaccine," which were distributed to South Sudanese health workers, reducing the number of preventable deaths in South Sudan. (WHO, n.d). Nevertheless, increased awareness about the murders of humanitarian workers was not enough to ensure their safety, which could result in a severe staff shortage where citizens will be unable to access healthcare. Therefore, ensuring citizens' and health workers' safety is vital and must be the priority in the next steps WHO and the South Sudanese Ministry of Health take.

Venezuela's Health Emergency

Besides Venezuela's economic and humanitarian crisis, officially declared in 2014, Venezuela has also suffered from an ongoing health emergency for several years. In 2019, Venezuela was the Latin American country most affected by the Malaria virus outbreak; "[over] 50% of all malaria cases in Latin America [occurred] in Venezuela, 70 percent of which are in the state of Bolívar, where the outbreak of malaria [was] undoubtedly a great cause for concern" (ICRC, 2019). Thus, Venezuela's lack of quality resources severely impacted the spread of this virus. Apart from this, the country's frequent national power shortages and lack of clean water worsen its healthcare situation. As a result, crisis resources and equipment such as ventilators, dialysis machines, and refrigerators have stopped working, affecting thousands of lives daily.

Additionally, with the lack of medicines and hygiene products, as well as the recent COVID-19 pandemic, the situation has only worsened. One source mentioned how the "Venezuelan health system has been overwhelmed, focusing its limited resources on addressing the emergency" (IFRC, 2022). Moreover, the COVID-19 pandemic limited access to healthcare, leading to the outbreak of diseases such as measles and malaria. This occurred because most hospitals and the limited healthcare workers in the country were focused on the pandemic, which was the current rising concern. However, this shift in focus led to ignorance of diseases like measles and malaria, which caused a spike in cases. The Venezuelan health crisis proves how a country's lack of resources, power, and quality healthcare negatively affects its citizens and leads to being unprepared for health crises.

The Lack of Healthcare during the Russo-Ukrainian War

Aside from the damage caused by bombings and grenade attacks, the people of Ukraine are currently facing an unprecedented potential health crisis that began in 2020. After Russia invaded Ukraine to prevent the country from joining the North Atlantic Treaty Organization (NATO), which would cause rising tensions in the Russo-Ukrainian border, Ukraine has faced medical repercussions that are not commonly addressed. Public health officials predict that the Russo-Ukrainian War will have far-reaching consequences that could affect several generations. In less than a month, more than 3 million people have fled the country, and nearly 2 million became internally displaced. Those still in Ukraine face medical and pharmaceutical tool shortages, supply chain problems, and a potential surge in epidemics such as tuberculosis and COVID-19. Consequently, around 3,000 people have died due to a lack of access to medication (Handzel, 2022). As a result, these shortages directly affected Ukraine's population due to the scarce availability of quality healthcare resources. The tough times the country is facing are causing an increase in the demand for medical resources, and the shortage is only leading to more challenges in the area.

From the beginning of the war, there were reports of shortages of vital medicines and medical equipment such as artificial oxygen machines. As of 2022, "1,700 patients were expected to need oxygen treatment for COVID-19" (Handzel, 2022). However, various healthcare shortages led to a pause in the manufacturing of supplies and a decrease in the number of doctors and nurses, which only increased the unavailability of healthcare workers. Consequently, many citizens faced the repercussions of untreated COVID-19 and other health issues. Supply chain disruptions have also led to shortages of critical medicines such as insulin because many domestic distributors are not operating within the country in order to not interfere with the rising tensions in the country. Destroyed facilities from the military operations have led to pop-up clinics and labs where medical staff attempt to carry out their duties (Handzel, 2022). Still, the quality of healthcare provided is insufficient due to the circumstances and has only strengthened the possibility of more health complications.

People worldwide have come together to support the war-torn country as the Ukraine crisis worsens;multiple international organizations such as Project HOPE, The American Medical Association, and Doctors Without Borders have begun providing aid, helping to relieve the healthcare system (Handzel, 2022). Nevertheless, doctors worldwide continue to condemn the measures taken against the Ukrainian people, and more direct approaches are needed to help the innocent citizens affected by the current circumstances.

Past UN Actions

Universal health coverage (UHC), which ideally ensures all communities and individuals have access to health services, regardless of financial challenges, has been one of the UN's main targets since adopting the Sustainable Development Goals (SDGs). Its policies ensure universal

access to services that address the causes of illness and death, as well as the adequate quality of services to improve the health of those who receive them. UHC is based on the 1948 WHO constitution, which declares health as a fundamental human right, and is committed to ensuring the highest possible level of care for all; countries reaffirmed this commitment at the 2019 UN General Assembly High-Level Meeting on UHC, which was an essential step towards reaching quality healthcare. In this meeting, countries built on and explained their position on prioritizing health services for all. Furthermore, a member of the WHO Secretariat affirmed that "countries that progress towards UHC will make progress towards the other health-related targets, and towards the other goals" (WHO, 2021). Therefore, nations that contribute to WHOis mission are also predicted to achieve the highest attainable standard of health for all.

In 2020, a resolution called upon the WHO secretariat to increase its support for healthcare to finalize its 'Primary Health Care Operational Framework' in time for the 2020 World Health Assembly (WHA). This resolution recognizes the role of responding to health emergencies, promoting healthy communities, and achieving UHC. It urges countries to use WHO guidelines on health policy and system support to improve community health workers' programs and allocate adequate resources to such programs. As for the guidelines, the resolution also calls upon the UN to assess and collect data, monitor the implementation of regulations, and support member states in implementing the guidelines. The resolution also calls upon delegations to accelerate progress toward UHC, focusing on vulnerable, poor, and marginalized individuals and groups. Reaching the UHC goal also prioritizes increasing health financing, building resilient and sustainable health systems, strengthening health-related workforces, and investing in primary health care.

Countries such as Brazil, Mexico, Thailand, and more have begun working on the resolution by taking action to achieve UHC. With the help of WHO, these nations have applied a lens that incorporates public health measures for the early detection and prevention of diseases specifically in women. Additionally, WHO is reinforcing social insurance, which removes the financial barriers that prevent citizens from accessing healthcare services. Although this proposal is drafted, it is yet to be implemented in nations such as Ghana, the Philippines, Vietnam, and Rwanda due to their lower incomes. Their financial hardships create difficulties in meeting the UHC guidelines, causing these countries to continue suffering from scarce healthcare resources and services (IISD, 2019).

As mentioned previously, the United Nations SDGs for 2030 have also contributed to quality healthcare. The third SDG aims to reduce preventable maternal, child, and newborn deaths, achieve universal health coverage, reduce the number of deaths by illnesses, and increase health finances. (SDG, n.d.). Even though some progress had been made to achieve these goals, the UN has backtracked because of the pandemic, which affected more than 500 million people worldwide. It led to 6 million deaths, mainly because countries were unprepared for the pandemic and did not have enough capacity in hospitals and emergency rooms. Additionally, the pandemic disrupted essential services in 92% of countries, "shortened life

expectancy" and further created inequities in access to essential healthcare services (SDG, n.d.). Nevertheless, the pandemic highlighted the importance of healthcare for all, with multiple health companies such as Pfizer and Johnson & Johnson working quickly to develop a vaccine that was both effective and easily accessible. As a result, 69.5% of people worldwide were vaccinated through the United Nations and Government Health Agencies (SDG, n.d.).

IV. Key Players and Points of View

Myanmar

Myanmar has continuously made it challenging for its citizens to gain access to quality healthcare. The country's percentage of GDP spent on healthcare is amongst the lowest in the world, with the country only spending 0.5 to 3 percent on it and receiving the lowest amount of international aid per capita. Additionally, the country's political situation, which is currently unstable, has only worsened its healthcare. Myanmar's soldiers are on the lookout for doctors to try to prevent them from helping citizens. The healthcare workers also " have been at the forefront of a nationwide civil disobedience movement that has crippled the economy, and the regime has targeted health care workers from the start" (Paddock, 2022). Health professionals are concerned about the resistance and mistrust the dictatorship has fostered because it would make people reject any attempts they make to reinvigorate health programs and take steps to fight pandemics such as COVID-19. Due to the pandemic, frontline healthcare professionals are increasingly burdened and there is a need for alternative modalities to reduce the disruption of vital life-saving health services. In Myanmar, " combined with already pressurized national health system and ongoing political instability, it has been challenging to deliver basic health services where they are most needed and would make the big difference" (WHO, 2022). Finding a new way to provide essential healthcare services has been a top priority for Myanmar because the public sector cannot quickly import supplies or bring in support for the populations in need of it.

Sierra Leone

Sierra Leone has constantly struggled to provide healthcare for all of its citizens. The country experienced a civil war that ended in 2002, which destroyed most of the country's health facilities. The effects of this war were so long-lasting that the country is still recovering today, twenty years later. Few people have access to proper health care coverage, as there are only "22 physicians for every million people" (RTT News, n.d.). Most people live in rural areas, and 60% of the rural population does not have access to clean water. Additionally, the life expectancy is 54 years, and about "42% of the population is under 15 years old" (WHO, n.d.). Moreover, diseases such as malaria, tuberculosis, and HIV are the leading cause of death, with Malaria being the biggest killer. Other diseases, such as "cardiovascular diseases, cancer,

diabetes, and chronic respiratory [diseases]," are the leading cause of premature death and disability (WHO, 2018). Such diseases, though can be treated, are lethal in Sierra Leone because of the expensive cost of medical care and the limited amount of treatment. The country's state is highly deficient, and according to WHO, the country has a score of 0.00 on the health systems performance index (RTT News, n.d.).

In order to improve the health systems, the Ministry of Health and Sanitation implemented its National Health Sector Strategic Plan 2017-2021 in partnership with the Social Development Goal on Health (WHO, 2018). The country's health sector has been facing obstacles due to a lack of funding, many diseases, and a lack of physicians. Their second proposal, the Sierra Leone Social Health Insurance, established in 2018, was created to improve "financial accessibility" for healthcare services(WHO, 2018). Another issue the country faces is drug availability, as there have been shortages in the past. As a response, the government has installed legal and policy frameworks in the pharmaceutical sector, but they have not been well enforced (WHO, 2018).

After the West African Ebola virus epidemic ended in 2016, the focus on the health sector was changed to humanitarian assistance for recovery and longer-term goals. As a result, Sierra Leone has continuously accepted assistance from developing partners such as the WHO and the UN. They are also part of bilateral and multilateral partnerships that can provide Sierra Leone with financial support from several NGOs that provide a wide range of services for the health sector. Sierra Leone has improved access to essential health services, but they currently do not meet the expected standard. There are also inequities in the access to services between districts and income levels. In order to improve the country's healthcare, Sierra Leone would need to address its main issues and ensure its proposals, like the National Health Sector Strategic Plan, are enforced.

Egypt

Egypt has been working on healthcare reform as a governmental policy. However, Egypt's complicated health system has been in a state of crisis, especially after the Arab Spring in 2010, which was a string of anti-government protests, and became a significant contributor to the high rates of preventable and infant mortality (WHO, 2018). The country's health system is divided into two sectors: the public and private sectors. The public sector is formed by government and quasi-governmental organizations, such as the Health Insurance Organization (HIO), created to provide all Egyptians with basic coverage. Regardless, the public health system has constantly been facing challenges such as "underfunding, low-quality care, as well as a lack of medical equipment and qualified personnel" (Columbia Public Health, 2022). Although the HIO was formed to cover medical services to all Egyptians, it only covers 60% of the population. (Columbia Public Health, 2022).

Mohamed Kamel, an Egyptian citizen that graduated from the Alexandria Medicine Faculty, stated that although the government is putting in much effort to ensure universal health

coverage in Egypt, "there is still unequal access to healthcare" because "the current plans for comprehensive insurance of health are only covering a few governorates that are not heavily populated" (Kamel, 2020). Thus, he believes that adapted plans by the government "must be modified to achieve 100% coverage in governorates" (Kamel, 2020). If not, HIO's 60% coverage will "erode trust in health systems and societal cohesion" because not all Egyptians are promised access to healthcare, which they feel is unfair (Kamel, 2020). However, if the citizens were to get health coverage, they would still face a higher chance of getting harmful practices and long-term disease from poor-quality and scarce health services. Unfortunately, the only way for Egyptians to approach better quality care was by seeking care in facilities in the private sector if they can afford it, which leaves the citizens in a difficult financial situation *(*Columbia Public Health*, 2022*).

Nevertheless, the Universal Health Insurance Law, passed by the Egyptian government in 2018, aims to lower the cost of healthcare for patients, meaning that Egyptians could potentially access healthcare without financial hardship (WHO, n.d). In fact, "the World Bank finances programs and projects to help Egypt reduce poverty and boost shared prosperity" by investing 530 million dollars in a 5-year-long project, which the Ministry of Health and Population implemented in 2018 (World Bank, 2018). The Universal Health Insurance Law plans on "expanding family planning services, the screening, and treatment of the groundbreaking Hepatitis C program, the screening of 1 million units of blood annually," and enhancing health services at "600 primary healthcare facilities and 27 hospitals" (World Bank, 2018). Dr. Hala Zaid, the Minister of Health and Population, highlights the advantages of this project, particularly praising the Egyptian government: "Health is a top priority for the government [...] Accordingly, the project will allow us to achieve our goal of ensuring that every Egyptian has access to quality healthcare that will enable them to lead prosperous lives and contribute to Egypt's development." (World Bank, 2018). Therefore, this project gives Egyptians the opportunity to get access to high-quality healthcare by enhancing numerous ways to satisfy an individual's health, such as the program for treating Hepatitis C. Despite these attempts, Egypt still has a long way to go to ensure proper health coverage for all.

Mexico

Mexico has deprived its citizens of quality healthcare for some years. According to Francisco Pérez Fayad, the national coordinator for all 31 healthcare diagnosis forums in the country, Mexico's "healthcare system's installed capacity is inefficient in providing efficient care, [enabling] early diagnoses and treatments, and [treating] diseases" (Miranda, 2019). The unavailability of quality healthcare limits physicians' resources and harms patients because of the lack of availability. As stated by Natalie Kitroeff, "patients die because they are given the wrong medications, or the wrong dose [...] people are often not sedated properly, then wake up and yank out their own breathing tubes" (Kitroeff, 2020). Such incidences are critical and can have severe consequences on the patient, some even resulting in death. Furthermore, many

hospitals' resources for medical professionals are so poor that their protective gloves, an essential tool in the medical field, crack the moment they are slipped on. In addition, hospital capacity has shown a significant shortfall. On average, the country has only 1.5 beds per 1,000 people. However, a clear difference in regions can be seen between Mexico City, where there are 2.4 beds per every 1,000 inhabitants, and Chiapas, where there is only one bed per every 2,000 inhabitants. Therefore, the difference in economic status between the Mexican states has proven to be the main factor contributing to the lack of quality healthcare (Miranda, 2019).

Nevertheless, the country has begun taking action to redeem its healthcare sectors. Mexico's healthcare system is fragmented into three main types of healthcare providers that supply medical services to various population groups. The first is The Mexican Social Security Institute (IMSS), which provides insurance to private-sector workers and their families. This health insurance covers up to 57 million Mexicans. It provides full government health insurance, including inpatient and outpatient care, obstetric care, injury, and disability benefits. It is still important to acknowledge that the IMSS only protects the officially employed part of Mexico, leaving a vast part of the population vulnerable, the poorest who do not have officially registered jobs. In addition, The Mexican National Institute of Social Security and Social Services (ISSSTE) provides health insurance for public-sector employees and their families. The federal government funded the program, which includes over 12 million beneficiaries; yet, they are not as efficient as the IMSS and are often unavailable due to the high demand for healthcare services (Colombia Public Health, 2022).

Government Social Programs are the third and most crucial healthcare provider for citizens not covered by the other systems. The federal government almost entirely funds these programs. The Institute of Health for Wellbeing (INSABI) was created to replace the public health insurance system "*Segro Popular*." The system allows users to receive free medical and pharmaceutical care without restrictions, as no registration or payment of fees will be required. Still, as of today, there is little data that measures the effectiveness of INSABI. However, the INSABI chief defends the program, asserting that shortcomings and uncertainties result from the ambitious project's resistance as it impacts economic interests (Colombia Public Health, 2022).

United States of America

Currently, the United States (U.S.) is known for its unstable medical care. Although the county aims to provide global health for middle to lower-income countries, they currently struggle to make this goal a reality. The majority of Americans receive their health care through private insurance which comes from support or in direct connection to their employer. The U.S. instituted a form of a mandated health insurance in the Affordable Care Act (informally known as “Obamacare”) in 2010. The United States' global health affairs are divided into two offices in the U.S. Department of State, which focus on preventing global health emergencies: the Office of the U.S. Global AIDS Coordinator and Health Diplomacy (OGAC) and the Office of International

Health and Biodefense (IHB). These offices have been effective in promoting quality healthcare within the country. For instance, the President's Emergency Plan for AIDS Relief (PEPFAR), implemented by OGAC, "has saved more than 17 million lives, prevented millions of new HIV infections, and accelerated progress toward controlling the HIV/AIDS epidemic in more than 50 countries worldwide" (U.S. Department of State, n.d.). However, these countries lack medical resources and personnel in response to the global AIDS pandemic. Thus, OGAC provides relief "through supported testing services for 63.4 million people and training of more than 300,000 new health care workers" (PEPFAR, 2022).

Contrastingly, the IHB plays a broader international role in preventing and protecting diseases. From the viral influenza, the 2014 Ebola epidemic, and the recent COVID-19 pandemic, the IHB has supported many of these cases through direct approaches, such as vaccine production and reduction in barriers for effective humanitarian responses. The IHB's relief and support against the COVID-19 pandemic are significant because they support the host-government-led preparedness allows for the country's growth and self-protection in future pandemic situations, which helps ensure the country's quality healthcare in the future (U.S. Department of State, 2021). Moreover, the production of these types of vaccines has led to the overall protection of worldwide citizens, with vaccines being available to all. Although national health care is in the United States' main focus, there are benefits in the international scene that directly improve the country's progression, through diplomacy or self-protection.

V. Possible Solutions

The World Health Organization has made massive progress toward ensuring high-quality care in most developing countries, such as the Democratic Republic of Congo (DRC), where "a wide range of responders [...] worked hard to end the DRC's 10th Ebola outbreak, in 2018" among other developing countries (World Health Organization, n.d). The placement of treatment centers, the expansion of vaccine distribution, and the provision of numerous medical supplies all played a significant role in slowing the spread of the Ebola virus and achieving quality healthcare not only in DCR, but worldwide. However, many developing countries still face a great deal of substandard healthcare and a severe lack of clinical research and medical education, making it extremely difficult for health services and facilities to avoid casualties from poor-quality care. Patients often receive harmful treatments and inaccurate diagnoses, especially those requiring immediate medical attention. Because of this, the committee must create long-term solutions to guarantee quality care and reduce the extreme lack of medical training, resources, and knowledge.

The National Academy of Medicine (NAM) offers seven primary goals to satisfy and improve people's health by assuring high-quality medical care, where these possible solutions are highly recommended to be effective in developing countries (NAM, n.d). The first proposed

solution, titled “effective”, provides accurate diagnosis and proper working treatments to the individuals who need them by assuring efficiency and organization in a healthcare system. The second, named “safe”, acknowledges health quality service while avoiding patients being harmed. Hygiene is a significant contributor to this suggested goal because sanitation leads to less contamination among patients and health workers, especially in undeveloped nations that severely lack medical supplies, such as masks and laboratory kits. The third goal, which is “people-focused”, centers on respecting individual patient preferences and ensuring they are valued and involved in decisions tailored to their needs while treating them with compassion (WHO, n.d.). “Timely”, the fourth care proposed, ensures patients can reduce their waiting times depending on their conditions (Gagnon, 2022). Furthermore, “Equitable” focuses on getting citizens access to the healthcare they need by decreasing the cost of treatments and applying universal health coverage to most developing countries. Just as importantly, the sixth primary goal, “integrated,” allows different health workers and facilities to work together to improve patient care. The last healthcare solution proposed, “efficient,” enhances the usefulness of the resources at hand and prevents waste.

Furthermore, the WHO Regional Director for Africa, Dr. Matshidiso Moeti, illustrated how they used the aforementioned primary goals to achieve better health care in developing countries during the Ebola outbreaks. Dr. Moeti states an example of using these healthcare strategies, integrated and safe. This is seen when WHO Africa offered “laboratory kits and equipment, as well as supplies for personal protection, including masks and gloves, and other kits meant to help protect healthcare workers [to] ensure they do not get infected in the course of their work on the [Ebola] outbreak” (UN, n.d). These healthcare solutions were used to protect health workers' health from the Ebola virus when treating patients who might have it. He also mentions the other primary goals that helped decrease the spread of this outbreak, which successfully prevented unnecessary deaths through developing vaccines. However, Dr. Moeti mentions that within the healthcare strategy called people-centered, there is a substantial lack of information due to poor communication between UN agencies and WHO Africa and an absence of community engagement to get “people the information they [truly] need” (United Nations, n.d.). This communication is essential to improve patients’ health to their tailored needs by “following up with what people [need to] hear and believe to make sure they take the correct measures to protect themselves” (United Nations, n.d).

WHO also wants “health services to focus on quality improvement because they can create significant change within a medical institution, achieving everything from financial savings to, most importantly, saving patient lives” (Gagnon, 2022). Countries must focus on the quality enhancement of care in order to establish universal health coverage (UHC), which would allow all citizens to have access to the “health services they need” (WHO, n.d). The quality of pre-service education programs, building institutional capacity, improving student assessment, and maintaining effective licensing systems for health professionals are among the most critical topics. Finally, the committee must remember that these solutions do not fully account for the

issue's complexity. Therefore, delegates must research, plan, and present new and developed solutions that will provide high-quality healthcare while considering their potential long-term efficacy and practicability.

VI. Current Status

Currently, there are still many countries throughout the world that require medical training, resources, and knowledge. The underdevelopment of continental Africa is the most prominent example of a widespread shortage of medical personnel. Although international organizations, such as WHO, have begun education initiatives in this continent, "it is projected that by 2030, Africa would need an additional 6.1 million doctors, nurses, and midwives. Based on the current trajectory, only 3.1 million would be trained and ready for service delivery" (Okoroafor, 2022). Moreover, in a survey done on 47 African countries, there is a "ratio of 1.55 health workers per 1000 people. This is below the WHO threshold density of 4.45 health workers per 1000 people needed to deliver essential health services and achieve universal health coverage" (Rawlinson, 2014). With its growing population, Africa lacks general healthcare workers and education for current and future development. This results in a more significant impact on the quality of life and economic growth, slowing down development in other sectors such as infrastructure or education. Although general healthcare is essential for Africa, diseases such as cancer plague much of this region today. Cancer cases have risen throughout underdeveloped regions of the continent, and the estimated number of new cancer cases is predicted to increase to "1.28 million, with 970,000 deaths each year by 2030" (WHO, 2022). As such, the situation in many African countries, such as Tanzania's and Mozambique's lack of medical staff, demonstrates that the lack of quality healthcare and training is still an issue that plagues much of the world today.

Nevertheless, Africa is not the only continent with lack of medical care. With many nations and groups of people around the globe lacking medical education, resources, and information, it is essential to solve this issue so each delegation's citizens can live healthy lives. Access to quality healthcare is expensive due to a severe lack of medical awareness, resources, knowledge, and available funding. As a result, most citizens cannot afford it, which affects the livelihood of those who require medical care. Therefore, the committee is responsible for finding possible solutions that involve quality improvement in all countries, especially in developing countries, to prevent numerous deaths due to a lack of proper healthcare.

VII. Bibliography

Alemayehu, C., Mitchell, G., & Nikles, J. (2018, March 22). *Barriers for conducting clinical trials in developing countries- A systematic review - International Journal for Equity in health*. BioMed Central. https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-018-0748-6

Aliou, S. (1992). *What health system for nomadic populations?*. World Health Forum, 13(4), 311–314. https://apps.who.int/iris/bitstream/handle/10665/52279/WHF_1992_13_4_p311-314_eng.pdf

Barnes, S. B. (n.d.). *The 30th Anniversary of the Safe Motherhood Initiative*. New Security Beat. https://www.newsecuritybeat.org/2018/01/30th-anniversary-safe-motherhood-initiative/

Brazelton, M. A. (2022). *Health for all?: Histories of international and global health*. History Compass, 20(1), e12700. https://doi.org/10.1111/hic3.12700

Britannica. (2022, August 24). *Apartheid*. Encyclopedia Britannica. https://www.britannica.com/topic/apartheid

Columbia Public Health. Egypt: Summary. (2022, June 27). https://www.publichealth.columbia.edu/research/comparative-health-policy-library/egypt-summary#:~:text=The%20public%20health%20system%20faces,medical%20equipment%2C%20and%20qualified%20personnel

Country Cooperation Strategy At a Glance: Sierra Leone. (2018, May). https://www.who.int/publications/i/item/WHO-CCU-18.02-SierraLeone

Cullen, M. (2020, April 7). *Health Disparities During Apartheid in South Africa*. The Borgen Project. https://borgenproject.org/health-disparities-during-apartheid/

Egypt - World Health Organization. (2018). World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/326086/WHO-HIS-SDS-2018.21-eng.pdf?sequence=1

Gagnon, D. (2022, October 7). *What is Quality Improvement in healthcare?* Southern New Hampshire University.

https://www.snhu.edu/about-us/newsroom/health/what-is-quality-improvement-in-healthcare

Global Health Policy. (2022, September 26). *The U.S. Government and Global Health*. KFF. https://www.kff.org/global-health-policy/fact-sheet/the-u-s-government-and-global-health/

Goal 3 | Department of Economic and Social Affairs. (n.d.). Sustainable Development Goals. https://sdgs.un.org/goals/goal3

Grudzen, C. R., & Legome, E. (2007, November 28). *Loss of international medical experiences: Knowledge, attitudes and skills at risk - BMC Medical Education*. BioMed Central. https://bmcmededuc.biomedcentral.com/articles/10.1186/1472-6920-7-47

Handzel, S. (2022, April 22). *Physicians shortage: Which US regions affected most*. MDlinx. https://www.mdlinx.com/article/physician-shortage-which-us-regions-affected

Handzel, S. (2022, April 22). *Physicians at war: Health challenges in Ukraine* | MDlinx. https://www.mdlinx.com/article/physicians-at-war-health-challenges-in-ukraine/31AUlIewHpKzgBezeFsyno

Hardiman, D. (2006). *Healing Bodies, Saving Souls. Medical Missions in Asia and Africa*. National Library of Medicine. https://pubmed.ncbi.nlm.nih.gov/17132180/

Health. UNICEF South Sudan. (n.d.). https://www.unicef.org/southsudan/what-we-do/health

Henderson, L. N, & Tulloch, J. (2008, September 15). *Incentives for Retaining and Motivating Health Workers in Pacific and Asian Countries - Human Resources for Health*. BioMed Central. https://human-resources-health.biomedcentral.com/articles/10.1186/1478-4491-6-18

Human Rights Watch. (2020, March 12). *Venezuela's Health Care Crisis Now Poses a Global Threat*. Human Rights Watch. https://www.hrw.org/news/2020/03/12/venezuelas-health-care-crisis-now-poses-global-threat#:~:text=The%20country's%20health%20system%20is,steepest%20rise%20in%20malaria%20cases

Human Rights Watch. (2021, January 13). *World Report 2021: Rights Trends in Venezuela.* Human Rights Watch. https://www.hrw.org/world-report/2021/country-chapters/venezuela

Imperato, P.J. (1975). P*roblems in providing health services to desert nomads in West Africa.* Tropical Doctor 5, 116–123. https://journals.sagepub.com/doi/abs/10.1177/004947557500500311?journalCode=tdoa

International Committee of the Red Cross. (2019, October 17). *Venezuela: Making Access to Health Care a Priority*. International Committee of the Red Cross. https://www.icrc.org/en/document/venezuela-making-access-health-care-priority

International Federation of the Red Cross. (2022, January 29). *Venezuela: Health Emergency - Final Report (MDRVE004)* ReliefWeb. https://reliefweb.int/report/venezuela-bolivarian-republic/venezuela-health-emergency-final-report-mdrve004

Kamel, M. (2020). *A view of the health services after Covid-19: An Egyptian perspective.* Taylor & Francis. https://www.tandfonline.com/doi/full/10.1080/20905068.2020.1789391

Kitroeff, N. (2020, May 28). *'It's not the virus': Mexico's Broken Hospitals become killers, too.* The New York Times. https://www.nytimes.com/2020/05/28/world/americas/virus-mexico-doctors.html

McArthur, J. (2017, March 30). *How successful were the millennium development goals?*. The Guardian. https://www.theguardian.com/global-development-professionals-network/2017/mar/30/how-successful-were-the-millennium-development-goals#:~:text=Between%208.8%20to%2017.3%20million,to%20improvements%20in%20maternal%20mortality.

Mexico: Summary. (2022, June 7). Columbia Public Health. https://www.publichealth.columbia.edu/research/comparative-health-policy-library/mexico-summary

Miranda, P. (2019, March 29). *OECD: Mexican Healthcare System is lagging behind. El Universal.*

https://www.eluniversal.com.mx/english/oecd-mexican-healthcare-system-lagging-behind

Naher, N., Hoque, R., Hassan, M. S., Balabanova, D., Adams, A. M., & Ahmed, S. M. (2020, July 9). *The influence of corruption and governance in the delivery of frontline health care services in the Public Sector: A scoping review of current and future prospects in low and middle-income countries of south and south-East Asia - BMC public health*. BioMed Central. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-020-08975-0

National Academies of Sciences, Engineering, and Medicine (NASEM). (n.d.). Center to Advance Palliative Care. https://www.capc.org/collaborations/national-academy-medicine/

Okoroafor, S. C. (2022, May 7). *An overview of Health Workforce Education and accreditation in Africa: Implications for scaling-up capacity and quality - human resources for health*. BioMed Central. https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-022-00735-y#citeas

Oshitani, H., Kamigaki, T., & Suzuki, A. (n.d.). *Major Issues and Challenges of Influenza Pandemic Preparedness in Developing Countries*. NCBI. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2600290/

Ouellette, J. *(2020, September 13). How the Warsaw Ghetto beat back typhus during World War II. Ars Technica. https://arstechnica.com/science/2020/09/how-the-warsaw-ghetto-beat-back-typhus-during-world-war-ii/*

Paddock, R. C. (2021, June 12). *In Myanmar, Health Care's Collapse Takes Its Own Toll*. The New York Times. https://www.nytimes.com/2021/06/12/world/asia/myanmar-coup-doctors-health.html

Paddock, R. C. (2022, April 19). *Myanmar's Health System Is in Collapse, 'Obliterated' by the Regime*. The New York Times, https://www.nytimes.com/2022/04/19/world/asia/myanmars-coup-doctors.html

PAHO. (2022). *History of PAHO - PAHO/WHO*. https://www.paho.org/en/who-we-are/history-paho

Pan American Health Organization. (2022). Encyclopædia Britannica. https://www.britannica.com/topic/Pan-American-Health-Organization

PEPFAR. (2022, July 12). *The U.S. president's emergency plan for AIDS relief (PEPFAR)*. KFF. https://www.kff.org/global-health-policy/fact-sheet/the-u-s-presidents-emergency-plan-for-aids-relief-pepfar/#:~:text=PEPFAR%20activities%20focus%20on%20expanding,services%20(see%20Table%202)

Racoma, B. *Countries lacking proper healthcare*. (2020, April 9). Day Translations Blog https://www.daytranslations.com/blog/countries-no-healthcare/

Rawlinson, F. M. (2014, December 11). *The current situation in education and training of health-care professionals across Africa to optimize the delivery of palliative care for cancer patients*. eca. https://ecancer.org/en/journal/article/492-the-current-situation-in-education-and-training-of-health-care-professionals-across-africa-to-optimise-the-delivery-of-palliative-care-for-cancer-patients

Sheik Mohamed, A., & Velema, J. P. (1999). *Where health care has no access: the nomadic populations of sub-Saharan Africa*. Tropical medicine & international health, 4(10), 695-707. https://pubmed.ncbi.nlm.nih.gov/10583904/

Social and Economic Burden Associated With Typhoid Fever in Kathmandu and Surrounding Areas: A Qualitative Study. (2017, July 29). NCBI. Twenty years in South-East Asia 1948-1967. https://apps.who.int/iris/bitstream/handle/10665/126401/Chapter%20-1.pdf?sequence=9&isAllowed=y

South Sudan: Violence Against Health Care in conflict 2021. ReliefWeb. (2022, July 11). https://reliefweb.int/report/south-sudan/south-sudan-violence-against-health-care-conflict-2021#:~:text=The%20Safeguarding%20Health%20in%20Conflict,decreased%20from%20the%20previous%20year

Strategy for Health 2016-2030. (2016, August). UNICEF. https://www.unicef.org/media/119736/file/UNICEF-Strategy-for-Health-2016-2030.pdf

The 10 Worst Countries in the World For Health Care. (n.d.). RTTNews. https://www.rttnews.com/slideshow/3683/the-10-worst-countries-in-the-world-for-health-care.aspx

The Public Health Workforce Crises: USC MPH Online. Online Masters in Public Health. (2020, February 27). https://mphdegree.usc.edu/blog/a-closer-look-at-the-public-health-workforce-crisis/#:~:text=Contributing%20Factors%20to%20the%20Health%20Care%20Shortage&text=The%20aging%20population%20generating%20a,Limited%20capacity%20of%20education%20programs

UNICEF History. (n.d.). UNICEF. https://www.unicef.org/history

UNICEF joint health and nutrition strategy for 2006-2015. (2005). Economic and Social Council. https://www.unicef.org/media/119736/file/UNICEF-Strategy-for-Health-2016-2030.pdf

United Nations. (n.d.). *Dangers of poor quality health care revealed 'in all countries': WHO Report*. United Nations. https://news.un.org/en/story/2018/07/101394

United Nations. (n.d.). *Half the world lacks access to essential health services – UN-backed report*. United Nations. https://www.un.org/sustainabledevelopment/blog/2017/12/half-world-lacks-access-essential-health-services-un-backed-report/

United Nations. (n.d.). *Health - United Nations Sustainable Development*. United Nations. https://www.un.org/sustainabledevelopment/health/

United Nations. (n.d.). *How World Health Organization is helping African countries deal with Covid-19 | Africa Renewal*. United Nations. https://www.un.org/africarenewal/magazine/how-world-health-organization-helping-african-countries-deal-covid-19

U.S. Department of State. (2021, January 5). *Office of International Health and Biodefense - United States Department of State*. U.S. Department of State. https://www.state.gov/bureaus-offices/under-secretary-for-economic-growth-energy-and-the-environment/bureau-of-oceans-and-international-environmental-and-scientific-affairs/office-of-international-health-and-biodefense/

U.S. Department of State. (n.d.). *Global Health - United States Department of State*. U.S. Department of State. https://www.state.gov/policy-issues/global-health/

World Bank. (2021, December 7). *Medical Education Reform Will Boost Cambodia's Health Care Capacity*. World Bank Blogs. https://blogs.worldbank.org/eastasiapacific/medical-education-reform-will-boost-cambodias-health-care-capacity

World Bank. (2018, July 5). *Low Quality Healthcare is increasing the burden of illness and health costs globally*. World Bank. https://www.worldbank.org/en/news/press-release/2018/07/05/low-quality-healthcare-is-increasing-the-burden-of-illness-and-health-costs-globally

World Bank Group. (2018, June 27). *45 million Egyptians to benefit from improvements to the Public Health System*. World Bank. https://www.worldbank.org/en/news/press-release/2018/06/27/45-million-egyptians-to-benefit-from-improvements-to-the-public-health-system

World Economic Forum. (2019, November 25). *Every year nearly 6 million people die in developing countries from low-quality healthcare - this is how we help them*. https://www.weforum.org/agenda/2019/11/effects-and-costs-of-poor-quality-healthcare/

World Health Assembly adopts resolutions on Universal Health Coverage. (2019, June 4). SDG Knowledge Hub. https://sdg.iisd.org/news/world-health-assembly-adopts-resolutions-on-universal-health-coverage/

World Health Organization. (2021, April 1). *Universal Health Coverage (UHC)*. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

World Health Organization. (2022, June 22). *Chronic staff shortfalls stifle Africa's health systems*. https://www.afro.who.int/news/chronic-staff-shortfalls-stifle-africas-health-systems-who-study

World Health Organization. (2022, June 7). *Ensuring Access to Life – Saving Health Services in Myanmar amidst the Crisis*. https://www.who.int/myanmar/news/feature-stories/detail/ensuring-access-to-life---saving-health-services-in-myanmar-amidst-the-crisis

World Health Organization. (n.d.). *Heroes of the ebola response*. World Health Organization. https://www.afro.who.int/heroes-ebola-response#:~:text=Despite%20facing%20security%20challenges%2C%20emergency,to%20join%20the%20Ebola%20fight.

World Health Organization. (n.d.). *Quality of Care*. World Health Organization. https://www.who.int/health-topics/quality-of-care#tab=tab_1

World Health Organization. (n.d.). *South Sudan crisis*. World Health Organization. https://www.who.int/emergencies/situations/south-sudan-crisis

World Health Organization. (n.d.). *South Sudan vaccinates health workers against ebola*. World Health Organization. https://www.afro.who.int/news/south-sudan-vaccinates-health-workers-against-ebola

World Health Organization. (n.d.). *Universal Health Coverage*. World Health Organization. https://www.who.int/health-topics/universal-health-coverage#tab=tab_1

World Health Organization. (n.d.). *World Bank and WHO: Half the world lacks access to essential health services, 100 million still pushed into extreme poverty because of health expenses*. World Health Organization. https://www.who.int/news/item/13-12-2017-world-bank-and-who-half-the-world-lacks-access-to-essential-health-services-100-million-still-pushed-into-extreme-poverty-because-of-health-expenses