#studyguide

SC-19

COVID-19

#finalmun25

1.Letters

1.1 Letter from the Secretary General

Most distinguished participants,

It is with great enthusiasm and immense pride that I welcome you to the Final Model United Nations Conference 2025. I am deeply honored to serve as your Secretary General for this year's conference; an event that not only celebrates the spirit of diplomacy and international cooperation but also challenges us to think critically, lead confidently, and engage meaningfully with the complexities of our world.

Over the course of the next three days, you will step into the shoes of global leaders, tackle urgent international crises, and navigate the nuanced dynamics of negotiation and compromise. These experiences are not just exercises in diplomacy they are powerful lessons in empathy, problem-solving, and collaboration. Whether this is your first MUN or your tenth, our goal is to provide a welcoming and inclusive space where you can thrive, grow, and form unforgettable memories.

The FINALMUN'25 team is here to support you every step of the way. We are committed to ensuring that every delegate feels heard, respected, and empowered throughout the conference.

FINALMUN'25 is a space where friendships are forged, where perspectives are broadened, and where future changemakers take their first steps. On behalf of the entire Secretariat, I once again extend my warmest welcome to each and every one of you.

We are excited to witness the passion, creativity, and leadership you will bring to the committees. Let us make FINALMUN'25 a conference to remember.

**This committee holds a special place for me, which is why I personally took on the responsibility of preparing the study guide. I aimed to make it as detailed as possible, while also highlighting the key areas you should focus on. Wishing you all the best in your preparations.*

Yours sincerely,
Eylül İdil Orhan
Secretary General

1.2 Letter from the Director General

Dear everyone,

Welcome to FINALMUN 2025!

This conference means a lot to me, not just because it's our school's first-ever MUN, but because I get to be a part of it as the Director General. It feels a bit surreal, to be honest. When we started planning FINALMUN25 , we had one main goal in mind: creating a space where people could come together, challenge each other's ideas, and still enjoy every second of it. We wanted it to be something more than just formal sessions.

Every person who will join us every delegate, chair, press member, and guest is part of something we've dreamed about for a long time. And if you're reading this, it means you're part of that dream now, too. As long as you respect the boundaries we've set and follow the spirit of our rules, I'm sure you'll have a great time , maybe even better than you expect.

I genuinely can't wait to see you all in action. You've already been welcomed with lots of excitement (and yes, maybe a bit of nerves, too), and I really hope this conference becomes a memory you'll smile at later on.

See you at FINALMUN25!

Yours sincerely,
Melek Güner
Director General

1.3 Letter from the Under Secretary General

Dear Delegates,

I would like to start my speech by thanking the entire FINALMUN'25 team, especially İdil Orhan, who welcomed me among them, valued me and supported me even though I was not a Final Schools student.

We will have a unique experience by being together in the Special Committee for three days, both in the events and in the effective speeches in which you defend your countries.

I am waiting with the same excitement and curiosity as you. I hope that this experience will contribute to our educational lives and that it will leave beautiful memories in our memories for a long time. As the FINALMUN'25 team, we have planned an unforgettable three days for you, and I hope you will leave with beautiful memories.

You will not regret participating in FINALMUN'25.

Yours sincerely,
Özge Özçelik
Under Secretary General

2. Introduction to the Committee

2.1 Committee Overview

The SPECIAL Committee offers a unique simulation framework that reimagines international diplomatic reactions within a historical context. Centered on the early stages of the COVID-19 pandemic, the committee operates strictly within the temporal boundaries of the crisis's initial emergence. Required to act based solely on the information available at that time, reflecting the uncertainty, fragmented data, and limited global coordination that defined the period.

Unlike conventional MUN formats, this structure prioritizes real-time response mechanisms, transforming the decision-making process into a dynamic reflection of how diplomatic channels function under pressure. As the crisis unfolds, developments are assessed through the lens of the political, economic, and social priorities of the moment. Strategic deliberations must be conducted with minimal data, delayed communications, and evolving public health narratives, all of which challenge the coherence and effectiveness of international policy formation.

Decision-making is built on contextual realism, emphasizing the constraints that shaped institutional reactions during the pandemic. The committee traces the spectrum of international approaches, from isolated national strategies to delayed multilateral coordination efforts. Each measure taken within the simulation mirrors the complexity of governing through ambiguity, as COVID-19's global implications begin to surface amid uncertainty and strategic hesitation. In this framework, the SPECIAL Committee functions not merely as a platform for reenacting crisis scenarios but as an analytical space for reconstructing the architecture of historical decision-making. Through this lens, the committee provides a high-fidelity simulation of how diplomatic ecosystems respond to emergent global disruptions, with particular attention to the systemic challenges revealed by the pandemic's first wave.

2.2 Mandate and Scope

Committee's main goal is to analyze the political, economic, and social challenges caused by the COVID-19 pandemic and offer alternative solutions within the historical timeline. Each session is fixed to a certain date, and *discussions must be based only on what was known on* . Referring to events that happened later or making proposals based on future developments is not allowed, as it would break the timeline structure of the committee.

The mandate of the committee extends to various aspects of the pandemic, including public health, economic stability, education systems, and social cohesion. Delegates are encouraged to consider the broader implications of their decisions and collaborate with others to develop comprehensive solutions. The committee also emphasizes the importance of international cooperation and solidarity, recognizing that global challenges require collective action and shared responsibility.

2.3 Timeline Mechanism

One of the most important features of the committee is its timeline mechanism. Each session is connected to a specific crisis or turning point in history. Delegates can only use the data and *facts known on that date to make decisions or suggest actions*. Once the committee reaches a solution or a major conclusion about the crisis, the session ends and the committee moves forward to the next date in the timeline. Delegates *must not share information from the future or skip parts of history.* This approach helps maintain historical consistency and challenges delegates to think responsibly, creatively, and strategically under pressure.

The timeline mechanism is designed to simulate the dynamic nature of crisis management, where decisions must be made quickly and under uncertain conditions. By focusing on specific moments in history, delegates can gain insights into the factors that influence decision-making and the consequences of their actions. This process also highlights the importance of adaptability and resilience, as participants must navigate the complexities of evolving situations and respond to new challenges as they arise.

3. Agenda Item: COVID-19

3.1 Background of the Pandemic

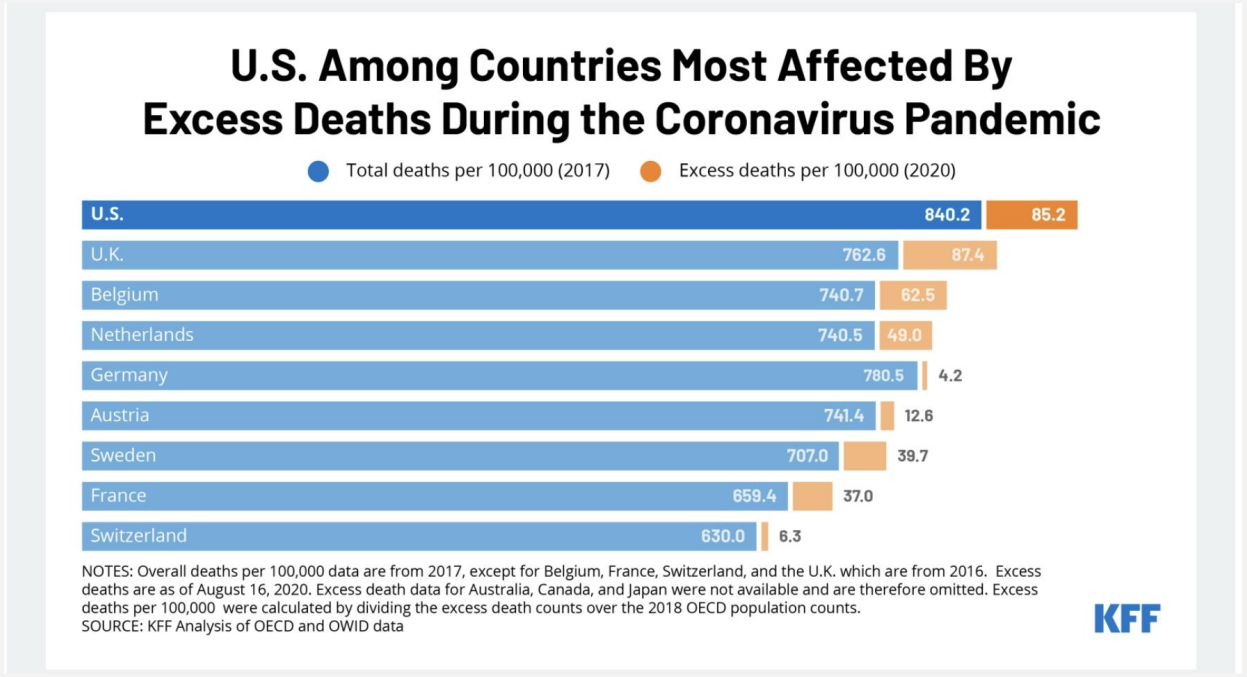
The COVID-19 pandemic stands as one of the most impactful global health crises of the modern era. First identified in December 2019 in Wuhan, China, the novel coronavirus (SARS-CoV-2) quickly spread across the globe, infecting millions. On March 11, 2020, the World Health Organization (WHO) officially declared COVID-19 a global pandemic.

This was not merely a health crisis; it profoundly disrupted political, economic, and social systems. In the early stages, many governments closed borders, imposed lockdowns, and had to rapidly reorganize their healthcare systems. In some countries, health infrastructure came dangerously close to collapse intensive care units were overwhelmed, ventilators were scarce, and healthcare workers faced extreme physical

and psychological exhaustion. There was also global controversy surrounding the origins of the virus debates about whether it was zoonotic or lab-based triggered geopolitical tensions and often hindered cooperation. These uncertainties exacerbated mistrust among nations and impacted the efficacy of a coordinated global response.

Between 2020 and 2022, there were over 650 million reported cases and more than 6.6 million deaths globally. However, experts believe the actual numbers may be significantly higher due to underreporting, lack of testing, and inconsistencies in data collection across regions. Global spread and case numbers:

- **First known case:** November 17, 2019, in Wuhan, China.
- **Pandemic declaration:** The World Health Organization (WHO) officially declared COVID-19 a global pandemic on March 11, 2020.
- **Total confirmed cases (as of April 2025):** 775,866,783 worldwide.
- **Total confirmed deaths:** 7,057,132 globally.
- **Estimated actual death toll (based on excess mortality):** Between 18 and 33 million.



3.2 Vaccine Development and Distribution

The development and distribution of COVID-19 vaccines marked an unprecedented milestone in global medical science. Within mere months of identifying the SARS-

CoV-2 virus, scientists across the globe mobilized to develop vaccines using a variety of technological platforms including mRNA, viral vector, protein subunit, and inactivated virus approaches. By the end of 2020, the first emergency-use

authorizations were granted, most notably to Pfizer-BioNTech and Moderna, whose mRNA vaccines became a symbol of scientific triumph. However, this monumental achievement in vaccine development was rapidly overshadowed by massive global disparities in distribution and access, which quickly became one of the defining ethical failures of the pandemic.

High-income countries, with their vast financial and political resources, negotiated advance purchase agreements (APAs) with pharmaceutical companies months before clinical trials were even completed. These agreements allowed them to pre-order and stockpile millions even billions of vaccine doses, often far exceeding the needs of their own populations. For example:

- **Canada** secured enough doses to vaccinate its population five times over.
- **The United States** and **European Union countries** placed large pre-orders and even invested directly in vaccine development (such as Operation Warp Speed in the U.S.).
- In contrast, many low-income countries were left at the back of the queue, unable to compete in a market dominated by wealth and geopolitical influence.

This aggressive early acquisition by wealthy nations often referred to as “vaccine hoarding” created a bottleneck in global supply chains, severely delaying vaccine access in large parts of the Global South. While rich countries began vaccinating their populations in early 2021, many poorer nations were still waiting for their first shipments well into 2022.

COVAX

To address these imbalances, the COVAX initiative co-led by the WHO, GAVI (Global Alliance for Vaccines and Immunization), and CEPI (Coalition for Epidemic Preparedness Innovations) was established. COVAX aimed to ensure equitable access to vaccines regardless of a country's income level, pledging to deliver at least 2 billion doses by the end of 2021, including enough to vaccinate 20% of every participating country's population. However, despite its noble goals, COVAX faced serious challenges:

- Wealthy countries often by passed COVAX and negotiated directly with manufacturers.

- Funding fell short of projections, and donor commitments were delayed or insufficient.

- Production setbacks (such as India's Serum Institute halting exports due to its domestic crisis) further limited global supply.

- As a result, COVAX had only delivered around 900 million doses by the end of 2021 less than half of its original target.

By mid-2021, the World Health Organization warned of a "catastrophic moral failure" if the global community failed to correct these inequities. WHO Director-General Dr. Tedros Adhanom Ghebreyesus criticized rich countries for "undermining global solidarity" and prolonging the pandemic by enabling new variants to emerge in unvaccinated populations.

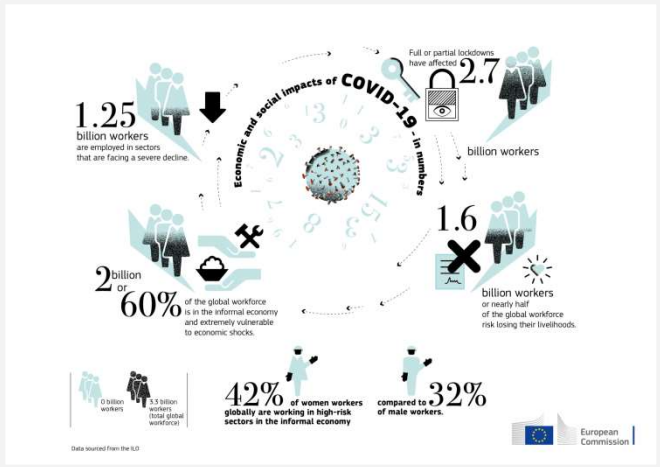
The unequal distribution of COVID-19 vaccines had deeply consequential effects on global public health and international relations. By mid-2022, vaccination rates in Sub-Saharan Africa remained below 10%, while high-income countries such as Germany, Israel, and the United Kingdom had already reached first-dose coverage rates exceeding 70% as early as the first half of 2021. In some of the world's most vulnerable nations, including Haiti, Chad, and South Sudan, less than 5% of the population had been vaccinated well into the third year of the pandemic. This stark contrast reflected not only economic disparities but also deep-rooted systemic inequities in global health infrastructure. These imbalances had a ripple effect across the world. Regions with low vaccination coverage became fertile ground for the virus to spread unchecked, increasing the likelihood of mutations. It was under such circumstances that dangerous variants like Delta and Omicron emerged variants that would eventually reach and affect even the most vaccinated populations, undermining global progress and prolonging the crisis.

Moreover, the vaccine divide exacerbated existing geopolitical tensions. As Western countries focused on securing additional doses for their own populations, countries like China and Russia stepped in with so called "vaccine diplomacy," supplying vaccines to low- and middle-income countries in exchange for strategic alliances and regional influence. This use of vaccines as diplomatic currency highlighted the ways in which global health tools were employed not merely as humanitarian aid but also as instruments of soft power. Even within countries that had sufficient vaccine supply, distribution was often uneven and riddled with social inequalities. In rural and remote regions, access to vaccines was limited due to underdeveloped infrastructure and

logistical challenges. al polarization, and weakened public confidence in health authorities.

3.3 Socioeconomic Impact

COVID-19 pandemic introduced not just a public health threat but also one of history's biggest global social as well as economic dislocations. The global gross domestic product (GDP) dropped in 2020 by an estimated 3.1%, which was the biggest global economic contraction after the Second World War. The decline was because of the shutdown in global value chains, drop in demand for commodities, drop in production, and near total shutdown in most crucial industries such as tourism, aviation, and hospitality. Among the most immediate and global socio-economic impacts was an acute spike in unemployment and loss of income. As the International Labour Organization (ILO) estimated, 255 million jobs were reduced or lost in 2020. More seasonal, informal



work, migrant workers, and small enterprises were usually most hit. Women took an added penalty in the pandemic particularly not just because female employment is in enormously disproportionate numbers concentrated in service sectors, but because unpaid home care and home work volumes ballooned enormously in school closures and lockdowns.These rendered national as well as global income inequality much worse. As far as higher-income segments worked largely from home and still financially held on to their grasps, lower-income segments could not afford to hold on to holding on to working at all or worked in hazardous environments without protection and benefits.

The twin fact in such a manner exacerbated and concretized prevailing class inequalities. Moreover, those without proper internet or infrastructure were left even further behind even in even basic services such as e-education and e-health, effectively making digital inequality an amplifier for economic injustices. As estimated by the United Nations Development Programme (UNDP), the pandemic drove over 100 million back into extreme poverty, erasing progress in poverty reduction made over years. The pandemic hit lower- and middle-income nations hard, making them even more financially vulnerable, causing depreciation in their exchange

rates, increased debt, and inflation. The global price surge in food further worsened hunger and malnutrition, particularly in areas that were hit hard in humanitarian terms.

World governments responded to such effects in the form of fiscal stimulus packages as well as social protection policies. Rent holidays, wage subsidies, transfer payments direct, relief in taxation, and relief distribution of food were some. Coverage as well as effectiveness, though, largely depended on the capacity of an economy in a nation. Germany, for example, initiated a recovery package for close to 10% of the GDP, but most African nations could not even offer minuscule relief because they did not possess much in public finance and external debt liabilities. The socio-economic impacts of COVID-19 extended well beyond short-term shocks, but rather emphasized long-term structural weaknesses. Education, healthcare, social security, and labor market inadequacies were in sharp relief and, in a sense, further entrenched. Unless conscious policy shift, as well as international cooperation, takes place, the pandemic can potentially bequeath a legacy in increased inequality and foregone development potential in the near term.

3.4 Educational Distribution and Digital Divide

By mid-2020, an estimated 1.6 billion students — about 90% of all the students on the planet had been denied face-to-face contact. The damage was much deeper than an academic loss in school; their sociability, their mental, even their physical safety were all harmed. Governments swiftly shifted to e-education systems right away. The change, though, raised humongous barriers in front of the students residing in localities where the communicative infrastructure is not so effective. The communicative gap stalled the very fundamental notion of equal opportunity in education. Students born in economically weak families could no longer proceed further in their education because either they did not possess internet facilities or even as fundamental electronic appliances as a computer, tablet, or smartphone.

As an illustration, in Sub-Saharan Africa, as few as 20% of pupils could potentially access the web at home, while in South Asia, even less than 40% could. Even in middle-income nations such as Turkiye rural or larger-family students were not even able to access daily web-based lessons. Oftentimes, students would need to be sharing a device between an unspecified number of siblings or be using TV-based distance education with very limited interactivity. Not very unexpectedly, such ICT inequality was less about technique. Digital literacy on the teacher's side, parents' education, and students' capacity for self-study affected the performance of distance education significantly as well. Most teachers were abruptly thrown into new e-locations without orientation, syllabi were condensed, and normal assessment practices were delayed, redesigned, or abolished. The social protection function school serves as a nexus

where children are able to be in a protected place, be fed, and be sheltered from abuse was removed as well when school closed. The lack of in-school education was most disruptive for high-risk groups such as children with special needs, children witnessing domestic violence in the home, and children for whom school lunches are mostly their nutrition. Massive school closures brought about much loss in knowledge, steep declines in motivation, and increased drop-out rates, most notably in disadvantaged areas. The children in poorer families fell even further behind in school, further aggravating intergenerational pass-throughs in inequality.

Briefly, the pandemic brought stark clarity that education's revolution is irreversibly digital but, unless adopted on an equal inclusive basis, such changes risk generating new and larger gaps.

- **Sub-Saharan Africa:** Only 20% of students have internet access at home.
- **South Asia** (e.g., India): Roughly 39% of households lack proper digital devices for children's remote education.
- **Brazil:** About 45% of students in rural areas had no access to online education during the pandemic.
- **Turkiye:** While 85% of urban students had access to remote learning, this rate fell to below 60% in rural regions.
- **United States:** Around 35% of students from low-income families lacked consistent access to remote learning tools during the first year of the pandemic.

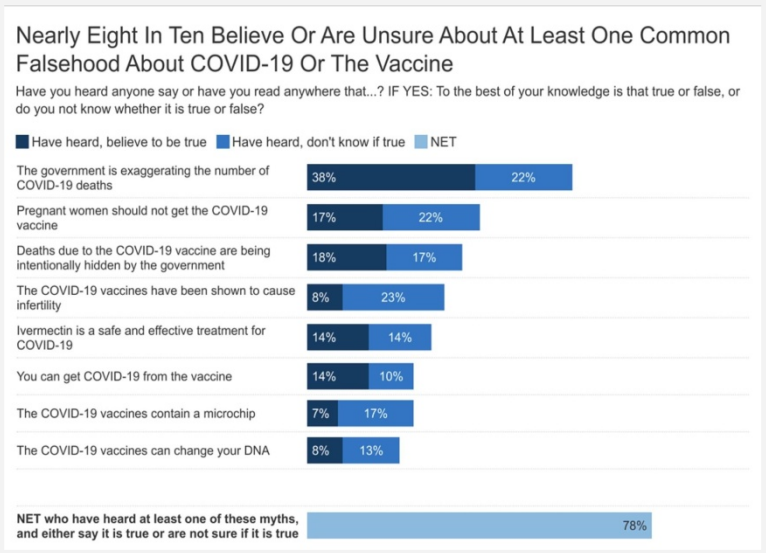
3.5 Misinformation and Public Trust

From the earliest days of the outbreak, false, misleading, and deliberately manipulated content spread rapidly through social media platforms and other digital channels, undermining public health efforts, eroding trust in science, and shaping individual behaviors in harmful ways. The World Health Organization (WHO) described this phenomenon as an "infodemic" an overabundance of information, both accurate and not, that makes it difficult for people to find trustworthy guidance. Misinformation emerged in many forms. Some narratives focused on conspiracy theories about the origin of the virus, while others falsely claimed that masks were harmful or that vaccines caused infertility, inserted microchips, or were part of government-led population control schemes. These baseless claims went viral, especially on platforms like WhatsApp, Facebook, YouTube, and TikTok, reaching millions of users in a matter of hours.

Beyond individual content, the public's trust in institutions was further shaken by conflicting or unclear messaging from government officials and health authorities. In some countries, leaders downplayed the seriousness of the virus, implemented

inconsistent restrictions, or failed to provide transparent data all of which contributed to skepticism and confusion. Mixed signals about vaccine side effects, contradictory statements between health agencies, and decisions perceived to prioritize economic concerns over public health deepened the sense of uncertainty among citizens. One of the most harmful outcomes of misinformation was its impact on vaccination campaigns. In many regions, false claims and distrust led to a rise in vaccine hesitancy and, in some cases, outright vaccine refusal. These trends were fueled by a combination of religious beliefs, historical injustices (such as medical exploitation during colonial times), and intense political polarization. Minority communities, in particular, often showed lower vaccination rates due to long-standing mistrust of medical authorities, even when vaccines were readily available.

Social media algorithms further amplified the problem by reinforcing confirmation bias users were shown content that aligned with their existing beliefs, making it even harder to break the cycle of disinformation.



As a result, rational, science-based discourse was drowned out by fear-driven narratives, and public health messaging struggled to reach those most at risk. The consequences were not theoretical. Misinformation led to widespread non-compliance with basic safety measures such as mask-wearing, social distancing, and testing. Most critically, it delayed or prevented vaccine uptake in many communities, prolonging the pandemic and allowing dangerous new variants to emerge. In some countries, mistrust escalated into protests, civil unrest, and even violence against health workers and government officials. The COVID-19 crisis has underscored a crucial reality: access to reliable information is a public health necessity. Rebuilding public trust requires consistent, transparent, and timely communication from state institutions and scientific bodies. It also demands greater investment in media literacy, responsible regulation of digital platforms, and more robust efforts to counter false narratives before they take hold. Ultimately, the pandemic tested not just the resilience of healthcare systems, but also the strength of our information ecosystems. Moving forward, reinforcing the credibility of science and rebuilding trust in public institutions will be essential to ensuring that future global crises do not become informational disasters as well.

According to a 2021 WHO survey, nearly 60% of respondents in low- and middle-income countries reported encountering misinformation about COVID-19 on social media platforms.

- **In the United States**, a study by the Kaiser Family Foundation (KFF) found that 78% of adults had heard at least one false statement about COVID-19 and that nearly one-third believed at least one of these to be true.
- **In France**, data from the Ipsos Global Advisor 2021 poll showed that one in four people believed COVID-19 vaccines could alter DNA an entirely false claim that spread rapidly online.
- **In India**, a joint study by Microsoft and Reuters revealed that more than 30% of COVID-related messages on WhatsApp contained misleading or unverified information.
- A report by UNESCO found that misinformation contributed to increased vaccine hesitancy in over 70 countries, with significant impact in regions already struggling with institutional trust.
- Globally, anti-vaccine Facebook groups saw a 400% increase in membership between March and December 2020, despite efforts by the platform to limit their reach.
- **In Nigeria**, a UNICEF report showed that 45% of parents who refused COVID-19 vaccines for their children cited false information as their primary reason.

3.6 Global Health Response

COVID-19 was the most universal and most significant global health emergency in recent history. Not just did the pandemic put the healthcare system under stress, the pandemic itself tested the international morality for global collaboration and the extent for global solidarity. During the pandemic response phase at the start, governments swiftly went national and implemented protectionism policies for essential items like personal protection equipment and ventilators. This cemented the reality that regardless of the nature of the pandemic itself as an international threat, the responses were nationalistic. Pandemic subjected unbearable pressure upon weak health systems, most specifically in low-resource countries, wherein death rates were skyrocketing and routine utilization of primary care was suspended. Non-communicable disease (such as diabetes or hypertension) care was suspended largely, hospital infrastructures were swamped, and prevention strategies were suspended. Psychiatric epidemics reached a peak across the globe, and elderly people were at heightened risks due to isolation and deteriorating service.

World Health Organization (WHO)

As the condition further worsened, WHO declared COVID-19 as a "Public Health Emergency of International Concern" in January 2020. While the announcement was with the intention for collective response, the majority of the countries disregarded WHO's advisory or postponed responding on the same. All these were guided by WHO in sharing scientific information, monitoring variants, informing the public, and preparing and drafting strategic response plans. One single most important plan was the COVAX plan, an arrangement for equitable distribution of vaccine doses, predominantly for low- and middle-income countries. A great idea on paper, COVAX was faced with serious logistics and financial issues. By mid-2021, the high-income countries were rolling out third and fourth doses, and in the entire Sub-Saharan Africa region, vaccine coverage was below 10%.

To put this into perspective, low-income countries like Germany, Canada, and Japan had reached over 70% first-dose coverage by mid-2021, and Haiti, Chad, and South Sudan were below 5%. This inequality was not merely the failure of morality but the failure of biology. Low vaccination rates created unregulated spread, speeding the development of new strains like Delta and Omicron. These new strains went on to spread within highly vaccinated populations, punctuating the interconnected nature of global health. WHO itself was criticized for weak powers and enforcement abilities too. Some countries stalled or pretended reports for data and diluted international monitoring. Delays in transparency by China at the beginning of the epidemic and politicization thereafter contributed to the loss of trust in the WHO and demands for reform for expanding the independence and abilities of the WHO.

Wherever WHO was ahead at the international level, subregional institutions like the Africa CDC and the European Centre for Disease Prevention and Control (ECDC) filled the local role at the level of informing responses. Poor countries were still largely dependent upon external help. While low-income countries were accorded financial assistance through the IMF and the World Bank, disbursals were slow and bureaucratic procedural matters ensured that assistance was held back for the most vulnerable. Moreover, the pandemic was made a geopolitical tool. There was "vaccine diplomacy" wherein the Sinovac and Sinopharm vaccines were exported by the PRC to its most important partners in Asia and Africa. Russia did the same with the Sputnik V vaccine. This strategy manifested the manner health emergencies could intersect with the shifting distribution of international power and the competition for soft power. As the pandemic was speeding further, national-level domestic production was the need. South African and African nations like Egypt and Senegal, and South American nations like Brazil and Argentina went for indigenous production. But the

pace was sluggish because the transfer of technology was unsuccessful and the regimes for patented medicines were closed.

3.7 Overall

The COVID-19 pandemic not only challenged global health systems but also exposed deep-rooted structural inequalities in nearly every aspect of modern life. From vaccine access to educational disruption, and from socioeconomic damage to the erosion of public trust, the crisis magnified vulnerabilities across the world. While scientific advancements like rapid vaccine development represented historic achievements, their uneven distribution revealed the ongoing imbalance between wealth and need. Meanwhile, misinformation spread faster than the virus itself, undermining public health efforts and trust in institutions. The global response though marked by moments of solidarity was often fragmented and reactive, pointing to the urgent need for reform in international health governance. Addressing these gaps is not just a matter of preparedness for future pandemics, but a moral imperative for ensuring a more equitable and resilient global society.

4. Timeline

4.1 January 2020 - Uncertainty and the First Alarm Signals

In January 2020, the world began to hear alarming news from Wuhan, China, about a series of pneumonia-like cases with no clear cause. By early January, Chinese scientists had identified a novel coronavirus as the agent, and on January 30, the World Health Organization (WHO) declared the outbreak a Public Health Emergency of International Concern (PHEIC). At this point, nearly 10,000 cases and about 200 deaths had been reported, but the real figures were likely higher due to limited testing capacity and delayed reporting. The most important feature of this period was uncertainty. The world did not yet know whether this virus spread mainly through droplets, surfaces, or aerosols; whether masks were necessary for the public; or what the fatality rate was. Some countries like Taiwan, South Korea, and Singapore acted quickly with border controls, testing, and contact tracing. Others, particularly in Europe and North America, hesitated, believing that the outbreak might be contained within Asia. This hesitation allowed undetected community transmission to spread silently.

At the same time, information transparency became a global controversy. Chinese authorities were accused of underreporting cases during the first weeks, which created mistrust and slowed down international preparation. The silencing of doctors like Dr. Li Wenliang, who tried to warn colleagues about the mysterious virus, became symbolic of this early communication failure.

4.2 June 2020 - The Economic and Social Costs of the First Major Lockdowns

By June 2020, the world had reported nearly 7 million confirmed cases and more than 400,000 deaths. After the massive wave of lockdowns in March and April, societies began to feel the deep consequences. Streets were empty, businesses shuttered, and entire industries ground to a halt.The economic impact was catastrophic. The International Labour Organization estimated a global loss of 400 million full-time jobs in the second quarter of 2020. Global labor income dropped by about 10% (3.5 trillion USD). Tourism and aviation collapsed almost entirely; airlines reported revenue declines of over 60%, while many small businesses permanently closed. In low-income nations, informal workers, street vendors, day laborers, and domestic workers, lost nearly all sources of income overnight. The World Bank calculated that in 2020 alone, 119 million people fell into extreme poverty, erasing decades of progress. The educational crisis was equally severe. With schools closed, 1.5 billion learners in over 190 countries were affected. Online education became the default, but inequalities in digital access quickly appeared.

In sub-Saharan Africa, fewer than 20% of households had internet access, while in Europe this figure exceeded 90%. Girls were disproportionately affected, with rising risks of early marriage and child labor as families struggled financially. The social dimension was also dramatic. Lockdowns increased domestic violence cases; UN Women reported that helplines in some countries saw a 30–40% surge in calls from women seeking help. Mental health issues also escalated, as isolation and financial stress triggered widespread anxiety and depression.

4.3 November 2020 - The Second Wave and the Collapse of Health Systems

By November 2020, the global tally had crossed 60 million cases and 1.4 million deaths. After a summer of relative calm in some regions, the colder months triggered a devastating second wave. In the United States, daily new cases surpassed 200,000. In Europe, countries like Italy, France, and the UK reported overwhelmed hospitals, recalling the chaos of the first wave. Health systems buckled under pressure. Intensive care units filled rapidly, forcing hospitals to set up temporary wards in stadiums and tents. Healthcare workers, who had already endured months of exhausting shifts, now faced extreme burnout. A Lancet study later revealed that nearly one in five healthcare workers suffered anxiety or depression during this period. In some places, suicide rates among medical staff rose alarmingly.

Beyond COVID-19 patients, millions of others were left untreated. Cancer screenings dropped by up to 90% in some countries, routine vaccinations for children were delayed, and elective surgeries were postponed indefinitely. These disruptions created what experts call a "shadow pandemic" of untreated illnesses. Politically, governments faced backlash. Citizens questioned why hospitals were so fragile despite months of preparation. In some nations, protests erupted against renewed lockdowns. This period exposed the structural weaknesses of healthcare systems, the lack of surge capacity, and the failure of global solidarity in sharing resources like ventilators and PPE.

4.4 February 2021 - The Beginning of Vaccines and Unequal Distribution

The year 2021 began with hope. Vaccines such as *Pfizer-BioNTech, Moderna, and AstraZeneca* were rolled out, and by February, over 150 million doses had been administered worldwide. But this hope quickly revealed a darker reality: vaccines were not being shared fairly. High-income countries secured the vast majority of supplies. The United States, the UK, and the European Union signed contracts for billions of doses enough to cover their populations multiple times. Canada had purchased enough vaccines to immunize its citizens five times over. Meanwhile, many African and South Asian countries had not received a single dose. WHO Director-General Dr. Tedros Adhanom Ghebreyesus warned of a "catastrophic moral failure" if vaccine equity was ignored.

COVAX, the international initiative designed to ensure fair distribution, struggled with supply shortages and logistical barriers. By mid-February, 75% of all administered vaccines had gone to just 10 countries, while the poorest nations were left waiting.

4.5 August 2021 - The Delta Variant and Rising Global Fear

By August 2021, global cases surpassed 200 million, and deaths exceeded 4.3 million. The Delta variant, first identified in India, spread rapidly to more than 130 countries and became the dominant strain worldwide. Delta was more contagious than earlier strains and caused more severe illness, even in younger populations. Delta exposed the dangers of uneven vaccination coverage. Countries with high vaccination rates, such as the UK and Israel, saw rising infections but relatively fewer hospitalizations. By contrast, regions with low vaccination including parts of Africa, Latin America, and Southeast Asia experienced devastating surges.

In the U.S., counties with low vaccination rates saw death rates seven times higher than highly vaccinated ones.

Another major issue was vaccine hesitancy. Misinformation campaigns on social media led millions to refuse vaccination. In some places, protests against mandates turned violent. As a result, even where vaccines were available, herd immunity targets could not be reached. Economically, governments faced a dilemma: reopen economies to recover from the earlier shocks, or reimpose restrictions to control Delta? Many countries tried hybrid approaches, leading to public confusion and anger.

4.6 November 2021 - The Omicron Variant and Pandemic Fatigue

In November 2021, South African scientists detected the Omicron variant. With over 30 spike protein mutations, it spread faster than any previous variant. Within weeks, Omicron dominated global infections. Governments reacted swiftly with travel bans and border closures, but this response was controversial. Many African leaders condemned these bans as punitive, arguing that countries should not be punished for detecting and reporting new variants. This raised an important ethical question: would countries be less likely to share data in the future if transparency resulted in economic penalties?

Meanwhile, societies faced pandemic fatigue. After nearly two years of restrictions, people were exhausted. Protests erupted in Europe against lockdowns and vaccine mandates. Trust in governments declined as citizens questioned the effectiveness of constantly changing policies.

4.7 February 2022 - Post-Pandemic Recovery and the Road to Normalcy

By February 2022, more than 10 billion vaccine doses had been administered globally. In high-income countries, over 70% of the population had received at least one dose, while in low-income countries the rate remained below 10%. This stark inequality prevented the complete suppression of the virus and left room for new variants to emerge. Nevertheless, governments began discussing the transition to normalcy. Europe started lifting restrictions, schools reopened, workplaces resumed, and international travel cautiously expanded. Stock markets and global trade showed signs of recovery, though the scars of the pandemic unemployment, inflation, and supply chain disruptions persisted.

The education sector grappled with unprecedented learning losses. UNESCO estimated that students worldwide had lost the equivalent of a full academic year, with disadvantaged groups suffering the most. Governments debated how to invest in

catch-up programs, digital infrastructure, and teacher training.Healthcare systems also entered a new phase: recovering from the burden of untreated diseases, while preparing for potential future outbreaks. Policymakers recognized that without structural reforms, the next pandemic could be even more destructive.

5. Key Country Roles

United States

During the first wave, the United States was one of the countries most severely affected in terms of cases and deaths. In densely populated cities, the virus spread rapidly, and the healthcare system in some regions became heavily strained. Particularly, low-income and uninsured individuals struggled to access treatment. Hospitals exceeded intensive care capacity, and healthcare workers faced long shifts and extreme stress.

Case numbers surged in March–April 2020, and the second wave in winter struck the country severely. Through Operation Warp Speed, Pfizer and Moderna vaccines were developed and vaccination began in December 2020. Although the vaccination program progressed quickly, political polarization caused inconsistencies in mask mandates, social distancing, and public compliance. Economically, unemployment reached 14% in April, and small businesses suffered significant losses.

United Kingdom

The United Kingdom experienced particularly high death rates among the elderly and care home residents during the first wave. In major cities like London, hospitals struggled with limited intensive care beds. Regional lockdowns were implemented after the initial waves.

The development of the Oxford-AstraZeneca vaccine made the UK a leader in vaccine production. Mass vaccination began in December 2020. However, case numbers rose again during the winter, and the service sector faced severe economic impacts. Millions of students shifted to online learning, exposing social inequalities.

China

As the initial epicenter, Wuhan and other provinces in China implemented strict lockdowns from January 2020. Cities were isolated, public transportation halted, and millions were confined to their homes. Early case numbers rose rapidly but were largely controlled by February through strict measures. China developed Sinovac and Sinopharm vaccines and exported them to low- and middle-income countries. It became a global center for masks and personal protective equipment production. Early

delays in reporting and incomplete data caused international trust issues. City lockdowns significantly slowed economic activity, disrupting production and logistics chains.

Russia

Russia developed the Sputnik-V vaccine, one of the first COVID-19 vaccines approved for emergency use globally. It was produced both for domestic use and for export to Latin America, the Middle East, and Africa. Case numbers surged in densely populated areas. Vaccine hesitancy slowed the vaccination program. Intensive care units reached capacity, and shortages of oxygen and medications occurred. Economic impacts included declines in industry and service production.

Germany

Germany managed the first waves relatively well thanks to its strong healthcare system and intensive care capacity. BioNTech, in partnership with Pfizer, developed one of the first highly effective mRNA vaccines, approved in December 2020. Germany coordinated vaccine distribution and pandemic policies within the European Union. Social measures and testing remained at high levels. Economically, industrial and export sectors were prioritized for recovery, and unemployment rates remained lower than in other major European countries.

France

France experienced multiple waves, especially in cities like Paris and Lyon. Intensive care units were overwhelmed, and temporary hospital facilities were established. Deaths reached high levels during the first wave. France contributed to vaccine research and supported the COVAX program. Strict lockdown measures were enforced, including curfews, closures of restaurants, and cultural event restrictions. Economic losses were concentrated in the service and tourism sectors.

Japan

Japan faced unique challenges due to its large elderly population. During the first waves, case numbers remained relatively low, but the postponement of the Tokyo 2020 Olympics sparked national and international debates. Testing, contact tracing, local quarantines, and social compliance measures were implemented. Economic slowdown affected tourism and service industries. The healthcare system functioned effectively, although some regions experienced capacity shortages.

Italy

Italy was the first European country heavily impacted by COVID-19. Lombardy faced an overwhelming case load, and hospitals approached collapse. Intensive care beds were insufficient, and healthcare workers were overworked. Death rates were especially high among the elderly during the first wave. Strict quarantine measures were implemented, and cities and regions were isolated. Economic effects were severe, especially in tourism and manufacturing. Italy's early experience served as a warning for other European countries and highlighted lessons in healthcare preparedness.

India

India faced extreme challenges due to its massive population and densely populated cities, especially during the second wave in 2021 fueled by the Delta variant. Hospital beds, oxygen, and medical supplies were insufficient. At the same time, India produced millions of vaccine doses for domestic use and international distribution to low- and middle-income countries. Economic impacts included widespread unemployment and production losses.

Brazil

Brazil was the most severely affected country in Latin America. Case numbers and deaths were extremely high, and the healthcare system faced severe strain. Hospitals in some states were completely overwhelmed, with shortages of critical medicines and equipment. Political conflicts and inconsistent messaging complicated public compliance with pandemic measures. Economic losses were most pronounced in the service and agricultural sectors. Vaccination programs gained momentum in the second half of 2021, but the effects of the pandemic continued to be felt for a long time.

South Africa

South Africa faced significant challenges during the pandemic, with early cases concentrated in urban centers like Johannesburg and Cape Town. The healthcare system struggled with limited intensive care units and a high prevalence of other infectious diseases such as HIV and tuberculosis, complicating patient management. Social inequalities became more apparent as low-income communities had reduced access to medical care and protective equipment. Lockdowns disrupted the informal economy, leaving many without income, while school closures affected millions of students with limited online learning access. The country also became a key source of

data for global health organizations when the Omicron variant was first identified, highlighting both its vulnerabilities and its importance in international monitoring.

Türkiye

Türkiye experienced multiple waves of infection, with high case numbers in major cities such as Istanbul, Ankara, and Izmir. Hospitals faced capacity issues, particularly intensive care units, while healthcare workers were under extreme pressure. The government implemented strict lockdowns, curfews, and travel restrictions to curb the spread of the virus. Economic activity was disrupted, especially in tourism, retail, and small businesses, affecting millions of workers. School closures forced rapid adaptation to online learning, revealing digital inequalities among students. Local vaccine development efforts began alongside participation in global vaccination programs. Türkiye's geographic location also made it a bridge for regional cooperation and vaccine distribution in Europe and the Middle East.

Mexico

Mexico was heavily affected by high infection and death rates, particularly in Mexico City and other densely populated regions. Hospitals struggled with insufficient ICU beds and shortages of oxygen and medications. Socio-economic disparities were exacerbated, as lower-income populations faced higher exposure risks and limited access to care. School closures disrupted education for millions of students, many of whom lacked reliable internet or digital devices. The government implemented a mix of partial lockdowns, curfews, and public health campaigns, while economic relief efforts attempted to support workers and small businesses. Public trust and communication challenges affected compliance with health measures, creating additional complications for pandemic management.

Iran

Iran confronted the pandemic under challenging circumstances, including international sanctions that restricted access to medical supplies and vaccines. Hospitals in major cities such as Tehran and Mashhad were overwhelmed during peak waves, with shortages of oxygen, ICU beds, and personal protective equipment. Social distancing and lockdown measures were inconsistently enforced due to economic pressures and political tensions. Educational institutions shifted to online platforms, but students faced difficulties due to limited digital infrastructure. The government coordinated vaccination campaigns with both domestic and imported vaccines, aiming to reach vulnerable populations despite logistical and supply chain challenges.

Spain

Spain was among the European countries most severely impacted during the first wave, especially in Madrid and Catalonia. Hospitals faced critical shortages of ICU beds, ventilators, and healthcare personnel, leading to emergency field hospitals and temporary treatment facilities. Mortality rates were high, particularly among elderly populations in care homes. Lockdowns and mobility restrictions were strictly enforced, while schools and universities moved to online education, creating challenges for students without reliable access to technology. The economic impact was profound, with the tourism-dependent regions suffering significant losses and rising unemployment. Spain also contributed data and expertise to European collaborative efforts in pandemic management and vaccine distribution.

Nepal

Nepal faced significant challenges during the pandemic due to its mountainous and rural geography, which limited healthcare access primarily to urban areas, while hospitals and intensive care units were insufficient to manage severe COVID-19 cases. Limited digital infrastructure made online education nearly impossible for most students, leading to major learning disruptions. Economically, tourism and agriculture were severely affected, with many families in rural areas struggling to make a living. Social isolation combined with economic hardship caused increased psychological stress in communities already vulnerable to health and social inequities.

Kenya

Kenya experienced rapid COVID-19 spread in urban centers while rural areas suffered from limited healthcare access. Hospitals had critical shortages of oxygen and intensive care equipment. Although the government implemented lockdowns and movement restrictions, compliance was challenging due to economic necessities. Schools remained closed for extended periods, and online education was largely inaccessible, deepening educational inequality. Urban low-income communities and rural families faced both economic and healthcare vulnerabilities, and psychological stress rose due to uncertainty and social isolation.

Bangladesh

Bangladesh, with its high population density and limited health infrastructure, was exposed to fast virus transmission. Intensive care beds and oxygen supplies were critically low. Lockdowns and social distancing were difficult to enforce, especially among the working class and informal economy workers. School closures left millions of students without education, with digital infrastructure shortages exacerbating

learning loss. Economic hardship increased, while social isolation and uncertainty heightened psychological stress across communities.

Haiti

Haiti's fragile healthcare system and limited resources made the country highly vulnerable to the pandemic's effects. Hospitals and clinics struggled to handle surges in cases, especially in the capital Port-au-Prince and other densely populated areas. Lockdown measures were attempted but largely ineffective due to economic necessity. Education was severely disrupted, with virtually no access to online learning. Social and psychological impacts combined with poverty and uncertainty, intensifying community stress and vulnerability.

Afghanistan

Afghanistan was extremely vulnerable to COVID-19 due to long-standing political and economic instability. Hospital capacity was very limited, and basic healthcare services were insufficient in many regions. Quarantine and social distancing measures were almost impossible to enforce in rural and conflict-affected areas. Education was severely disrupted, particularly for girls and rural students who could not access online learning. Economic losses and social restrictions compounded psychological stress and societal tensions, deepening the health crisis and exposing communities to multiple risks simultaneously.

6. Tips for Delegates

When participating in the Special COVID-19 Committee, it is essential to approach each discussion as if you are living in that exact moment of the timeline. Delegates must make decisions and proposals based solely on the information, resources, and circumstances available at that particular point in time. This means avoiding any knowledge of events that occur later in the pandemic, even if you are aware of them historically. Treat every session as a snapshot of reality during that specific period. Understanding this temporal focus ensures that debates remain realistic, urgent, and grounded in the context of the moment, reflecting the intense and immediate decision-making that was required during the pandemic.

COVID-19 is a truly global crisis, affecting countries and populations across every continent, making this United Nations meeting highly urgent, action-oriented, and decision-driven. Delegates are expected to respond to immediate challenges with practical solutions rather than theoretical or retrospective arguments. Memorizing the timeline and understanding the circumstances of each stage of the pandemic will allow delegates to anticipate problems, propose realistic interventions, and negotiate effectively with other nations. Each timeline moment contains its own unique challenges, and delegates should immerse themselves fully in the scenario as if it were unfolding in real time. It is critical to remember that the consequences of COVID-19 extend far beyond public health. While controlling the virus and addressing medical emergencies are primary concerns, the pandemic also triggered profound disruptions in education, social structures, economies, and psychological well-being. School closures left millions of students without access to learning, exacerbating existing inequalities and affecting the futures of entire generations. Social isolation, economic stress, job losses, and the fear of illness contributed to widespread psychological distress, affecting not only individuals but families and communities. Delegates must consider these multidimensional impacts when crafting solutions, ensuring that their proposals address health, education, economic stability, and mental well-being in a coordinated manner.

Problem-solving and creativity are essential. Delegates should analyze each timeline moment with a focus on identifying key problems and implementing feasible solutions. For instance, when case numbers rise rapidly, what measures can be enacted immediately to prevent healthcare systems from being overwhelmed? When schools close, how can countries maintain educational continuity and minimize long-term learning losses? How can mental health support be mobilized effectively to help populations cope with anxiety, isolation, and trauma? How can resources such as vaccines, medical equipment, and personal protective gear be distributed equitably, especially to countries or regions most in need? Each question should be addressed

considering both national capacities and opportunities for international cooperation. Collaboration and communication are vital. Although every country has its own priorities and limitations, understanding that COVID-19 is a shared global challenge allows delegates to propose solutions that are both practical and cooperative. Negotiation skills, clarity in expressing national constraints, and the ability to form strategic alliances can determine the success of any intervention. Delegates should strive to balance national interests with the broader needs of the international community, recognizing that pandemic response is most effective when countries act together rather than in isolation.

Attention to detail and data is equally important. Delegates should familiarize themselves with the specific statistics and facts relevant to each timeline period, including infection and mortality rates, healthcare capacity, vaccine availability, school closures, economic indicators, and the prevalence of social or psychological issues. Using accurate data strengthens arguments, lends credibility to proposals, and ensures that resolutions reflect the realities faced by populations at the time. This meticulous approach allows delegates to craft responses that are not only theoretically sound but also operationally viable in a real-world context.

7. Questions to be Concerned

1. How can governments effectively manage hospital capacity and ensure equitable access to medical supplies for all social and economic groups during a pandemic?

2. How can countries accelerate vaccine research, approval, and fair distribution despite future uncertainties and supply chain limitations?

3. How can governments ensure equal access to online education during school closures and support economically disadvantaged students across all social groups?

4. How can governments address the psychological effects of stress, anxiety, and social isolation, while mitigating the social consequences of lockdowns and movement restrictions?

5. What immediate interventions can countries implement to protect workers, support businesses, and reduce economic inequality during each stage of a pandemic crisis?

6. How can governments collaborate effectively under the United Nations framework to coordinate medical supply distribution and humanitarian aid while respecting national priorities and capacities?

7. How can governments prevent the spread of misinformation and build public trust during a health crisis?

8. Bibliography

https://www.who.int/health-topics/coronavirus#tab=tab_1

https://www.theguardian.com/business/2024/apr/15/covid-pandemic-made-poorest-countries-even-worse-off-world-bank-warns

https://en.wikipedia.org/wiki/COVID-19_pandemic_in_Haiti

https://www.undp.org/coronavirus/socio-economic-impact-covid-19?utm_source

https://www.usglc.org/coronavirus/economies-of-developing-countries/?utm_source

https://covid19.saglik.gov.tr/tr-66300/covid-19-nedir-.html

https://www.who.int/initiatives/act-accelerator/covax

https://www.gavi.org/covax

https://pmc.ncbi.nlm.nih.gov/articles/PMC9047429/

https://www.worldometers.info/coronavirus/

https://data.who.int/dashboards/covid19/cases

https://www.mayoclinic.org/diseases-conditions/coronavirus/symptoms-causes/syc-20479963

https://www.nhs.uk/conditions/covid-19/

https://ourworldindata.org/coronavirus

https://my.clevelandclinic.org/health/diseases/21214-coronavirus-covid-19

https://www.worldbank.org/en/publication/wdr2022/brief/chapter-1-introduction-the-economic-impacts-of-the-covid-19-crisis

https://en.wikipedia.org/wiki/Economic_impact_of_the_COVID-19_pandemic

https://iupress.istanbul.edu.tr/tr/book/the-covid-19-pandemic-and-its-economic-social-and-political-impacts/chapter/the-effects-of-the-covid-19-pandemic-on-economic-growth

https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide

https://www.nimh.nih.gov/health/topics/covid-19-and-mental-health

https://joghnp.scholasticahq.com/article/117080-the-implications-of-covid-19-on-mental-health-addressing-the-global-mental-health-challenges

https://pmc.ncbi.nlm.nih.gov/articles/PMC8758130/

https://www.unicef.org/lac/en/impact-covid-19-mental-health-adolescents-and-youth