



GATORMUN XXIII

World Health Organization
Background Guide

Kayla Bello

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World Health Organization (WHO)

Letter from the Director:

Distinguished Delegates,

Welcome to GatorMUN XXI! My name is Kayla Bello, and I am so excited to be directing the World Health Organization: Equity and Ethics in AI-Powered Healthcare. I'm a third-year student at the University of Florida majoring in Economics with a Minor in Health Administration and pursuing a certificate in AI in Healthcare. I've been involved in Model UN since my freshman year of college, but GatorMUN will always be special to me—it was the first conference I ever attended back in high school. Since then, I've directed a specialized GA committee, chaired DISEC (shoutout to all my amazing delegates last year), and currently serve as the Secretary-General for SunMUN IV, UF's collegiate MUN conference.

This committee is deeply personal to me. I've spent the past few years studying how health systems function, where they fail, and what it takes to make care more equitable. Technology is changing healthcare rapidly, but access to those changes isn't equal—and that's the tension we'll explore this weekend. Our first topic will focus on expanding access to AI in healthcare systems in low- and middle-income countries, where health worker shortages, infrastructure challenges, and underinvestment have created massive barriers. The second topic will dive into ethical concerns—how we can protect patient data, prevent bias, and create guidelines that work across cultures and legal systems.

Throughout committee, I'll be looking for delegates who know their country's stance, but who also go beyond the background guide to think critically and creatively. The best delegates won't just push their own ideas—they'll lift others up, ask the hard questions, and bring people together to build strong, balanced solutions. I care about collaboration, kindness, and intentional leadership. Whether you're a first-timer or a seasoned delegate, my hope is that this weekend challenges you to stay thoughtful, passionate, and grounded in why we do this work in the first place.

If you have any questions before or during the conference, feel free to reach out via email at bello.kayla@ufl.edu with the subject line "WHO Committee." I truly can't wait to meet you all and see your ideas come to life.

Warmly,
Kayla Bello

World Health Organization (WHO)

Rules of Procedure

Quorum

A majority of voting members answering to the roll at each session shall constitute a quorum for that session. This means that half plus one of all voting members are present. Quorum will be assumed consistent unless questioned through a Point of Order. Delegates may request to be noted as "Present" or "Present and Voting."

Motion to Suspend the Rules for the Purpose of a Moderated Caucus

This motion must include three specifications

- Length of the Caucus
- Speaking Time
- Reason for the Caucus

During a moderated caucus, delegates will be called on to speak by the Committee Director. Delegates will raise their placards to be recognized. Delegates must maintain the same degree of decorum throughout a Moderated Caucus as in formal debate. This motion requires a simple majority to pass.

Motion to Suspend the Rules for the Purpose of an Unmoderated Caucus

This motion must include the length of the Caucus. During an unmoderated caucus, delegates may get up from their seats and talk amongst themselves. This motion requires a simple majority to pass. The length of an unmoderated caucus in a Crisis committee should not exceed fifteen minutes.

Motion to Suspend the Meeting

This motion is in order if there is a scheduled break in debate to be observed. (ie. Lunch!) This motion requires a simple majority vote. The Committee Director may refuse to entertain this motion at their discretion.

Motion to Adjourn the Meeting

This motion is in order at the end of the last committee session. It signifies the closing of the committee until next year's conference.

Points of Order

Points of Order will only be recognized for the following items:

- To recognize errors in voting, tabulation, or procedure
- To question relevance of debate to the current Topic
- To question a quorum.

A Point of Order may interrupt a speaker if necessary and it is to be used sparingly.

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Points of Inquiry

When there is no discussion on the floor, a delegate may direct a question to the Committee Director. Any question directed to another delegate may only be asked immediately after the delegate has finished speaking on a substantive matter. A delegate that declines to respond to a question after a formal speech forfeits any further questioning time.

Points of Personal Privilege

Points of personal privilege are used to request information or clarification and conduct all other business of the body except Motions or Points specifically mentioned in the Rules of Procedure. Please note: The Director may refuse to recognize Points of Order, Points of Inquiry or Points of Personal Privilege if the Committee Director believes the decorum and restraint inherent in the exercise has been violated, or if the point is deemed dilatory in nature.

Rights of Reply

At the Committee Director's discretion, any member nation or observer may be granted a Right of Reply to answer serious insults directed at the dignity of the delegate present. The Director has the ABSOLUTE AUTHORITY to accept or reject Rights of Reply, and the decision IS NOT SUBJECT TO APPEAL. Delegates who feel they are being treated unfairly may take their complaint to any member of the Secretariat.

Directives

Directives act as a replacement for Draft Resolutions when in Crisis committees, and are the actions that the body decides to take as a whole. Directives are not required to contain operative or preambulatory clauses. A directive should contain:

- The name(s) of the author(s)
- A title
- A number of signatories/sponsors signatures' necessary to
- introduce, determined by the Director

A simple majority vote is required to introduce a directive, and multiple directives may be introduced at once. Press releases produced on behalf of the body must also be voted on as Directives.

Friendly Amendments

Friendly Amendments are any changes to a formally introduced Directive that all Sponsors agree to in writing. The Committee Director must approve the Friendly Amendment and confirm each Sponsor's agreement both verbally and in writing.

World Health Organization (WHO)

Unfriendly Amendments

Unfriendly Amendments are any substantive changes to a formally introduced Directive that are not agreed to by all of the Sponsors of the Directive. In order to introduce an Unfriendly Amendment, the Unfriendly Amendment must be the number equivalent to 1/3 of Quorum confirmed signatories. The Committee Director has the authority to discern between substantive and non-substantive Unfriendly amendment proposals.

Plagiarism

GatorMUN maintains a zero-tolerance policy in regards to plagiarism. Delegates found to have used the ideas of others without properly citing those individuals, organizations, or documents will have their credentials revoked for the duration of the GatorMUN conference. This is a very serious offense.

Crisis Notes

A crisis note is an action taken by an individual in a Crisis committee. Crisis notes do not need to be introduced or voted on, and should be given to the Crisis Staff by sending the notes to a designated pickup point in each room. A crisis note should both be addressed to crisis and have the delegate's position on both the inside and outside of the note.

Motion to Enter Voting Procedure

Once this motion passes, and the committee enters Voting Procedure, no occupants of the committee room may exit the Committee Room, and no individual may enter the Committee Room from the outside. A member of the Dias will secure all doors.

- No talking, passing notes, or communicating of any kind will be tolerated during voting procedures.
- Each Directive will be read to the body and voted upon in the order which they were introduced. Any Proposed Unfriendly Amendments to each Directive will be read to the body and voted upon before the main body of the Directive as a whole is put to a vote.
- Delegates who requested to be noted as "Present and Voting" are unable to abstain during voting procedure. Abstentions will not be counted in the tallying of a majority. For example, 5 yes votes, 4 no votes, and 7 abstentions means that the Directive passes.
- The Committee will adopt Directives and Unfriendly Amendments to Directives if these documents pass with a simple majority. Specialized committees should refer to their background-guides or Committee Directors for information concerning specific voting procedures.

World Health Organization (WHO)

Roll Call Voting

A counted placard vote will be considered sufficient unless any delegate to the committee motions for a Roll Call Vote. If a Roll Call Vote is requested, the committee must comply. All delegates must vote: "For," "Against," "Abstain," or "Pass." During a Roll Call vote, any delegate who answers, "Pass," reserves his/her vote until the Committee Director has exhausted the Roll. However, once the Committee Director returns to "Passing" Delegates, they must vote: "For" or "Against."

Accepting by Acclamation

This motion may be stated when the Committee Director asks for points or motions. If a Roll Call Vote is requested, the motion to Accept by Acclamation is voided. If a delegate believes a Directive will pass without opposition, he or she may move to accept the Directive by acclamation. The motion passes unless a single delegate shows opposition. An abstention is not considered opposition. Should the motion fail, the committee will move directly into a Roll Call Vote.

Tech Policy

Technology will not be allowed throughout the course of the committee. Delegates are prohibited from using their technology inside the committee room. However, they are encouraged to do research before and during assigned breaks.

Introduction to Committee

The World Health Organization (WHO) plays a critical role in shaping global health policy and guiding the ethical use of technology in medicine. As artificial intelligence becomes more integrated into healthcare systems, it is essential to ensure that these tools are used equitably and responsibly across the world. This committee will explore how the international community can harness AI in ways that close gaps in healthcare—not deepen them.

The first topic will address the barriers low- and middle-income countries face in accessing AI-powered healthcare solutions. Delegates will consider how infrastructure limitations, funding challenges, and health workforce shortages prevent equitable access to new technologies and will debate mechanisms like public-private partnerships, international aid, and technology transfers to make AI tools more accessible. The second topic focuses on the ethical implications of using AI in global health. Delegates will explore concerns around data privacy, algorithmic bias, informed consent, and regulatory standards. The debate will center on how to build globally relevant frameworks that ensure AI is used to promote health equity and protect patient rights. This committee invites thoughtful, solutions-oriented debate that addresses real-world limitations while pushing for global cooperation and innovation.

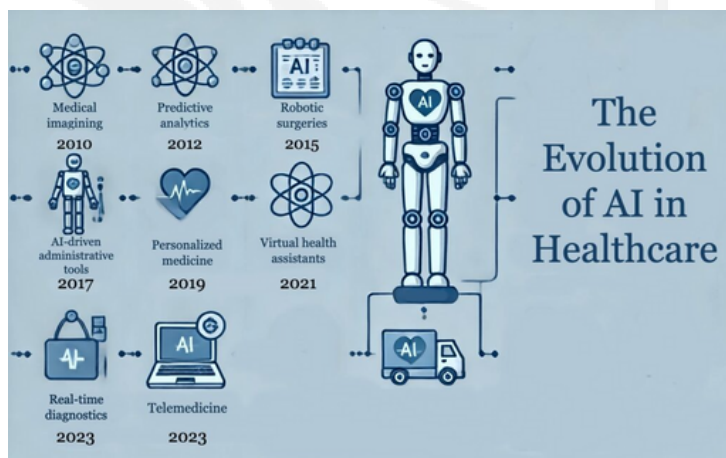
Topic A: Expanding Access to AI Health Technologies in Low- and Middle-Income Countries

When talking about global health equity, it's essential to acknowledge that while health disparities exist everywhere, the burden is not evenly shared. Low- and middle-income countries (LMICs) carry the greatest burden of disease, often facing both infectious and noncommunicable conditions at the same time, without the systems in place to respond effectively. Many of these countries are grappling with high rates of tuberculosis, maternal mortality, cardiovascular disease, and cancer, but with limited infrastructure, too few trained professionals, and inconsistent access to essential medicines. They're not just under-resourced, they're being asked to manage massive health challenges with systems that were never designed to support them.

To understand why, it's important to look at the historical roots. Many LMICs were once colonized by European powers who prioritized extraction and control over building sustainable systems for health, education, or governance. The healthcare infrastructure that existed during colonization often served elite, urban populations, or supported foreign workers, not the broader public. After independence, newly formed governments inherited health systems that were fragmented, underdeveloped, and deeply unequal. In many cases, international funding remained inconsistent, and domestic resources were limited. As a result, countries were left trying to manage growing populations and rising health needs without the foundational investments that high-income countries had decades earlier. That legacy still shapes the systems in place today.

AI as a Potential Tool

In recent years, artificial intelligence (AI) has been introduced as a tool that could help strengthen healthcare systems, especially where resources are limited. AI refers to technologies that can analyze data, recognize patterns, and make predictions or recommendations. In healthcare, that might look like an AI model reading a chest X-ray to detect tuberculosis, or predicting which patients are at highest risk of complications. The reason AI is being looked at seriously is that it can do some things faster, at scale, and without needing a human expert in the room every time.



AI doesn't replace health systems, but it has the potential to extend what's already there. For countries facing a health worker shortage, AI can help fill some of the gaps, especially in diagnostics and routine monitoring. It can reduce the time doctors spend on administrative tasks, help triage patients more efficiently, and provide clinical support in settings where specialists are unavailable.

World Health Organization (WHO)

AI tools have already been used for diagnosing diabetic retinopathy, predicting heart disease risk, supporting cancer detection in pathology images, and even helping health workers prioritize which patients need urgent care (World Economic Forum, 2025, Monlezun et al., 2025, World Health Organization, 2021). These are areas where time and expertise are critical, and where delays can cost lives.

The idea isn't that AI will solve everything. It's that it could reduce pressure on overwhelmed systems and expand access to quality care, if it's done right. That's where the conversation shifts from what AI can do to what it takes to actually make it work.

What It Takes to Implement AI

Bringing AI into healthcare systems isn't just about installing software or importing a tool. It requires infrastructure, training, and trust. First, the basics: you need reliable electricity, internet access, and devices to run the programs. Many rural clinics in LMICs don't have consistent power or internet, which makes it nearly impossible to use cloud-based tools or upload patient data (Monlezun et al., 2025). Without those foundations, even the most advanced AI won't work.

Then there's the human side. AI tools need trained staff to use them effectively. That includes not just learning how to operate the system, but how to interpret the results and make real decisions based on them. It also requires systems for monitoring outcomes, fixing errors, and updating models as local needs change. In many LMICs, the health workforce is already stretched thin, and asking people to take on new tools without support can backfire. Finally, there's the issue of relevance. Many AI tools are trained on data from high-income countries and don't always translate well to different populations, disease patterns, or resource settings (World Health Organization, 2021). That means tools often have to be adapted, or built from the ground up, for LMIC contexts.

So while AI has potential, it only works if the foundations are there. If it's rushed, imposed without context, or disconnected from local systems, it can actually make things worse. But if it's developed in partnership with communities, supported by real infrastructure, and integrated into broader health strategies, it can be part of something transformative.

Barriers and Challenges to AI Implementation in LMICs

Infrastructure Deficits: Power, Connectivity, and Data Systems

Even though AI holds enormous promise for improving healthcare, it still mostly benefits wealthier countries. That's because using AI in healthcare depends on having certain things in place, like reliable electricity, high-speed internet, and strong digital systems, and many low- and middle-income countries (LMICs) simply don't have those. In rural clinics, some health workers still rely on pen and paper, without basic equipment, let alone computers or internet access. These conditions make it difficult to use AI tools that require cloud-based storage, real-time data syncing, and continuous connectivity (World Economic Forum, 2025).

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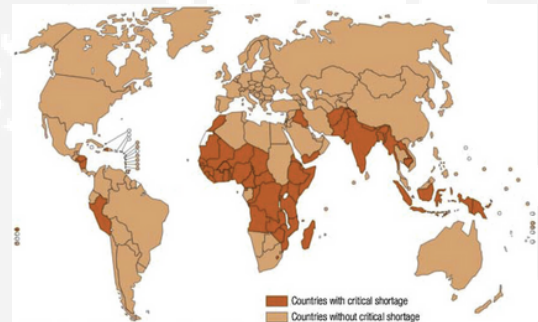
Even in areas with some access to infrastructure, regular power outages, unstable internet, and outdated hardware systems can prevent AI from functioning properly. Tools like diagnostic algorithms, digital health assistants, and remote monitoring platforms depend on consistent performance to be useful in clinical settings. If a system goes down mid-diagnosis or can't process a large dataset, it could lead to mistakes in care or loss of trust from health workers (World Health Organization, 2021).

Another issue is with data systems. AI can't function without large amounts of clean, organized data. But many LMICs don't have electronic health records (EHRs) in place. Patient information is often handwritten, scattered across multiple facilities, or stored in non-standardized formats. That makes it difficult to feed data into AI models or track trends over time. Without proper data management systems, even the most advanced tools will produce poor results or no results at all. Some countries are beginning to digitize health systems, but the process is slow and often underfunded (World Economic Forum, 2025).

Lastly, there's often a disconnect between the goals of AI developers and the on-the-ground realities in LMICs. Many pilot projects don't fully consider the infrastructure needs or local conditions before rolling out tools. If governments or health workers don't have a clear plan to maintain and integrate these tools long-term, they can become "one-and-done" projects that fizzle out (World Economic Forum, 2025). Stronger infrastructure investment and planning are key to closing this gap.

Health Workforce Capacity and Training

Even with the best AI technology, there's no impact unless there are trained people to use it. One of the biggest challenges LMICs face is a shortage of healthcare workers. The World Health Organization estimates that by 2030, there could be a global shortfall of 10 million health workers, with LMICs facing the worst gaps (Matupi, 2025). In many parts of sub-Saharan Africa, for example, there is just one doctor for every 5,000 people, compared to over a dozen in some wealthier nations (Matupi, 2025).



This shortage means that doctors and nurses are already overwhelmed. Asking them to adopt new technology, especially technology that requires additional training, can feel like an extra burden. AI tools are meant to support, not replace, healthcare workers, but they only work if the people using them understand how they function and trust their accuracy. Unfortunately, many training programs are rushed, not done in local languages, or leave out frontline staff entirely. This leads to misunderstandings, misuse of the tools, or total abandonment after initial enthusiasm (Bae & Bhatt, 2024).

World Health Organization (WHO)

Another issue is digital literacy. In many LMICs, even among healthcare workers, there are wide gaps in comfort and experience with computers and digital platforms. Without strong digital training, AI tools can feel intimidating or overly complex. There have been cases where health workers relied too heavily on tools without fully understanding the logic behind them, leading to errors in diagnosis or treatment (Horlacher & Rösch, 2025).

The problem is made worse when tech developers or donors launch small, isolated projects without long-term plans. If funding runs out or if staff leave, these projects often collapse. Local governments and communities are then left with broken systems and no way to repair or update them. Over time, this erodes trust, not just in AI, but in health innovation more broadly. To build sustainable tools, AI developers need to work with local experts, ensure long-term support, and design programs that can adapt to each region's specific needs (Bae & Bhatt, 2024).

Legal, Ethical, and Equity Concerns

Even when the technical side of AI is working, there are still big questions around privacy, consent, and fairness. Most AI tools rely on health data, often very personal information about people's illnesses, medical histories, and even their genetics. In places without strong data protection laws, patients may not even know how their data is being used. There's a risk of sensitive data being shared without consent or falling into the wrong hands (Iacob & Simonelli, 2021).

There's also a risk that AI tools might unintentionally make existing health inequalities worse. If an AI tool is trained on data from wealthier countries, it might not work well for people in LMICs. For example, a skin cancer detection app trained mostly on lighter skin tones may not recognize symptoms accurately on darker skin. If these tools are not built or adjusted to fit the people they are meant to help, they could lead to misdiagnoses or worse health outcomes (Godinho et al., 2022).

Finally, many global health decisions are still made without meaningful input from the countries and communities they affect. Some AI projects are designed in tech labs far from the people who will actually use them. When AI tools are implemented without considering the cultural, linguistic, and political realities of local communities, they can fail, no matter how advanced the technology is. For AI to succeed in LMICs, it needs to be built with communities, not just for them (Iacob & Simonelli, 2021).

Funding and Sustainability

A major obstacle to scaling AI in low- and middle-income countries is financial sustainability. While many exciting digital health projects have been piloted across Africa, South Asia, and Latin America, the majority have relied on short-term funding from international donors like the Bill and Melinda Gates Foundation, the World Bank, or NGOs (Yi et al., 2024). These grants may help launch promising tools, such as AI-powered diagnostics or data collection platforms, but they rarely provide the long-term financial support needed to maintain, update, and integrate these technologies into public health systems.

World Health Organization (WHO)

This creates a pattern of “pilot fatigue,” where countries experience repeated waves of well-intentioned but short-lived projects. Once funding dries up or donor priorities shift, governments are left with unsupported systems, gaps in training, and sometimes, tech tools that no longer function. This can damage public trust in

innovation and lead to skepticism about future technologies (Yi et al., 2024, Horlacher & Rösch, 2025). Moreover, it puts pressure on already-strained health ministries to allocate their own limited resources to maintain tools they may not have asked for in the first place.

For AI to thrive in LMICs, it must be paired with sustainable financing models. Some experts suggest blending public funding, private sector partnerships, and in-kind contributions such as infrastructure support from telecom companies (Horlacher & Rösch, 2025). Others have explored social enterprise models that generate small revenue from digital tools, such as AI triage apps in clinics, that can be reinvested into system upkeep. Countries may also consider South-South collaborations, where tools and knowledge are shared across LMICs facing similar barriers. Delegates should think creatively about how funding structures can be redesigned to promote long-term independence, not just early-stage enthusiasm.

Past International Involvement

WHO-led Efforts

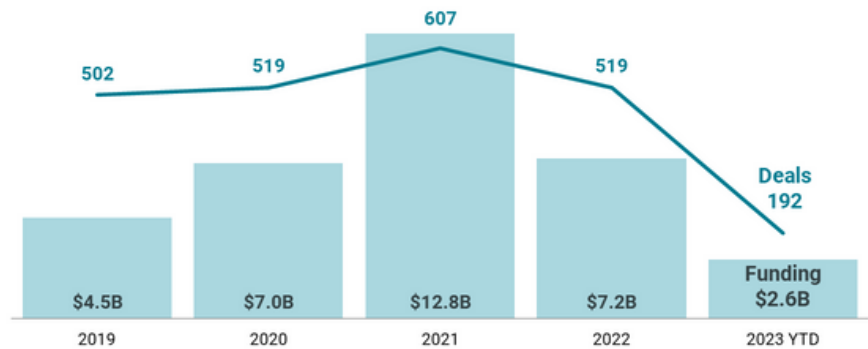
The World Health Organization (WHO) has been at the forefront of global efforts to guide countries on how to use artificial intelligence in healthcare. In 2020, the WHO launched its Global Strategy on Digital Health (2020–2025), a document that lays out a vision for how member states can build the foundations necessary to integrate digital health tools, including AI. The strategy focuses on core areas like workforce training, ethical standards, and system-wide governance to ensure that AI isn’t just adopted for its novelty, but implemented in ways that improve care and protect rights (World Health Organization, 2021). Rather than promoting specific technologies, the WHO emphasizes building countries’ long-term capacity to evaluate, regulate, and manage these tools themselves.

While the WHO acknowledges that AI can play a meaningful role in advancing Universal Health Coverage (UHC) and Sustainable Development Goals (SDGs), it has also been careful to issue warnings.



Healthcare AI funding and deals slow down in 2023

Disclosed equity funding & deals (as of Q2'23)



CBINSIGHTS

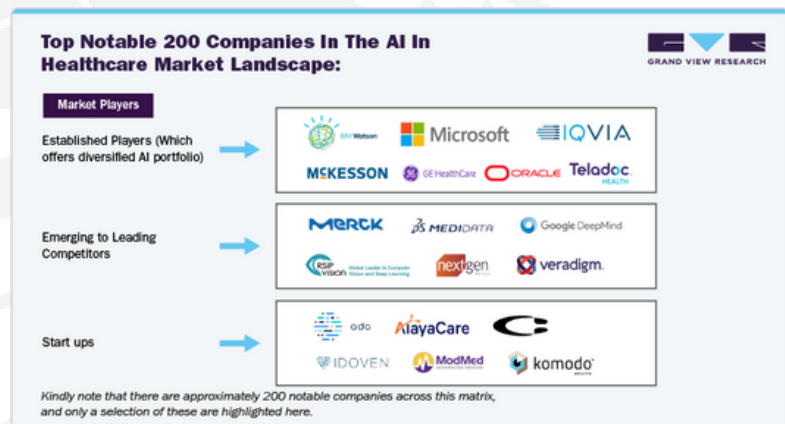
World Health Organization (WHO)

For instance, relying too heavily on AI could distract from more basic but urgent investments, such as strengthening supply chains, hiring more health workers, or expanding electricity and internet access (World Health Organization, 2021). These warnings reflect a key point for delegates to consider: technology can be a tool for progress, but it is not a substitute for functioning systems. The WHO's involvement has been less about pushing specific projects and more about helping countries think strategically and responsibly as they explore new innovations.

Other Actors and Partnerships

Beyond the WHO, many global players have taken interest in advancing AI-based health tools in LMICs. Large tech companies like IBM, Microsoft, and Google have all launched pilot programs or donated tools to assist with diagnostics and health system monitoring in countries such as India, Kenya, and Brazil (Monlezun et al., 2025). IBM Watson, for instance, was used to support cancer diagnosis in underserved areas, while Microsoft has explored AI to manage patient records and supply chains. However, many of these efforts have remained small-scale, and questions remain about their sustainability once the initial funding or support ends.

Development agencies and financial institutions have also stepped into this space. The World Bank and the United Nations Development Programme.



Recent Developments and Case Studies

Rwanda: Using AI for Radiology and Disease Detection

In Rwanda, a country that has often led public health innovation in East Africa, the government has partnered with private companies and organizations like Babylon Health to expand access to care using AI tools. One program uses AI to help doctors interpret chest X-rays and detect signs of tuberculosis, a major health issue in the region. Because Rwanda faces a shortage of radiologists, this AI system speeds up diagnosis and allows health workers to begin treatment faster, even in rural clinics (World Health Organization, 2021).

However, there are still challenges. In many areas, the internet is unreliable, and some staff members are not fully trained in how to use the tools. That means the AI system can't fully reach its potential unless those infrastructure and training issues are addressed. Still, Rwanda's example shows that even a lower-income country can be a leader in using AI for health, as long as the programs are tailored to its needs and built with long-term support in mind (Horlacher & Röscher, 2025).

World Health Organization (WHO)

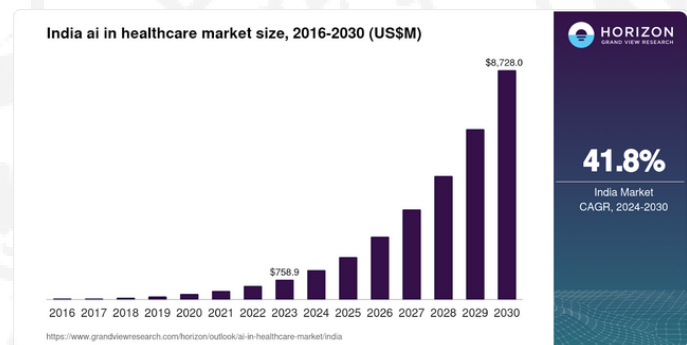
India: Predictive Tools and AI Chatbots for Primary Care

India has seen major growth in digital health tools, especially during and after the COVID-19 pandemic. One standout example is the use of AI-powered chatbots and predictive algorithms to support overburdened clinics. These tools can screen patients, remind people about medications, and flag early warning signs of disease. They've been especially useful in areas with a high volume of patients but not enough doctors (World Health Organization, 2021).

Several of these programs are supported by public-private partnerships, meaning the government and companies work together to fund and roll out the technology. However, a concern has been that many tools were built with urban populations in mind, and don't always work well in more rural or lower-income areas. Some don't function in local languages or don't account for different cultural norms around health (Matupi, 2025). This raises important questions about equity in digital health design, and what it really means to build "accessible" AI tools.

Kenya: Digital Health Records and AI Triage

In Kenya, a program called "mDaktari" has used mobile phones and simple AI tools to help patients figure out if they need to go to a clinic, or if home care is safe. This triage system has been especially helpful for families who live far from health centers, as it reduces the need for unnecessary travel and overcrowding at clinics (Iacob & Simonelli, 2021).



Another innovation in Kenya is the digitization of health records in government clinics. This makes it easier to track patient history, which is essential for using AI safely and effectively. For example, an AI system that recommends treatment based on symptoms is more accurate when it has access to someone's medical background. Still, many clinics lack the equipment or electricity to support these systems, and staff turnover means training has to be constant (World Economic Forum, 2025). Kenya's experience shows how small-scale AI programs can grow, but only with planning, investment, and community trust.

Lessons for Delegates

These case studies show that AI in LMICs is not a distant dream, it's already happening. But success depends on more than just having the technology. Programs work best when they are co-designed with local governments and communities, when they consider real infrastructure needs, and when training and funding are built in from the start. Delegates should keep these examples in mind as they consider what types of AI programs their countries might support, and what partnerships and planning those programs would need to succeed.

World Health Organization (WHO)

Bloc Positions

Although every country has unique priorities and challenges, several regional or political groupings tend to share similar perspectives when it comes to AI in healthcare. These blocs can help delegates understand how alliances may form and what their country's main concerns or interests might be.

Tech Providers have made large investments in AI and are eager to export their technologies abroad. These countries often frame AI as a tool for global development but may tie their support to the adoption of their own platforms or data systems. This raises concerns about digital dependency and fairness in procurement (World Economic Forum, 2025; Horlacher & Rösch, 2025).

Global Equity Advocates emphasize the importance of human rights, sovereignty, and community-centered innovation. They support AI tools but only when they are implemented through transparent processes that allow local governments to maintain control and protect public interest (Monlezun et al., 2025).

LMIC Implementers are actively piloting AI programs but remain focused on practical concerns. These include ensuring affordability, training frontline health workers, and keeping control over national health data (Monlezun et al., 2025; Yi et al., 2024). These countries often welcome partnerships but want to avoid repeating historical patterns of external control.

Cautious Watchers are skeptical of foreign-led digital programs, viewing them as potential vehicles for surveillance or political influence. These states tend to favor national control over digital systems and may advocate for stricter rules around AI adoption, especially when it involves outside actors (Horlacher & Rösch, 2025).

Questions to Consider:

1. What infrastructure is most essential for AI in healthcare to work in LMICs, and how can countries start building it even with limited electricity or internet?
2. How can partnerships with international tech companies avoid repeating neocolonial patterns and instead empower local systems and voices?
3. What steps can be taken to make sure AI tools are actually relevant to local languages, cultures, and medical needs?
4. How can LMICs protect their health data when working with global actors and ensure they maintain long-term control over their systems?
5. What kinds of healthcare tasks or gaps is AI best suited to support in LMICs, and what are the biggest limitations to keep in mind?
6. What mix of funding (public, private, or donor-supported) can help AI programs succeed without collapsing once initial money runs out?
7. How can AI support healthcare workers in LMICs without replacing them, and what kind of training or oversight would that take?

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Key Terms

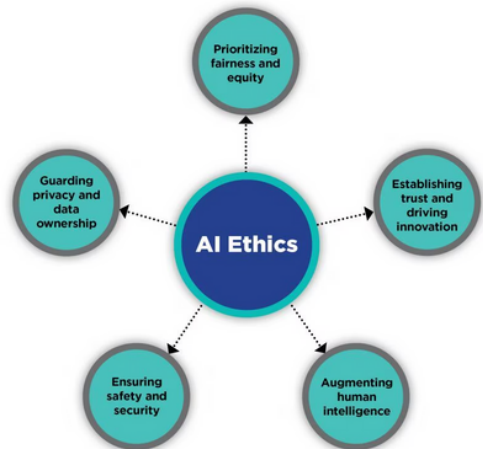
- **Artificial Intelligence (AI):** AI refers to technologies that can perform tasks typically requiring human intelligence, like analyzing data, recognizing patterns, or making predictions. In healthcare, this might look like AI reading X-rays, helping with triage, or spotting disease outbreaks early.
- **2. Global Health Equity:** This is the idea that everyone, no matter where they live or how much money they have, should have a fair chance at being healthy. It means addressing the root causes, like poverty, colonial legacies, or systemic underinvestment, that leave some countries struggling more than others.
- **3. Low- and Middle-Income Countries (LMICs):** LMICs are countries categorized by the World Bank based on income levels. Many of them face overlapping challenges like weak infrastructure, fewer healthcare workers, and limited access to advanced technologies.
- **4. Data Sovereignty:** Data sovereignty means that a country controls the data generated within its borders, especially sensitive health data. It's important because it protects patient privacy and ensures LMICs don't become dependent on foreign companies or donors for their own health insights.
- **5. Digital Health Infrastructure:** This includes all the tech tools and systems that make digital healthcare possible, from reliable electricity and internet to cloud storage and electronic health records. Without these basics, even the best AI tools can't function.
- **6. Task-Shifting:** Task-shifting is when duties normally handled by highly trained professionals are passed on to other trained workers, like having community health workers take on basic diagnostics. AI is being explored as a way to support this process, especially in places with workforce shortages.
- **7. Solution Dumping:** This happens when a tech company or donor introduces a tool without making sure it fits local needs or includes community input. It can make projects unsustainable and even harmful, despite good intentions.
- **8. Universal Health Coverage (UHC):** UHC is a global goal that every person should have access to quality, affordable healthcare. AI is often pitched as a tool to help reach this, but only if it's used thoughtfully and equitably.

Topic B: Developing Ethical Guidelines for AI in Global Health Systems

Ethics in Global Health

Ethical frameworks have long shaped the practice of global health, rooted in principles like equity, autonomy, human rights, and the obligation to “do no harm.” These ideals are reflected in documents such as the *Declaration of Helsinki* and policies from the World Health Organization (WHO) that emphasize consent, fairness, and community participation in health interventions (Dolfing, 2024). Historically, global health efforts have aimed to protect vulnerable populations from exploitation, particularly in the context of medical research and foreign aid. But as healthcare tools grow more complex and technology-driven, these ethical foundations are being tested in new ways.

Artificial intelligence challenges traditional norms by inserting algorithmic systems into medical decision-making, often with limited human oversight or patient understanding. While AI has the potential to improve care and increase access, particularly in under-resourced settings, it can also reproduce systemic inequities if left unchecked. In this evolving landscape, the tension between innovation and protection is becoming more difficult to navigate. Existing ethical norms must now be interpreted in light of opaque technologies, cross-border data flows, and a global health market increasingly shaped by private-sector interests (Kerasidou, 2021).



Introduction to Medical AI

Over the past decade, AI has been integrated into a growing number of healthcare systems. These tools are used for medical imaging, clinical risk prediction, hospital workflow management, and even pandemic forecasting. The most well-known applications often rely on machine learning, where algorithms are trained on large datasets to identify patterns and make decisions. These technologies are largely developed in high-income countries (HICs) but are increasingly marketed and deployed in low- and middle-income countries (LMICs), often with little adaptation to local health systems or demographic data (MarketsandMarkets, 2023).

Private companies play a major role in shaping this landscape. Tech giants like Google and IBM have entered the health space, partnering with hospitals and governments to pilot AI tools. While some of these collaborations have been framed as efforts to improve global health equity, they often come with tradeoffs. For example, there are ongoing concerns that companies gain access to sensitive health data from LMICs without adequate transparency, community consultation, or long-term accountability (International Hospital Federation, 2023). In many cases, these partnerships operate in regulatory gray zones where ethical oversight is weak or underdeveloped.

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Why Global Ethics Guidelines Are Needed

As AI becomes more embedded in health systems around the world, the need for ethical guidance has become urgent. Countries vary widely in their capacity to regulate AI, and in many LMICs, legal protections around data privacy or digital health tools are still emerging. This creates a fragmented global landscape where powerful actors can move quickly and unevenly. Without shared standards, there is a risk that the benefits of AI will accrue to a small group of developers and funders, while the harms, from data misuse to biased decision-making, fall disproportionately on already-marginalized populations (Ishimwe et al., 2023).

The challenge is not just about developing new tools, but about doing so in ways that are fair, transparent, and aligned with the values of those affected. This includes respecting local norms around consent, ensuring that health data is not extracted without oversight, and building mechanisms for accountability when AI causes harm. Ethical guidelines can serve as a bridge between innovation and justice, helping global health systems harness the potential of AI while minimizing its risks. But such guidelines must be informed by the lived realities of different countries, and not imposed in top-down ways that replicate historical patterns of technological dominance (Kerasidou, 2021, BBC News, 2021).

Past International Involvement

UN and Multilateral Frameworks

Global institutions like the United Nations and the World Health Organization have taken early steps to establish ethical standards for AI in healthcare. The WHO's *Guidance on Ethics and Governance of Artificial Intelligence for Health* (2021) introduced six foundational principles, including transparency, accountability, inclusiveness, and sustainability, designed to steer countries in the development and oversight of AI technologies (Dolfing, 2024). This document was one of the first to directly link AI ethics to global health, with attention to risks like algorithmic bias, explainability, and privacy. However, the guidance is non-binding, meaning countries can adopt it voluntarily without legal or financial obligation, leading to inconsistent implementation, particularly in regions lacking regulatory capacity or technical infrastructure (Dolfing, 2024).

Similarly, the UN Secretary-General's High-Level Panel on Digital Cooperation produced a roadmap focused on equitable access to digital technologies, including AI in health systems (BBC News, 2021). While it emphasizes inclusive global cooperation, especially for underserved communities, the roadmap lacks dedicated accountability tools, and the goals outlined remain largely aspirational due to limited funding and follow-through (BBC News, 2021).

Another notable initiative is UNESCO's 2021 Recommendation on the Ethics of Artificial Intelligence, which was adopted by all 193 member states.

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It is especially notable for its strong language on anti-discrimination and intersectionality and for directly referencing AI use in healthcare (BBC News, 2021). However, like other multilateral efforts, it does not carry binding legal weight and leaves harmonization up to national governments, many of which vary widely in readiness to regulate or deploy health-focused AI responsibly.

Regional and Governmental Initiatives

Beyond global frameworks, regional alliances and national governments have also pursued AI governance structures with relevance to health. The OECD Principles on AI, endorsed by 46 countries, promote trustworthy, human-centered AI and have been influential in shaping major policies, including the European Union's draft AI Act (Kerasidou, 2021). While the OECD principles are comprehensive in scope, emphasizing robustness, transparency, and security, they are not healthcare-specific and tend to prioritize economic growth and innovation, raising concerns about whether they sufficiently address the needs of marginalized or underserved health populations.

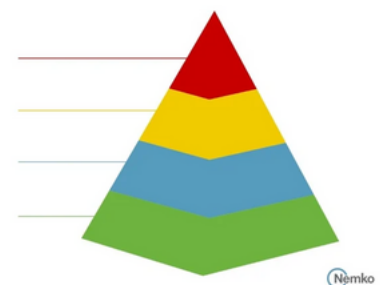
The EU's AI Act, for instance, categorizes medical AI as "high-risk," meaning tools must undergo extensive testing and documentation, but critics argue that loopholes in emergency health contexts could still expose patients to risk (Yi et al., 2024). Meanwhile, African countries have taken a different approach. African Union strategy documents caution against rushing into stringent regulation, advocating instead for building local capacity, securing digital infrastructure, and defending data sovereignty. These perspectives reflect a broader recognition that importing ethics frameworks from the Global North without adaptation may undermine innovation and ignore contextual challenges faced by developing health systems.

Public-Private Partnerships and Corporate Influence

The private sector has played an outsized role in shaping real-world applications of health-related AI, with mixed ethical outcomes. The Global Partnership on AI (GPAI), which brings together governments, academics, and corporations, aimed to build consensus on AI governance, including in pandemic response efforts. However, progress has been slow, and decision-making has been hampered by competing stakeholder interests and underrepresentation of Global South countries in leadership roles (BBC News, 2021). Corporations such as Google and IBM have also developed headline-grabbing AI health initiatives. Google's diabetic retinopathy screening program in India, for example, significantly improved diagnostic speed in rural settings but faced criticism for unclear consent protocols and limited localization of the underlying data models (International Hospital Federation, 2023; BBC News, 2021).

EU AI Act: Risk Levels

- **PROHIBITED AI SYSTEMS**
Prohibited
- **HIGH RISK AI SYSTEMS**
Must undergo a conformity assessment
- **LOW RISK AI SYSTEMS**
Must adhere to transparency requirements
- **NO RISK AI SYSTEMS**
No obligations



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Similarly, IBM's Watson Health initiative, once celebrated for its potential to revolutionize cancer care, was ultimately scaled down due to issues with clinical accuracy and commercial viability (International Hospital Federation, 2023). Microsoft's AI for Health initiative offers a somewhat different model, providing grants and technical support to nonprofits working on maternal health, disease surveillance, and more. While these projects have produced promising results, such as improved rare disease detection, they still raise questions about long-term independence, data ownership, and whether initiatives tied to corporate platforms can be held accountable to the public good (Bangkok Post Online Reporters, 2025).

Recent Developments

Pilot Programs and Deployment Initiatives

- A number of countries have begun piloting AI tools in healthcare delivery. For example, Rwanda has partnered with companies like Babylon Health to test AI-driven diagnostic tools in rural clinics, aiming to address physician shortages and improve access. While these programs show promise, they also raise concerns around data representativeness and consent, issues that are often overlooked in early deployment stages (Kerasidou, 2021). In India, there has been interest in expanding AI-powered diagnostic tools in ophthalmology, especially for diabetic retinopathy, which has already been explored through partnerships involving Google Health. These tools can speed up diagnostics and reduce the workload on specialists, but challenges remain regarding the accuracy of AI tools in diverse populations and ethical questions about data ownership and transparency (MarketsandMarkets, 2023).

Civil Society and Oversight Movements

As AI systems are increasingly deployed in healthcare, civil society organizations are playing a more active role in demanding oversight and accountability. Reports have criticized the lack of public participation in AI development and the opacity of systems deployed in vulnerable settings, such as refugee camps and low-resource hospitals. Several watchdog groups, including Amnesty International, have pushed for more transparent and equitable AI governance frameworks, advocating for human rights-centered approaches to AI in health (BBC News, 2021). There is also a growing movement to establish independent auditing bodies for healthcare AI, with calls for clearer metrics on safety, effectiveness, and bias (Kerasidou, 2021).

Corporate-Driven Advances and Backlash

The private sector remains deeply involved in real-world AI deployment, and many companies continue to develop proprietary tools for disease detection, hospital logistics, and patient triage. However, the increasing use of commercial algorithms in public health settings has prompted concerns about surveillance, data commodification, and the influence of profit motives.

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For instance, Microsoft's AI for Health and Google Health's research initiatives have contributed to global health tools, but critics note these are often deployed without sufficient community consultation or transparent ethics review (International Hospital Federation, 2023; MarketsandMarkets, 2023). These programs highlight the need for stronger oversight mechanisms to ensure that AI deployment is not only effective but also equitable and aligned with local health priorities.

Concluding Remarks

As artificial intelligence continues to expand its role in global health, the international community must recognize that the technology's potential is only as strong as the systems and values that guide it. It is no longer sufficient to discuss ethics or innovation in the abstract. Delegates must contend with the real-world consequences of inadequate regulation, data colonialism, and inequitable access to AI tools. While many frameworks already exist, their effectiveness depends on implementation, inclusivity, and context-specific adaptation. The goal cannot simply be to replicate models from wealthier countries, but to develop systems rooted in local needs, community input, and transparent oversight. This means asking difficult questions: Who gets to decide what "responsible AI" looks like? Who owns the data being used? And what happens when public health goals and private profit come into conflict?

Going forward, delegates should prioritize proposals that shift from broad principles to actionable mechanisms. Consider how your bloc can support equitable data governance, empower local institutions to lead on AI development, and ensure that regulatory frameworks keep pace with innovation. Whether through regional health AI hubs, enforceable ethical oversight bodies, or capacity-building programs for under-resourced health systems, your solutions must bridge the gap between theory and practice. Above all, AI must serve people, not just systems. It should uplift the voices of those most often left out of global health conversations and bring us closer to a world where technology enhances care, builds trust, and leaves no one behind.

Bloc Positions

Although every country has unique priorities and challenges, several regional or political groupings tend to share similar perspectives when it comes to AI in healthcare. These blocs can help delegates understand how alliances may form and what their country's main concerns or interests might be.

Tech-Powered Health Leaders are already integrating AI into their healthcare systems at scale. With strong research institutions, tech industries, and regulatory agencies, they see AI as a critical tool for efficiency and innovation. They advocate for flexible, non-binding international frameworks that encourage experimentation and public-private partnerships. However, they may underplay the need for global equity or fail to recognize how their models might not translate well to lower-resource settings.

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Governance-First Coalitions emphasize accountability, human rights, and the ethical governance of AI. They support stronger international regulation, transparency, and inclusion of vulnerable populations. Often skeptical of tech-led approaches without oversight, they push for patient-centric models, stricter consent processes, and protections against data exploitation, especially in global health initiatives. Their policies may be slower to adopt innovation but center equity and public trust.

Emerging Innovators are scaling up their digital health systems and see AI as a way to leapfrog structural challenges. They are interested in both innovation and governance but require financial and technical support to meaningfully engage. They often advocate for capacity-building, equitable data access, and South-South collaboration. Their participation is crucial in shaping ethical AI that works across different infrastructure levels.

Digital Sovereignty Defenders prioritizes national control over data, health infrastructure, and AI systems. Skeptical of foreign intervention and corporate influence, they focus on protecting cultural context, data privacy, and decision-making autonomy. They support AI frameworks that respect local values and prevent exploitation, especially in light of historical medical or digital colonialism, but may resist data sharing or globally centralized standards.

Questions to Consider

1. How can AI in healthcare be implemented ethically without reinforcing existing global health inequities?
2. What mechanisms can make international guidelines for AI in health enforceable across diverse national systems?
3. How can countries with limited infrastructure adopt AI tools without compromising basic health service delivery?
4. What standards are necessary to guarantee meaningful informed consent in AI-driven care?
5. How can governments regulate public-private AI collaborations to protect public health interests and data sovereignty?
6. What strategies can effectively identify and reduce algorithmic bias in health-related AI models?
7. Should global health data be treated as a shared public good, and what systems could govern this fairly?
8. What reforms are needed to ensure current ethical principles translate into accountable and inclusive practice?
9. How can countries with different capacities and priorities cooperate on AI development without deepening global divides?

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Key Terms

- **Algorithmic Bias:** Bias introduced into AI systems due to non-representative or flawed training data, often resulting in poorer health outcomes for certain populations. In healthcare, biased AI can lead to misdiagnoses or unequal treatment recommendations, especially for minority or underrepresented groups (Kerasidou, 2021).
- **Data Sovereignty:** The principle that data is subject to the laws and control of the country in which it is collected. In AI-based healthcare, this raises concerns about data extraction by foreign companies and the loss of national control over sensitive health information (Ishimwe et al., 2023).
- **Informed Consent:** In the context of digital health and AI, informed consent refers to ensuring patients understand and voluntarily agree to how their data will be collected, processed, and used by algorithms. Many current systems fail to obtain meaningful consent due to technical complexity and lack of transparency (International Hospital Federation, 2023).
- **Ethical AI Governance:** A system of policies, legal frameworks, and institutional oversight meant to ensure that AI tools in health are transparent, fair, and aligned with public values. It often includes accountability mechanisms, human rights protections, and standards for risk assessment (MarketsandMarkets, 2023).
- **Autonomy:** A foundational bioethical principle that individuals have the right to make decisions about their own healthcare. The use of opaque AI systems can undermine autonomy when patients or providers don't understand how decisions are made (Kerasidou, 2021).
- **Privacy:** The right to control one's personal data, particularly health information. Privacy is often at risk when AI systems collect vast amounts of sensitive data without adequate safeguards or anonymization (International Hospital Federation, 2023).
- **Global Equity in AI:** Refers to fair and inclusive distribution of the benefits and risks of AI in health systems across countries and populations. Ethical concerns arise when AI tools are developed in high-income countries (HICs) but deployed in low- and middle-income countries (LMICs) without sufficient contextual adaptation or local control (Kerasidou, 2021, Ishimwe et al., 2023).

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