The World Health Organization

President: Maia Goldman

TUMUN X

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Letter From the Chair:

Dear Delegates,

My name is Maia Goldman, and it is an honor to be the President of the General Assembly for the 2026 Tufts Model United Nations Conference. I am a first-year student at Tufts studying International Relations and Spanish with a concentration in Global Health, Nutrition, and the Environment, and I am from Tenafly, NJ. Outside of Model UN, I love learning languages, playing with my cats, and writing for the Tufts Daily! Through doing Model UN over the past three years, I've found my voice through exploring the nuances of global affairs, insightful discourse with fellow delegates, and committee strategies. I am thrilled to be helping you find your place in MUN as well, and I look forward to beginning this committee of the World Health Organization: Achieving Global Kidney Equity!

This subject matter is one that is personal to me, as I am a two-time kidney transplant recipient and was on dialysis for part of my senior year of high school. I've seen first-hand the inequities that exist in the medical world, as when I was on dialysis, I noticed that the patients attached to dialysis machines were all older than me, some in wheelchairs, and most alone. I wondered if they were able to work, had access to nutritious meals, or whether they had adequate health insurance. This opened my eyes to the idea that people were actively choosing between feeding their family and paying for necessary medical care, and that wasn't okay. Additionally, my second transplant center wasn't a National Kidney Registry center, and they were unable to pay for my donor's expenses—thus leaving us to pay for a staggering amount of money.

I've seen many politicians globally strive to try and resolve this issue through initiatives such as the 77th World Health Assembly's resolution on greater kidney transplantation accessibility, the Affordable Care Act, and a multitude of international cooperation and grants, however, it's not enough, and we need your help. This same diligence, passion, and respect is expected of delegates as you engage in discourse to address health disparities that restrict access to organ transplants worldwide. Change is universally desired, and the only way to achieve such is to engage in intellectual discourse and brainstorm feasible and impactful solutions.

Addressing global kidney transplantation and treatment equity is crucial for reducing global health disparities and ensuring the accessibility of kidney care based on medical need and not socioeconomic status. Both topics in this committee combat key challenges to promoting global kidney equity and getting closer to universal healthcare access. Topic A is improving funding of kidney transplantation and replacement options, and Topic B is reducing the unethicality and exploitation associated with kidney transplantation.

If you have any questions or concerns prior to opening debate in March, don't hesitate to contact me at Maia.Goldman@tufts.edu. I can't wait to get started!

Sincerely,
Maia Goldman
President of the General Assembly
TUMUN 2026

Procedure and Technology Policy:

This committee will proceed under traditional parliamentary procedure. The use of technological devices used for **solely educational purposes** will enhance the quality of this General Assembly through more efficient collaboration and during unmoderated caucuses to conduct Working Papers and Resolutions. Nevertheless, it must be stressed that supporting and considering the perspectives of other delegates will take priority. Therefore, to enforce engagement and collaboration, it is recommended that delegates come to committee sessions with **printed or handwritten notes**, as devices will not be accessible during moderated caucuses.

Position Papers:

To be eligible to receive an award within this committee," a one-page position paper will be required of each delegate responding to **each topic** within the background guide. Regardless of any consideration of an award, the construction of position papers will be warranted to facilitate a greater understanding of the topics of discussion, thus prompting more enriching debate and discourse during committee sessions. Within each position paper should be a background on the topic, a summary of your country's position, your country's history (policies, past actions, relevant UN resolutions, etc.), and proposed solutions for addressing the key questions in the background guide. **Please email one position paper for Topic A and one for Topic B to Maia.Goldman@tufts.edu before 4pm on 2/27.**

What is Chronic Kidney Disease (CKD)?

The kidneys play a significant role in how our bodies function. They filter waste, maintain chemical equilibrium, and sustain a normal blood pressure. Typically, renal (kidney) health is not something of significant concern. We just go about our daily lives without thinking twice about our kidneys - 81% of people can't even locate where their kidneys are [A]. However, Chronic Kidney Disease, or CKD, occurs when the kidneys have endured long-term damage of 3 or more months, thus greatly reducing—or sometimes even completely inhibiting—kidney function and the ability to perform their basic duties [B]. CKD affects 9.1% of the world's population and results in 1.2 million deaths annually [C]. CKD is classified into five stages, beginning with mild kidney damage and ranging all the way to ESRD, or end-stage renal disease, which reaches complete kidney failure. In stage 1, an individual can present as completely asymptomatic, but by the time stage 5 occurs, dialysis or a kidney transplant would be warranted to sustain survival [D].

Unequal Access to Kidney Transplants + Why It Must Be Addressed:

While earlier stages of the disease can be controlled through medication and lifestyle modifications, the debilitating nature of CKD in its later stages warrants use of other methods to deal with the limitations imposed by such and preserve a somewhat normal quality of life. To do so, many use dialysis, an artificial blood filtration process to remove excess fluid and other toxins in place of the kidneys. With dialysis being the only alternative to renal transplantation to address CKD, over 5 million patients require dialysis annually, yet only 100,000 kidney transplants are performed annually—a very disproportionate figure that must be solved [C]. While dialysis does serve as an

effective method that can sustain individuals for over twenty years [E], patients' quality of life diminishes. In addition to the financial costs, hemodialysis—dialysis that occurs at a center through an access port in one's arm, chest, or groin—entails a commitment of 3-5 sessions per week that last up to 3 hours each, resulting in physical and mental fatigue, taking a lot of time away from educational or employment commitments, and making this process inconvenient and exhausting [F].

The waiting list to receive a kidney transplant is extensive, and the healthcare infrastructure of many countries cannot afford to conduct kidney transplants. Therefore, many have to resort to hemodialysis, which is ultimately more costly than maintaining a transplant in most nations [C]. Dialysis expenses are quite high due to the investments required in equipment, staff, and supplies [J]. Many countries also utilize solely government funding, like Australia, Israel, and Korea. As a result, dialysis in some nations is funded by a combination of public funding from the government and private funding through insurance, such as in the US and Singapore, where this occurs notably often. However, insurance largely dictates the accessibility of dialysis and is a large financial incentive for dialysis providers due to payment rates. Countries without insurance-covered dialysis provide short hemodialysis treatment times, lower treatment frequency, and ultimately, poorer care [I]. Additionally, in lower-income countries with more limited healthcare budgets, funding dialysis requires difficult trade-offs with other public health issues. A limited number of centers and trained medical professionals further hinder equitable access to quality care, thus resulting in low- and middle-income countries struggling to incorporate dialysis

into their universal healthcare systems and making it more inaccessible as a whole [J].

For any patient to even access quality dialysis requires the acquisition of health insurance. For instance, in Mexico, only 49% of the population is insured with health insurance, and the only other way to afford dialysis would be to pay for out-of-pocket expenses [I]. However, in lower-income countries like Mexico, hemodialysis costs can range from $3,424 to $42,785 per patient [H], thus, many uninsured patients die of CKD due to dialysis being unaffordable for them. Since dialysis is so inaccessible for so many in developing countries, over time the healthcare systems further reinforce care disparities leading to long-term systemic inequities. Because dialysis is so underfunded within these countries, the quality of the treatment goes down with delayed initiation of the treatments, treatments are shortened, and patients receive fewer sessions, thus resulting in higher rates of morbidity and mortality. These issues disproportionately affect people of lower socioeconomic status—further exacerbating health inequities. Because an increasing number of people are on the verge of reaching ESRD due to not having an accessible treatment plan like dialysis, kidney transplants are becoming more in demand, and more pressure is being placed on national healthcare systems to fund them.

Many countries are unable to fund active kidney transplant programs, and many government support programs which do exist aren't as robust as necessary. As a result, many of the kidney transplant programs offered in countries are offered by "private-for-profit institutions," [C] or hospitals that operate like a business and are managed by private entities/corporations with the goal of generating profit for the owners [K], and living donors are the heart

of these organizations, also often at risk for being exploited. Because there is a global organ shortage for transplantation, there is a sizable gap between supply and demand. This results in people from all parts of the world seeking transplants overseas in developing countries without questioning the process behind the acquisition of the organ. Within disadvantaged countries, a lack of proper health infrastructure leads to health professionals who take advantage of the opportunity for financial gain [L]. As a consequence, living donors are extra vulnerable to advertisements put out locally or on social media by the organization. Additionally, brokers, recruited medical professionals, and fraudulent documents can all be detrimental to the success of these operations [M]. For-profit organizations ultimately prey on the human tendency to go after a profit margin even if human exploitation is entailed— reflecting the lack of limited resources and healthcare system within lower-income countries for transplantation [L]. For instance, only 286 transplants were performed in Africa in 2022 due to the low resources within the content that dedicated smaller budgets to healthcare [G].

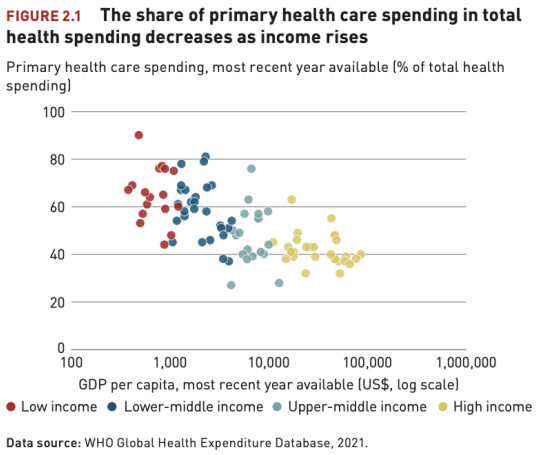
Ultimately, CKD is a global health crisis, and while kidney transplantation is seen to be more cost-effective than dialysis around the world, access is still hindered by financial and ethical challenges within different nations. The overwhelming reliance on dialysis when transplantation is necessary, the prevalence of private-for-profit institutions, and the shortage of reliable government support when it comes to transplant shortage only deepens those disparities in kidney transplantation globally, and will ultimately continue to take many lives and disproportionately affect the more financially-vulnerable populations.

Topic A: Funding of Kidney Transplantation and Replacement Options:

Problem Overview

Although 103 countries engage in transplant activity [N], managing CKD and dialysis consumes up to 3% of national healthcare budgets in developed countries—a figure expected to more than double by 2030 [Q]—implying that that figure is lower within developing countries [O]. Ultimately, the government funding behind transplantation internationally remains limited and insufficient, and kidney disease is especially prevalent within low- and lower-middle-income countries (LLMICs). Ultimately, kidney disease is one of the leading causes of premature mortality and is anticipated to climb up to becoming the fifth leading cause of death in the world by 2050 [Q]. Because kidney disease is a very costly disease to have, 90% of individuals within LLMICs are unable to afford dialysis which results in millions of deaths per year [Q].

This is further contributed to by the fact that public funding for kidney disease was only done in 56% of countries for acute kidney injury, or the sudden loss of function within kidneys; 40% for CKD; 63% for dialysis; and 57% for kidney transplantation. Additionally, within lower-income countries in Africa and Southeast Asia, public funding is far less common, and private funding and out-of-pocket expenditures are more common. Generally speaking, with regard to



primary healthcare, countries with higher GDPs tend to spend relatively less and

allocate a smaller portion of their healthcare budget on kidney disease treatment and infrastructure [R]. This creates a global funding bottleneck for renal care in LLMICs, as the lack of prioritized spending from wealthier nations limits the development of frameworks and shared resources that these LLMICs need to manage CKD. Therefore, it can be concluded that public funding for kidney care within LLMICs is limited and results in the larger reliance on out-of-pocket payments, thus limiting the amount of kidney care available for lower-income households due to a large fraction of an-already limited stream of income being utilized towards basic medical services. [R]

Because of the limited public funding toward organ transplantation, only roughly 54% of all countries perform transplants at all, still leaving just about half of all nations devoid of organ transplantation programs [G]. For a nation to establish such a program, nations have to abide by policies such as the WHO Guiding Principles on Human Organ Transplantation (1991) and the Declaration of Istanbul on Organ Trafficking and Transplant Tourism (2008, 2018), providing an ethical framework for organ transplantation to take place [aa]. Under these laws are the enforcement of organs never being sold and are traceable, and that there is legal oversight in place to stop trafficking and transplant tourism. Some other general guidelines that exist are specialized surgical facilities, the National Organ Transplant Act (NOTA) of 1984 that bans the sale of organs and ensures the allocation of organs fairly, and the Uniform Anatomical Gift Act (UAGA) that governs the donation process. Because of the lack of nations participating in organ transplantation, many individuals are left with the sole option of traveling abroad to receive a transplant, or transplant tourism (TT) [T]. According to a 2023 study done

within Canada, 59% of the participants were willing to travel outside of Canada to receive a transplantation; however, only 23% of the participants were willing to travel abroad to purchase a kidney—many of whom were hindered by receiving an income lower than $100,000—implying that while many can coordinate the logistics of travel, the additional financial costs of purchasing organs forces lower-income individuals to sacrifice the procedure [S].

Ultimately, the inadequate public funding allocated toward kidney transplantation and replacement not only limits access to this life-saving care, but also worsens global health inequities, as it reserves kidney transplantation as a luxury for only those with higher streams of income. Thus, vulnerable populations are left without safe treatment options and are left to seek out unethical organizations and private for-profit institutions to do such, which might bear the consequences of more

Region	Country
North and Central America	United States, Canada, Mexico, Guatemala, Dominican Republic, Cuba, Honduras, Nicaragua, El Salvador, Costa Rica, Panama, Jamaica, Trinidad and Tobago, Barbados
South America	Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, and Uruguay
Europe	The 27 member states of the European Union, United Kingdom, Ukraine, Belarus, Switzerland, Bosnia and Herzegovina, North Macedonia, Moldova, Albania, Norway, Iceland, and Turkey
Asia	Armenia, Azerbaijan, Afghanistan, Bangladesh, China, Georgia, India, Indonesia, Iran, Iraq, Israel, Japan, Jordan, Kazakhstan, Kuwait, Lebanon, Malaysia, Mongolia, Oman, Pakistan, Philippines, Qatar, Saudi Arabia, Singapore, South Korea, Syria, Sri Lanka, Taiwan, Thailand, United Arab Emirates, and Vietnam
Oceania	Australia and New Zealand
Africa	South Africa, Sudan, Ivory Coast, Ghana, Kenya, Egypt, Ethiopia, Nigeria, Namibia, Tanzania, and Mauritius

[G] *Countries conducting transplants*

surgical complications, likelihood of rejection, and infections which can cause serious morbidity and mortality [T].

Prior UN Involvement

Despite the currently complex context surrounding transplantation and donation internationally, the United Nations has taken action to mitigate the effects of and resolve this problem. On May 29, 2024, the 77th World Health Assembly reached a groundbreaking agreement on transplantation. With Spain having initiated this resolution, Member States approved a new resolution that would increase availability, responsible access, and ethical oversight on cell, tissue, and organ transplantation [P].

Under this resolution, measures combatting and preventing trafficking with the intention of removing and trafficking organs would be implemented, as well as initiatives intended to protect survivors and victims of such crimes. Additionally, Member States are committed to going about the processes needed to integrate ethical donation and transplantation into healthcare systems internationally to allow for more possibilities for deceased donation and protection against the exploitation of living donors [P].

Path Forward

While the WHO has produced critical and groundbreaking contributions, the commission must now step up and implement solutions. Before anything, CKD needs to be recognized as a Global Development Goals (SDGs), as it is expected to become the fifth greatest cause of death by 2050 [Q]. Therefore, despite the 77th World Health Assembly requesting that the Director General advance kidney disease as an NCD of increasing global priority [P], the necessary resolution is being averted and danced around. Instead of promoting the notion of a shared goal for improving the

greater well-being of humanity internationally through a SDG, WHO resolutions are simply providing ideas as opposed to active solutions.

Nations must unite and find feasible solutions to be implemented globally, and the WHO is the only committee that has the power and resources to do so. Through directives and joint resolutions, this committee will be responsible for finding solutions to topics including economic disparities, global health equity, international health funding models, and TT.

Some issues that the committee is encouraged to focus on are the costs for both peritoneal and hemodialysis, regulating insurance coverage (or lack of such) for non-medical costs (e.g., travel, money lost due to time off of work, etc.), policies for delegates' respective countries regarding funding, barriers for low-income nations accessing insurance or affording life-saving immunosuppressant drugs, insurance accessibility, policies on transplant tourism, and patient and donor financial support (e.g., National Kidney Foundation in the United States). The committee is also advised to investigate potential agencies to partner with the WHO to establish useful relations and support for programs being developed [U]. Potential agencies to consider include The Transplantation Society, International Society of Nephrology, Alliance for Paired Kidney Donation, and the United Network for Organ Sharing.

In addition to that, existing UN frameworks and WHO resolutions can be expanded from simply increasing availability and ethical oversight to implementing solutions that contribute to the funding of kidney transplantation and replacement options. Greater emphasis placed on equitable and sustainable financial solutions is absolutely necessary in order for Member States to directly implement these commitments in an impactful way. This

committee must work together to develop solutions that utilize global networks and resources provided by the WHO. Through negotiating with governments globally, UN relief programs, and organizations such as the Transplantation Society, International Society of Nephrology, the United Network for Organ Sharing, and the Red Cross, the committee will have the means and opportunity to create funding models that reduce out-of-pocket costs and expand access to transplantation and replacement options. As a specialized committee within the UN, this committee will have access to UN resources that can aid in coordinating funding and supporting equitable implementation of resolutions. Ultimately, ensuring equitable and sustainable funding for kidney care requires a joint effort by all countries as opposed to one nation alone.

Questions to Consider

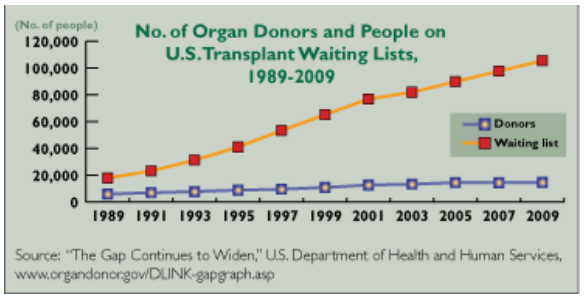
- How can governments around the world be incentivized to want to fund CKD and other treatment options? How can governments be discouraged from pocketing the money allocated toward funding such? Would consequences have to be instilled, or is there a better and more effective deterrent?
- What role could the WHO play in organizing international funding to support kidney care and treatment options, especially within low- and lower-middle-income nations? Would the WHO serve as a supervisor and the Member States organize, or would the WHO take on a more administrative role in constructing a sustainable and effective funding system?
- How could NGOs, international organizations, and the private sector facilitate the expansion of accessible kidney care and treatment? Would they partner with governments, or take on another option? What organizations would be most effective to utilize?
- How can public and/or private insurance systems be altered to include non-travel costs (e.g., travel, money lost due to time off of work, etc.) as well as the medical costs? Would they have to partner with an organization or NGO like the National Kidney Registry in the United States?
- How can sustainable funding models be developed for kidney transplantation and other replacement options in a way that doesn't overburden limited healthcare budgets? Would this include collaboration with NGOs or other organizations? Would this require change in the hospitals themselves through the use of new technology within the field of transplantation as a whole?

Topic B: **Unethical Organ Donation and Exploitation of Donors and Recipients:**

Problem Overview

Even if funding does improve for kidney care internationally, many nations still remain void of transplantation programs - kidney transplantation is currently a luxury for nations with higher GDPs which can afford to sustain such programs. Many vulnerable populations lack access to safe treatment options and resort to unethical organizations and private-for-profit organizations out of desperation. This creates consequences of more surgical complications, likelihood of rejection, and infections, which can cause serious morbidity and a higher risk of mortality [T].

As previously mentioned, transplant tourism refers to the practice of traveling abroad to receive a transplant due to the need for better care or care that is lacking in their country of origin. Due to the increase in desperate need for organ transplantation, it's said that organ trafficking accounts for up to 10% of transplants conducted internationally [V]. Moreover, the ratio of people on the transplant waiting list to donors is incredibly low. For instance, in 2009, over 105,000 individuals in the United States were on the waitlist, but fewer than 15,000 donors were available [W]. This necessitated people resort to transplant tourism due to the supply of donors within their nation not meeting the demand for healthy organs.

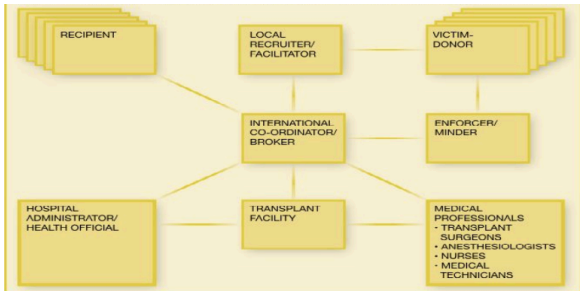


[W]

Unfortunately, transplant tourism is notorious for the uncertainty it holds regarding the source of the organs, adequate

post-transplant donor care, and success for the recipient [T]. Because it's known that the prospective donors and recipients are willing to pay any sum of money for transplantation, they are financially incentivized to exploit these individuals at the hands of transplant poverty, and they fall into this trap.

Impoverished donors within the host country are also at risk of exploitation. Because many impoverished individuals within nations are in nearly uncollectible debt, they sell their organs and tissues as a means of recovering that debt. However, the amount given to these donors is substantially less than what they're initially promised, subjecting them to a treatment for which they receive insufficient compensation and to which they ultimately didn't consent [U]. Wealthy individuals from developed nations tend to purchase the transplant out of desperate need and that money gets unethically spent in the process between going from the organ purchaser and seller. This vast criminal network includes an international coordinator, a local recruiter, and associated and compensated medical centers and professionals—all of whom are getting a cut of the money from the purchase. As a result, donors—commonly from impoverished, developing countries—get very little reimbursement for their service [V].



[X] *How actors involved in organ trafficking networks are all connected*

Furthermore, potential donors are sometimes coerced to compensate for and engage in uninformed treatment like nephrectomies—the removal of the kidneys—and get substandard medical care post-transplant [U]. This bypasses many regulations and ultimately crosses the line

into organ trafficking, or the removal of organs without proper consent or compensation, discouraging legitimate organ donation through medical institutions.

The lack of standardized oversight and medical care means that the treatment is done within an unregulated setting which results in only 1% of donors being in good health after the surgery. Without formal regulation and oversight, these networks put effort into ensuring the continuous cycle of organ transplantation, prioritizing profit and speed over proper medical care and the long-term health of both the donors and recipients. The policies of these organizations often entails the premature discharge of patients, which hinders the proper healing of the incision. This may produce potential surgical complications such as postoperative haemorrhage (infection of the scar), lung artery blockages, and many more. Because premature discharge is very likely, the thorough development and administration of immunosuppressant medication to a recipient isn't feasible, and acute organ rejection can occur. Along with that, infections such as fungal infections, HIV, and hepatitis B and C might occur, in addition to other general physical and mental health deterioration [U].

Study, country	*n*	Patient Survival (%) 1-Year, 5-Year	Comments
Tsai et al,[16] Taiwan	2518	95.8, 87.8	Overseas kidney transplant recipients were older, predominantly male, on dialysis for shorter period, and with more comorbidities
Al Rahbi et al,[17] Oman	106	Not reported	60% were male, with average age of 41.5 years; 13% objected to receiving an organ from a family member
Amira et al,[18] Nigeria	26	84.6, 41.7	73% were male, with mean age 40.5 years; majority of transplants performed in India; infectious complications in 42%
Al Salmi et al,[19] Oman	162	Not reported	Main destination was Pakistan; *Aspergillus* infections occurred in 8% of patients
Stewart et al,[20] USA	1	Patient well at 4 months	Case study of 61-year old Pakistani-American male who travelled to Pakistan for a kidney transplant; complicated by life-threatening necrotising kidney allograft infection

[U] *Characteristics and outcomes of transplant tourists for kidney transplantation*

Ultimately, the unethical organ donation and exploitation of donors and recipients not only violates human rights and jeopardizes the safety of vulnerable people, but also erodes the overall trust of global transplant and healthcare systems. These networks prioritize profit and efficacy over proper medical care and the well-being of patients, leading to the erroneous assumption that all transplant programs

operate similarly, further discouraging ethical organ donation. Health disparities are further promoted, and global health inequities advance more than ever, which potentially lead to higher morbidity, mortality, and more reliance on unsafe transplant practices.

Prior UN Involvement (WHO)

In 2004, the UN General Assembly (UNGA) published 59/156: one of its first resolutions condemning organ trafficking and urging states to do everything possible to combat such acts [Y]. In order to understand how to counter organ trafficking, on September 8, 2017, 71/322 was published to facilitate understanding of what the most effective and persuasive language would be in the following resolutions on ethics surrounding transplantation and trafficking [Z]. Resolution 75/195 (2020) reiterated the significance of nations congregating to prevent organ trafficking, and Resolution 76/186 (2021) strengthened international cooperation through urging states to enhance law enforcement and protection of victims [Y].

The resolutions prior had only constituted the pieces needed to fully formulate a plan for action. Therefore, on December 15, 2022, the UNGA adopted a new resolution known as 77/236. Within this resolution, the issue of organ trafficking is explicitly recognized as a violation of human rights that cannot be ignored, as it can produce dire health consequences. This resolution acknowledges that organ trafficking is typically motivated by a shortage of healthy and legally-donated organs and socioeconomic-related issues [Y]. This resolution proposes that nations implement and strictly enforce measures that explicitly work against organ trafficking through thorough investigation and prosecution of traffickers. Through coordinated global efforts by all Member States, legal loopholes and trafficking of

human organs are to be denounced by placing human rights at the center to prioritize protecting both vulnerable donors and recipients. This resolution stresses the need for legal frameworks to not only protect vulnerable individuals, but also assist survivors of organ trafficking [Y].

Path Forward

While the UNGA has produced critical and groundbreaking contributions, the commission must now step up and implement solutions. Before anything, CKD needs to be recognized as a Global Development Goals (SDGs), as it is expected to become the fifth greatest cause of death by 2050 [Q]. Despite Resolution 77/236 (2022) urging that nations implement specific measures to combat organ trafficking [Y], instead of promoting the notion of a shared goal for improving the greater well-being of humanity internationally through an SDG, WHO resolutions are simply providing ideas as opposed to active solutions.

Nations must unite and find feasible solutions to be implemented globally. Through directives and joint resolutions, this committee will be responsible for finding solutions to topics including economic disparities, global health equity, ethical organ donation and transplantation, and TT.

Some issues that this committee is encouraged to focus on are addressing economic disparities within organ transplantation, the protection of vulnerable populations in organ markets, the regulation and standardization of transplant tourism, policies on transplant tourism, policies for delegates' respective countries regarding funding and patient and donor financial support (e.g., National Kidney Foundation in the United States). Because organ trafficking develops due to a lack of support from host governments, the committee is also advised to investigate formerly mentioned agencies

to partner with the WHO to establish useful relations and support for programs being developed [U] In addition to that, existing UN frameworks and WHO resolutions can be expanded from simply increasing availability and ethical oversight to implementing solutions that contribute to the condemnation of organ trafficking and unethical donation as a whole. Strong enforcement and the alignment of domestic policies with international standards are absolutely necessary in order for Member States to directly implement these commitments in an impactful way. This committee must work together to develop solutions that utilize global networks and resources provided by the WHO.

Through negotiating with governments globally, UN relief programs, NGOs, and the private sector, this committee will have the means to create global frameworks and effective legislation that align with intentions of international lawmaking bodies and promote transparency, well-being, and safety of patients. As a specialized committee within the UN, this committee will have access to UN resources that can aid in coordinating and supporting the equitable implementation of resolutions. Ultimately, ensuring ethical kidney care requires a joint effort by all countries as opposed to one nation alone.

Questions to Consider

- How can governments around the world be incentivized to want to fund CKD and other treatment options? How can governments be discouraged from pocketing the money allocated toward funding such? Would consequences have to be instilled, or is there a better and more effective deterrent?
- What role could the WHO play in organizing feasible and ethical pathways to organ/kidney transplantation, especially within low- and lower-middle-income nations? Would the WHO serve as a supervisor and the Member States organize, or would the WHO take on a more administrative role in constructing a sustainable, accessible, and effective transplantation system?
- How could NGOs, international organizations, and the private sector facilitate the condemnation of unethical kidney transplantation? Would they partner with governments, or take on another option? What organizations would be most effective to utilize?
- How can sustainable pathways to ethical transplantation and care be developed in a way that doesn't overburden limited healthcare budgets? Would this include collaboration with NGOs or other organizations? Would this require change in the hospitals themselves through the use of new technology within the field of transplantation as a whole?

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