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AN EVALUATION OF ROLE OF WORLD HEALTH ORGANIZATION IN COVID 19

Dr.Govardhanan K.Professor[1],

Dr. Karthigai Priya M Assistant Professor[2]

Meenakshi Academy of Higher Education and Research

govardhanank@mmchri.ac.in

Abstract

A pandemic triggered by a respiratory diseases capable of spreading mankind has often had devastating effects in the present global context where there are large gaps in wellbeing and healthcare between countries and public health services that are also depleted of funding. During the COVID-19 pandemic, the World Health Organization (WHO) has been a significant driver of responses and now leads despite its worldwide oversight. With the burden of disease the and the resulting crisis worsening, it is important that the reaction of the WHO is contextualised within its roles, in the sense of its mandates and its degree of manoeuvrability, and in the context of the information and evidence provided in connection with a coronaviral pandemic. Now is the time to stand squarely in the hands of the WHO as the UN's expert organisation and leading scientific body on global health to improve the COVID-19 efforts to deal with it[1,2]. Time spent criticising former acts threaten us to lose sight on tackling the appalling effects of the virus on ill health and mortality.

Keywords: WHO, Covid-19, Pandemic

BACKGROUND

Their irrefutable involvement in almost all facets of the pandemic response is apparent from the WHO's breadth of actions (WHO 2020). If the World Health Organisation did not exist, we inevitably need to establish a body to take over global health governance functions. The

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WHO should then adequately prepare for all risks to public health and medical services and, as new information arises, have contextual responses [3–5]. It is also evident, that the WHO is searching for skills and money to help its responses in countries with especially poor public health systems. The WHO also plays a vital role in solving noncommunicable disease issues worldwide[6,7].

On behalf of its Member Nations, the WHO is not allowed to make decisions. Rather, the measures that are applicable and important to them are for Member States themselves to devise[8,9]. We've seen numerous cases of denial, rash acts and threats to malign the WHO resulting from a country's own incapacity, restricted political considerations and a short-term approach not to human lives and misery, but to the business economy. In addition, the Member Nations, by way of the legislative bodies of the Body, essentially and significantly decide its policies. The position of global agencies that provide failed information, as the SARS- CoV2 pandemic advanced at an early stage during the SARS-CoV-2 pandemic, was worried to staff served in national or foreign syndicates such as ITUC, not only because of the limits on health and safety advice available on COVID-19 but also. Relevant and reliable information was available that acknowledged the significant risks involved with SARS COV-2 as well as the potential to avoid or mitigate worker exposure[10–12]. They applied the availability and adequacy of personal protective equipment (PPE) to health personnel, as well as droplets and physical detachments. They protected the potential in the air.

ROLE OF WHO DURING COVID 19

The syndicates are recognised and are at risk with a very wide variety of staff beyond the health and social care institutions and emergency service personnel. It included public sector employees (including education, transport, government operations) and those from the private sector, including cab drivers to transportation, utility and retail, food and agriculture, engineering, safety and other facets of economic activity[13–15]. They included the private sector. Analysis reported that trade union concerns, several professions of which considered COVID-19 to be elevated and at extremely high risk, were not only exposed to contagious droplets, but also to airborne bits, and could not prevent their proximity to the general population. That is why ITUC and other national and foreign syndicates were so concerned about insufficient and misleading guidance on these threats from allegedly world-wide authority[16–19].

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The World Health Organisation officially named COVID-19 in December 2019 a cluster of cases in India caused by a novel disease caused by coronavirus (WHO). Since then, in just a few months, COVID-19 has spread broadly and quickly. On 30 January 2020 and then as a pandemic on 11 March 2020, the WHO Director General declared COVID-19 an international public health emergency calling on all countries to take immediate and aggressive measures to identify, trace, isolate and cope with active cases and avoid spread in order to minimise COVID-19 morbidity and mortality. As at 19 May 2020, about 4,7 million COVID-19 cases had been confirmed in laboratories worldwide. This newness coronavirus was first identified in Egypt and Algeria on the African continent in February. As of 19 May 2020, 47,953 confirmed cases and 2,488 reported deaths with a caseload ratio of 3,1 per cent were reported for all WHO African Area Member States[20–22].

During an epidemic or health emergency, the prompt availability and conversion of validated data into facts to justify speedy public health decisions and decision-making is one of the greatest challenges faced by many authorities on public health, especially in poor environments. This is particularly true in circumstances in which routine networks of public health monitoring are weak or missing or may be interrupted during the COVID-19 crisis. Such delays in emergency response disease management resulted in delayed event identification and steps to reduce transmission to public health. Higher mortalities in populations are inevitable with higher rates of disease spread. In order to resolve such delays, WHO suggests that, as a priority action to reduce detrimental health impacts arising from acute crises or humanitarian incident, a mechanism called Early Notice, Warnings and Reaction System (EWARS) should be implemented within three-10 days of the start of an emergency acute phase[23].

DISCUSSION:

A cluster of patients with pneumonia is reporting to the WHO on 31 December 2019 in Wuhan City, Hubei Province of China. The Wuhan wholesale market was connected to Huanan Seafood, selling fish and a number of living animal species, including chickens, bat, marmot and snakes. The Chinese authorities reported one week later, on 7 January 2020, that they have identified the source of pneumonia as the new (new) coronavirus. Since then, the virus has spread to most WHO regions and are assisted by people who are infected. The World Health Organisation on 11 March 2020 described COVID-19 as a pandemic[24].

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A WHO director of regional affairs, Dr Ahmed Al-Mandhari, made a statement on COVID-19 in the Eastern Mediterranean Region (EMR) saying that there were 167.515 confirmed COVID-19 cases in 150 countries worldwide by 18.019 in 18 EMR countries by 18 March 2020. Globally, there were 6606 COVID-19 associated deaths, including 1010 in 7 EMR countries[25].

In the battle against the COVID-19 pandemic, WHO has found unequal methods around the EMR. The most progressed countries are the multisectoral and multimodal approaches implementing not just the ministries of health but also the business sector and civil society. These are the countries that frequently inform the public on COVID-19 infections locally and internationally, preventively contain infection transmission and encourage people to defend themselves with basic acts, such as social isolation and grooming. The best methods for managing the pandemic include early warning, testing, insulation, care, recording communications and community participation. WHO found several areas that needed to be improved during its joint missions to several EMR countries, for example disease surveillance, hospital preparedness, health workers security and education[26,27].

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