



STUDY GUIDE

SOA INTERNATIONAL MUN'19

World Health Assembly



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Vice Chairperson-Ananya Chatterjee



Greetings delegates,

We welcome you all to the simulation of the World Health Assembly at SOA MUN 2019. It is a privilege and honor for us to be the part of the Executive Board of this prestigious committee, for the duration of this grand conference. The World Health Assembly is an essential and a paramount international forum, for discussing issues pertaining to the agendas decided. In this simulation we will be discussing in depth the agenda which has been in the highlights for quite some time now. The agenda at hand is vast and multifarious and a successful discussion on them would require the collective participation of all of you. All of you need to realize that this agenda has layers and a plethora of substantial points, which the Executive Board expects you to discuss during the span of the conference. The Executive Board will ensure that the first timers will understand each and every aspect of the rules of procedure, the council in general, as well as the agendas. Delegates, you all are advised to go through the background guide properly. This document will help in your research. The aim of this guide is to provide clarity regarding the various aspects of the agenda as well as providing direction to channelize your research. However, you all should realize that this guide is not the ultimate source of information. This study guide has been structured in such a way that you can get a basic idea of the agenda and we strongly recommend that you research on various things on your own and try to understand the intricate details of the agenda. We sincerely hope that the simulation of the World Health Assembly at SOA MUN 2019 will help you gain experience to become better professionals and persons in future. We are always at your disposal and please do not hesitate to contact us.

Looking forward to see you all in action.

Regards,

Executive Board



World Health Assembly

General Information about the WHO

I. Introduction and History of the World Health Organization

The World Health Organization (WHO) is the supervising and coordinating authority on global health within the UN. Article 1 of the WHO Constitution states that the objective of the WHO is "the attainment by all peoples of the highest possible level of health". Health is defined in the preamble as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The WHO is a specialized agency of the UN and works with other specialized UN agencies through the coordination of the Economic and Social Council of the UN (About the UN, n.d.). The WHO produces health guidelines and standards, supports countries in their public health issues as well as finances and promotes health research. Through the organizational framework of the WHO, governments, UN entities, professional groups and NGOs can jointly deal with global health and improve all people's well-being (Working for Health, WHO, 2007).

The organization has quite comprehensive leadership priorities. Its current priorities are:

1. Advancing universal health coverage by empowering countries to sustain or expand access to health services, financial protection and effective, affordable medical products.
2. Combatting communicable diseases (CDs), like HIV/AIDS, Ebola, Malaria, Tuberculosis
3. Addressing non-communicable diseases (NCDs), mental health, injuries, and disabilities.
4. Promoting Healthy Lives through sexual and reproductive health, healthy ageing; good nutrition, food security, healthy eating; occupational health, substance abuse prevention
5. Addressing the socioeconomic and environmental determinants of health to reduce health inequalities within and between countries
6. Making sure that all countries can detect and react to public health threats through the International Health Regulations (The Guardian of Public Health, WHO, 2016)

Moreover, the WHO is responsible for the **World Health Reports**, a series of worldwide World Health Surveys. They provide information for policymakers, donor agencies, international organizations and others to help them in deciding health policy and funding (Global Health Observatory Data, n.d.). The WHO also organizes the **World Health Days**: global health awareness days celebrated every year which draw attention to important global health issues (WHO Global Health Days, 2017).

Accordingly, the WHO has defined its role in public health as follows:

1. Providing leadership on health and engaging in partnerships where joint action is needed;
2. Shaping the research agenda and stimulating generation and dissemination of knowledge;
3. Setting norms and standards and promoting and monitoring their implementation;
4. Articulating ethical and evidence-based policy options;
5. Providing technical support and building sustainable institutional capacity; and
6. Monitoring the global health situation and assessing health trends (About WHO, n.d.).

The very distant origins of the WHO can be traced back to the beginning of the 20th century, when its predecessor, the **Health Organization** of the League of Nations, was founded. The WHO was established on April 7th, 1948 and inherited the mandate and resources of its predecessor. The First World Health Assembly met in 1948 and established early priorities for the organization: eradication of malaria, tuberculosis, venereal diseases, maternal and child health, sanitary engineering, and nutrition (McCarthy, 2002). The biggest success of the WHO so far is the **eradication of Smallpox**: In 1958 the World Health Assembly decided to undertake a global initiative to eradicate smallpox, a serious disease with an overall mortality rate of 30–35 percent. After over two decades of fighting smallpox, the WHO declared in 1979 that the disease has been eradicated – the first disease in history to be eliminated by human effort (WHO Emergencies Preparedness, n.d.).

In 1969 the **International Health Regulations (IHR)** were established as an international legal instrument that is binding on all countries across the globe, including all Member States of WHO. The IHR are aimed at preventing and responding to public health risks that have the potential to transcend borders and threaten people in many other countries. Additionally, the IHR are designed to avoid unnecessary interference with international trade and travel. They have been modified several times to adapt to changing state of global health issues (FAQ about the IHR, 2005). The first **list of essential medicines** was created in 1977, registering all medicines that "satisfy the priority health care needs of the population"; According to the WHO, all people should have access to these medicines in sufficient amounts (Essential Medicines, 2015). Just



one year later, the ambitious goal of "**health for all**" was declared: The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition (Mahler, 1981). In 1986, WHO started to fight against HIV/AIDS pandemic and ten years later **UNAIDS** was formed, a program for comprehensive and coordinated global action on HIV/AIDS (UNAIDS Fact Sheet, 2001).

The **Global Polio Eradication Initiative** was established in 1988. It is the largest public health initiative in history with the aim of eradicating one of the most worrying childhood diseases. This resulted in gains in child survival, reduced infant mortality, increased life expectancy; reduced the annual cases from the hundreds of thousands to 37 cases in 2016 (Polio Eradication Initiative, n.d.).

Currently, the WHO works together with other UN entities to realize the **Sustainable Development Goals (SDGs)**. The SDGs followed the **Millennium Development Goals**, in which the WHO also played a vital role. The WHO works on **SDG 3 “Good Health and well-being”** by improving maternal health, ending epidemics, decreasing child mortality, achieve universal health coverage and ensuring access to sexual and reproductive health care services (WHO SDG 3, n.d.).

II. Modus Operandi of the World Health Organization

Membership in the WHO

Membership in the organization is open to all states according to article 3 of the WHO constitution. All UN member states and other countries may be admitted as members when their application has been approved by a simple majority of the World Health Assembly (Article 6 of the WHO constitution).

As of 2017, the WHO member states list includes 194 member states, all of them are also Member States of the UN, except for the Cook Islands and Niue. Additionally, the WHO has two associated members, Puerto Rico and Tokelau. Liechtenstein is currently the only UN Member state which is not part of the WHO. Several countries have observer status in the World Health Assembly: The Holy See, Order of Malta, the Palestinian Authority, the European Union, Taiwan (as Chinese Taipei) and the International Committee of the Red Cross.



Structure of the WHO

According to article 9 of the WHO constitution, the organization consists of three organs:

(a) the **World Health Assembly (WHA)** is the supreme decision-making body of the WHO. All WHO member states appoint delegations, (usually their health ministers) who meet once per year in Geneva, the location of WHO Headquarters. Together they are a forum through which the WHO is governed.

The responsibilities of the WHA are:

1. appointing the Director-General every five years
2. electing the Executive Board consisting of 34 members for 3 years
3. voting on matters of policy and finance of WHO, including the proposed budget
4. reviewing reports of the Executive Board and decides whether there are areas requiring further examination. (WHO Governance, n.d.)

(b) the **Executive Board** carries out the decisions and policies of the Assembly. Moreover, they advise the WHA and facilitate its work. It can be summarized as executive organ of the WHA. Its 34 members are elected due to their qualification and reputation in the field of health but also according to their home country, thus creating an equal geographical representation (WHO Governance, n.d.).

(c) The **Secretariat** comprises the **Director-General** and the technical or administrative staff of the WHO. The Director-General is the chief technical and administrative officer of the Organization but is subject to the authority of the Executive Board. According to the constitution, the Director-General is by the right of their office the Secretary of the WHA. On the regional level, the WHO has established regional offices to meet the special needs of an area. The regional divisions are: Africa (AFRO), Europe (EURO), Americas (AMRO), Eastern Mediterranean (EMRO), South-East Asia (SEARO) and Western Pacific (WPRO).

Many decisions are pre-made at the regional level, including important discussions over WHO's policy and budget. The natural cooperation partners can therefore be found within the respective regional division of the WHO. Voting blocks in the WHA also usually form according to regional interests.



Budget of the WHO

The programme budget 2018–2019 is US\$ 4421.5 million, which comprises the “base” programmes (CDs, NCDs, Health Systems, Health Promotion, Health Emergencies Programme) and special programmes (polio, research and training in tropical diseases and human reproduction), and the event-driven component of Outbreaks and crisis response.

The budget is financed through assessed and voluntary contributions. Assessed contributions are the dues countries pay to be a member of the Organization. The amount for each member is calculated according to the country's wealth and population.

Assessed contributions have been declining for the past years and account for one quarter of the funding by now (WHO, Summary of Assessed Contributions, 2017). Voluntary contributions come from Member States adding to their assessed contribution or from organizations and private persons. Nowadays, voluntary contributions account for three quarters of the WHO funding. However, voluntary contributions are usually earmarked for specific purposes, thus reducing flexibility of the WHO budgeting (WHO Voluntary Contributions, n.d.). Hence, delegates should pay special attention to funding in their health policy recommendations: the WHO is an institution that has to deal with financial inflexibility and funding issues.

Procedures and Voting

SOAMUN will simulate the World Health Assembly (WHA), since it's the WHO's supreme decision-making body. Governance mainly takes place in this forum of 194 member states and associates. Each delegation will have one vote in the WHA. In order to pass a resolution a simple majority (1/2 of votes) of the delegations present is needed.

The procedures and voting within the WHA are the MUN standard. The only exception in the WHA are the International Health Regulations. The IHR are the only internationally binding legal instrument besides UN Security Council Resolutions (What are the IHR, 2016). This enables delegates in the WHA to demand certain policy action (within the framework of the IHR) from the international community. Delegates can use this legal advantage in their health policy recommendations.



III. Reference List

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Global Strategies on Health, Environment and Climate change: The transformation needed to improve lives and well being sustainably through healthy environment.

Introduction:

There is near unanimous scientific consensus that greenhouse gas emissions generated by human activity will change Earth's climate. The recent (globally averaged) warming by 0.5°C is partly attributable to such anthropogenic emissions. Climate change will affect human health in many ways—mostly adversely. Here, we summarise the epidemiological evidence of how climate variations and trends affect various health outcomes. We assess the little evidence there is that recent global warming has already affected some health outcomes. The Intergovernmental Panel on Climate Change (IPCC), drawing on the published results of leading modelling groups around the world, forecasts an increase in world average temperature by 2100 within the range 1.4–5.8°C. The increase will be greater at higher latitudes and over land. Global average annual rainfall will increase, although many mid latitude and lower latitude land regions will become drier, whereas elsewhere precipitation events (and flooding) could become more severe. Climate variability is expected to increase in a warmer world.

Safe drinking-water, sanitation and hygiene are crucial to human health and well-being. Not only are they a prerequisite for health, they also contribute to livelihoods, school attendance and dignity and help to create resilient communities living in healthy environments. Drinking unsafe water impairs health through illnesses such as diarrhoea, and untreated excreta contaminate groundwaters and surface waters that are used for drinking water, irrigation, bathing and household purposes, creating a heavy burden on communities. Deaths from diarrhoea as a result of inadequate WASH were reduced by half during the period of the Millennium Development Goals (1990–2015), with the significant progress on provision of water and sanitation playing a key role. Overall, improvements achieved over the period of the Millennium Development Goals had a positive impact on the livelihoods of many and reduced the burden of disease related to unsafe WASH.

The Sustainable Development Goals offer unprecedented opportunities to improve health by dramatically increasing availability and use of WASH services. WHO can contribute by supporting countries to improve policy, governance and monitoring. The Goals also present increased demands for WHO's technical assistance related to formulation of national targets, effective regulation and

surveillance systems, risk management and WASH indicators. This work is supported by WHO's traditional role of monitoring, which will encompass establishing robust baselines for achievement of the Goals and tracking progress towards national and international WASH targets.

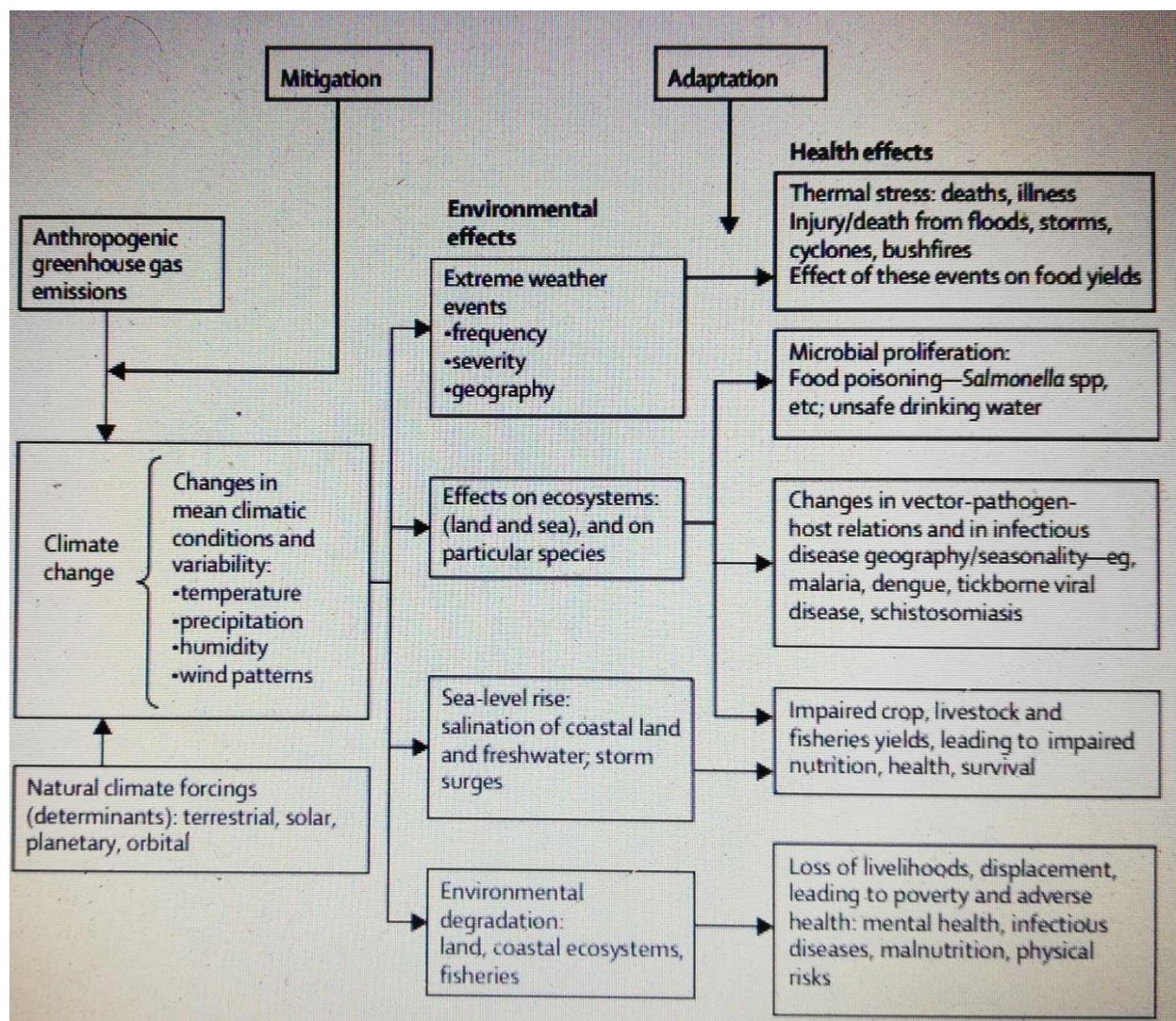


Fig: Describes the brief, flowchart of how climate change affects the environment and health. Delegates are requested to pay detailed attention to these effects and draw conclusions in subsequent debates about the following and find solutions to the same.

Before the prospect of anthropogenic climate change emerged, epidemiologists were not greatly interested in climate-health relations. Modern epidemiology has focused mainly on studying risk factors for noncommunicable diseases in individuals, not populations. Meanwhile, there have been occasional



studies examining deaths due to heatwaves, some epidemiological studies of air pollution incorporating temperature as a covariate, and a continuation of the longer standing research interest in meteorological effects on microbes, vectors, and infectious disease transmission. Overall, the health risks of climate-related thermal stress, floods, and infectious diseases have been the most amenable to conventional epidemiological studies.

Climate change and infectious diseases

Where health surveillance data are available for several decades up to the present day, it may be possible to determine whether any observed changes in disease might be related to changes in climate. Interpretation is complicated by potential competing explanations due to changes in important health determinants over time, as well as changes in the way in which diagnoses may be recorded. Empirical observation of the health consequences of recent climate change, followed by formulation, testing and then modification of hypotheses would require long time-series (probably several decades) of careful monitoring. While this process may accord with the principles of empirical science, it would not provide the timely information needed to inform current policy decisions on GHG (greenhouse gas) emission abatement, so as to offset possible health consequences in the future. Nor would it allow early implementation of policies for adaptation to some level of climate change, which is now inevitable owing to past GHG emissions. Therefore, the best estimation of the future health effects of climate change will necessarily come from risk assessment based on current understanding of the effects of climate variation on health from observations made in the present and recent past, acknowledging the influence of a large range of modulating factors.

Climate change will affect the potential incidence, seasonal transmission, and geographic range of various vector-borne diseases. These diseases would include malaria, dengue fever, and yellow fever (all mosquitoborne), various types of viral encephalitis, schistosomiasis (water-snails), leishmaniasis (sand-flies: South America and Mediterranean coast), Lyme disease (ticks), and onchocerciasis (West African river blindness, spread by black flies).

The formal modelling of the effects of climate change on vector-borne diseases has focused on malaria and dengue fever. Modelling of dengue fever is conceptually simpler than for malaria. Whereas malaria entails two main pathogen variants (*falciparum* and *vivax*) and relies on several dozen regionally dominant mosquito species, dengue fever transmission depends principally on one mosquito vector, *Aedes aegypti*. Both statistical and biologically based (mathematical) models have been used to assess

how a specified change in temperature and rainfall pattern would affect the potential for transmission of these and other vector-borne diseases.

Furthermore increases or decreases in the geographical distribution of disease transmission may occur, as climate-driven changes in vectorial capacity cause transmission to become unsustainable in previously endemic areas, or sustainable in previously non-endemic areas. Even small increases in disease distributions may mean that new populations are exposed. New populations often lack acquired immunity, which can result in more serious clinical disease. There is now a substantial body of literature on the association between the El Nino cycle, a major determinant of global weather patterns, and some infectious diseases. There is for example reasonably strong evidence for an association with El Niño and malaria epidemics in parts of South Asia and South America and with cholera in coastal areas of Bangladesh.

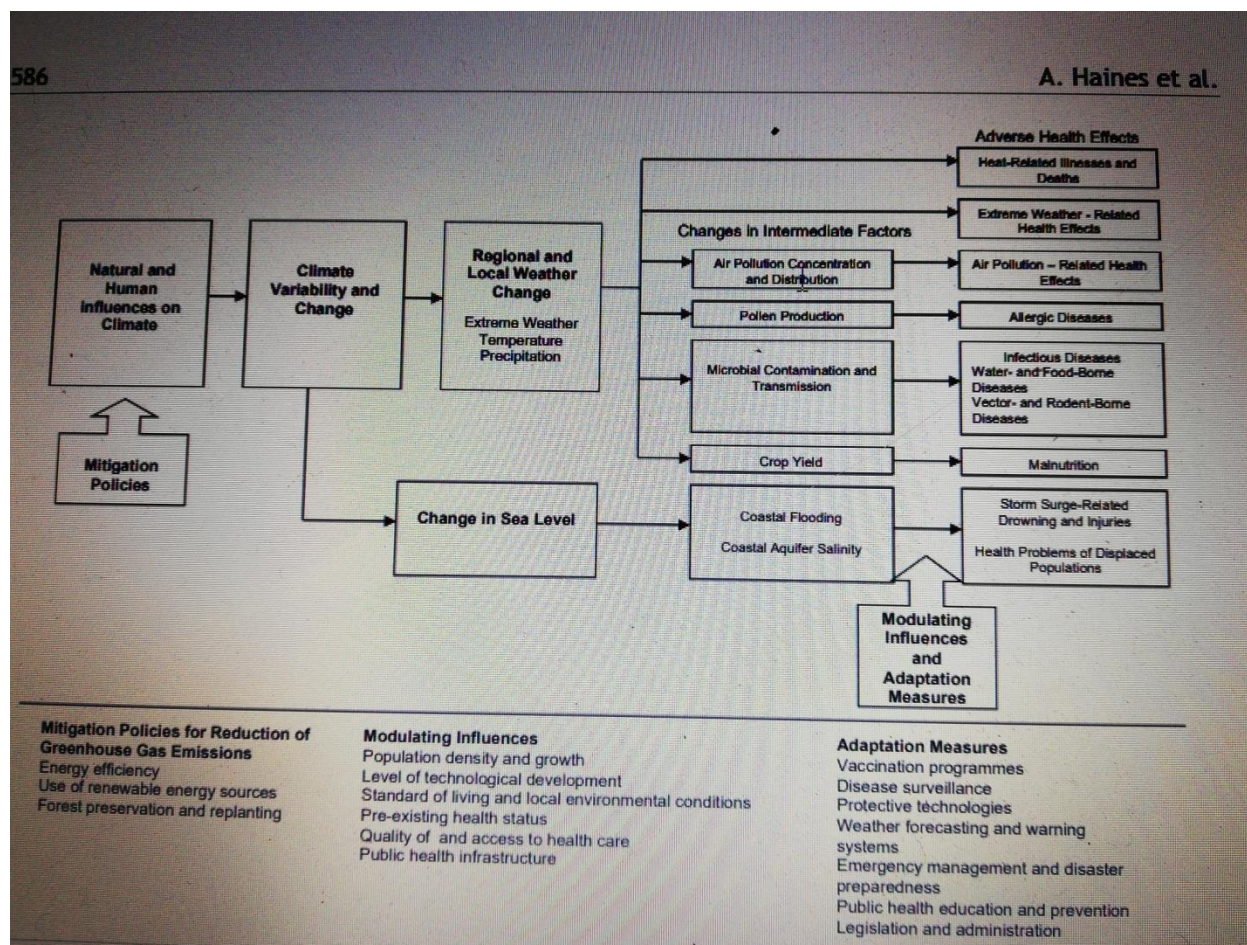


Fig: Health and infectious diseases strategy.



World Health Organization on health and climate change:

https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_15-en.pdf

https://www.who.int/phe/publications/Annex_WHO-Global-strategy-on-health-en.pdf?ua=1

http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R14-en.pdf

http://www.euro.who.int/_data/assets/pdf_file/0011/122231/RC60_eRes7.pdf?ua=1

Delegates are requested to go through these 4 documents which are the main documents to the agenda. The scope, challenge and the outcomes for the given agenda can be drawn from these 4 documents.