HoMMUNC XXXII

October 28th, 2017

32nd Annual

Horace Mann Model United Nations Conference

WHO

World Health Organization

Heath Bleustein
Co-Chair

Charlie Hayman
Co-Chair

HoMMUNC XXXII

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Letter from the Secretariat

Dear Delegates,

It is our pleasure to welcome you to Horace Mann's 32nd Annual Model United Nations Conference, HoMMUNC XXXII! Since 1985, HoMMUNC has brought together future world leaders in a day full of intellect, discourse, and compromise. The conference engages academically minded high school and middle school students to contemplate and discuss imperative global concerns. We are honored to have inherited the responsibility of organizing this conference for all of you, the over 1000 delegates that will attend HoMMUNC this year. We hope you are excited as we are for the conference to begin!

We encourage you to deeply explore your topics and arrive at HoMMUNC prepared to engage in the discourse of your committees and truly involve yourself in the negotiation process, regardless of your age or experience in Model UN. Each committee is comprised of a wide-ranging group of delegates and will address a pressing global issue. We challenge you to delve deep into your topics and think innovatively. Take this opportunity to learn as much as you can, create the best solutions possible, and lead your committee to a world-changing resolution.

Model United Nations has played a tremendous role in our lives over the past three years, and we are thrilled to share this activity with all of you. It has been our pleasure preparing HoMMUNC XXXII along with our dedicated junior and senior staff over the past six months. We hope you have an enriching and enjoyable experience at the conference.

Sincerely,
Jenna Freidus, Valerie Maier, and Evan Megibow
Secretaries-General

Letter From the Chair

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Evan Megibow
Secretaries-General

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Hi,

I am a senior at Horace Mann and I've been going to HM since I was 3 years old. I've done Model UN since 9th grade and it has been amazing experience. Model UN was the first club that I joined at HM and I've made countless memories in the club that I will never forget. Outside of Model UN, I'm a leader on the service learning team, a member of the Horace Mann Business League, and a member of the HM tennis team. In my free time I play basketball, golf, the drums and I hang out with my friends. I'm a member of the Horace Mann Wind Ensemble, and I am the percussion section leader. If you have any questions about Model UN, please feel free to contact me at any time.

Sincerely,
Heath Bleustein
heath_bleustein@horacemann.org
Co-Chair, WHO

Hi,

My name is Charlie Hayman, and I'll be your co-chair for HoMMUNC XXXII. This will be my third HoMMUNC, and even though I am sad it will be my last, I am excited to share it with all of you! This will be my fourth and final year as a member of the Horace Mann Model UN Team. I am an avid ski racer, so I am a member of my school's ski racing team as well a club team. I am also a member of my school's cross country and crew teams. In addition, I am a Health Peer Mentor at HM, an editor for my school's newspaper, the Review, and a participant in Habitat for Humanity builds. I also enjoy watching the New York Giants and hanging out with friends. If you have any questions, please contact me by email. I can't wait to see all you all there!

Best,
Charlie Hayman
charles_hayman@horacemann.org
Co-Chair, WHO

Committee Background and Procedure

The role of the World Health Organization (WHO) is to direct and coordinate international health within the United Nations. The concept of WHO dates from the San Francisco Conference in 1945 when representatives from 50 countries gathered to complete the Charter of the United Nations. At that meeting, diplomats also discussed the need for countries to work together to control the spread of dangerous diseases and agreed to establish a global organization. The WHO constitution was drafted and approved at the International Health Conference in New York City one year later and went into effect on April, 7 1948, which is now celebrated each year as World Health Day.

WHO's initial focus was to combat communicable diseases such as tuberculosis, malaria, yaws, syphilis, smallpox and leprosy. Over the years, its focus has expanded, and WHO has led many successful immunization and public health programs. After the discovery of polio vaccines in the 1950s, WHO facilitated global campaigns that have nearly eradicated the disease except in three countries: Afghanistan, Nigeria and Pakistan. WHO created an Expanded Programme on Immunization in 1974 aiming to deliver vaccines to all the world's children, and after a 12-year vaccination program, smallpox was eradicated in 1979. The organization says that its DOTS strategy (Directly Observed Treatment, Short-Course) to diagnose and treat tuberculosis has saved 49

million lives since it was established in 1995.[1]

WHO is based in Geneva and now includes six regional offices, 150 country offices, and more than 7,000 people. The organization is financed by Member States' dues, as well as by voluntary contributions from Member States, foundations, and, to a lesser extent, the private sector. WHO's areas of work include health systems; promoting health for all ages; communicable and non-communicable diseases; corporate services; and preparedness, surveillance, and response. In recent years, WHO has completed a reform process designed to accelerate progress towards the Sustainable Development Goal to "ensure healthy lives and promote well-being for all." The reformed WHO's six leadership priorities include: advancing universal health coverage; achieving health-related development goals (maternal and child health, HIV, malaria, TB, completing the eradication of polio, and neglected tropical diseases); addressing the challenge of noncommunicable diseases and mental health, violence and injuries and disabilities; ensuring that all countries can detect and respond to acute public health threats; increasing access to medical products; and addressing the social, economic and environmental determinants of health to improve outcomes and reduce inequality.

WHO Medical Aid Workers in Angola
https://media1.britannica.com/eb-media/96/84996-004-E34E5FE7.jpg

At the start of each HOMMUNC committee session, there will be a roll call where the chair will take attendance of delegates, to which each delegate must simply respond "present." If late, send a note to the dais to let them know of your presence. At the beginning of committee, we will set the agenda to discuss the effects of climate change on human health and then move into debate. Debate will begin with a speakers' list, in which delegates may discuss any aspect of the topic they wish. The rest of committee will be comprised of moderated and unmoderated caucuses. Moderated caucuses will make up the majority of committee, during which delegates vote on and debate a specific aspect of the topic. During unmoderated caucuses, the rules of formal debate are suspended and delegates may leave their seats. This time is used to build blocs and write working papers and draft resolutions. Delegates must make a "motion" in order to open the speakers' list or propose a moderated or unmoderated caucus. The chair will take several motions at one time, then will hold a vote on them in order of most to least disruptive, and a motion will pass with a simple majority. For example, a delegate could say "Motion for a ten-minute moderated caucus with one-minute speaking time for the purpose of discussing ___." After a certain period of time, the chair will accept working papers. Working papers require sponsors, helped draft the resolution, and signatories, who would like to see the resolution debated, of a certain number decided by the chair. Working papers will be presented by the

sponsors, after which there will be a Q&A session of a certain amount of time decided by the chair, and the possibility, time allowing, to merge or revise into draft resolutions which will be voted on.

Topic A: Ensuring Access to Healthcare in Areas of Armed Conflict

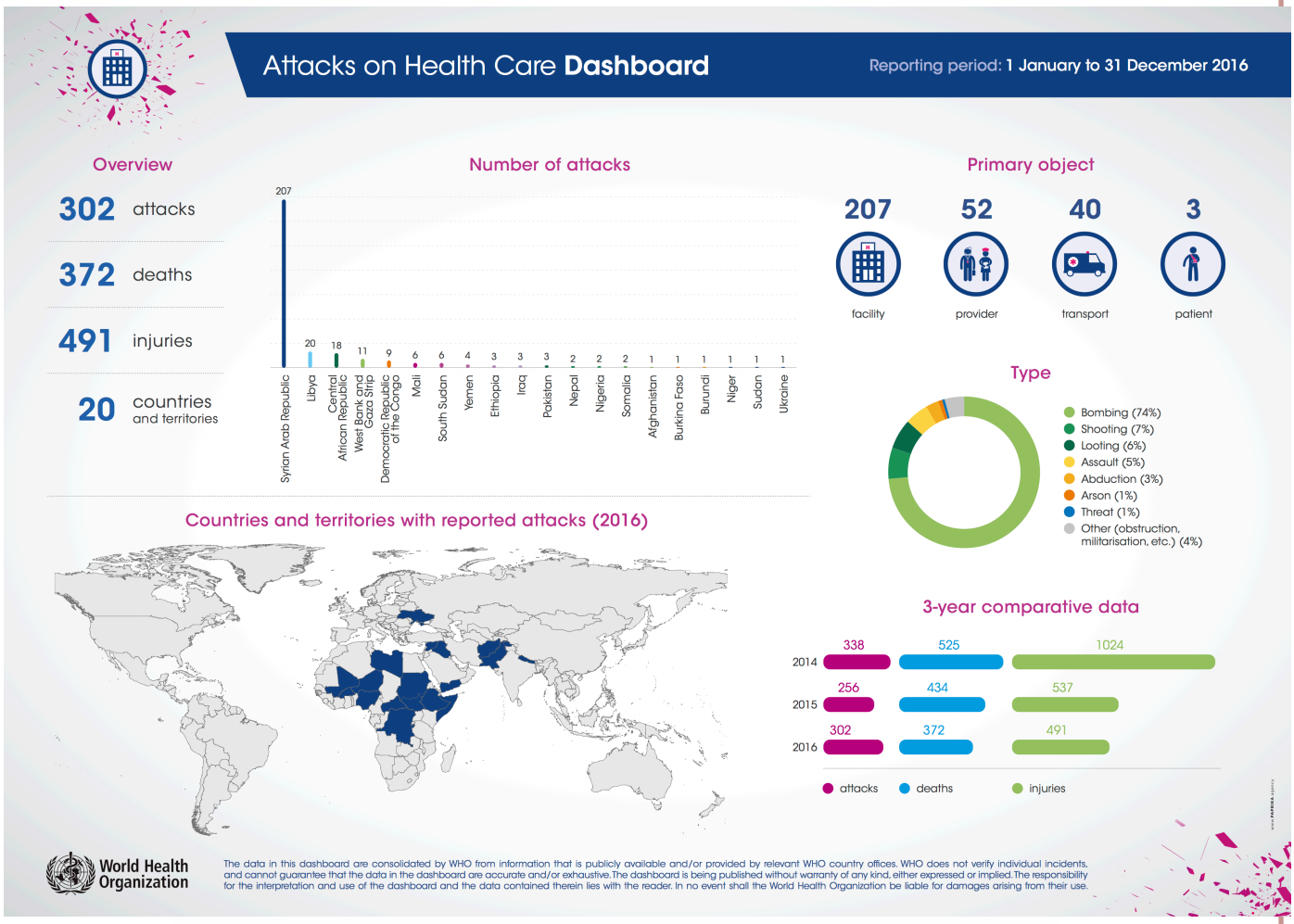
Overview

In areas of armed conflict, where the need for health care is most acute, health care is often least available. Combatants, who are wounded or sick, and therefore no longer able to fight, are protected under International Humanitarian Law but often do not receive medical care. Civilians, including small children, are caught in the crossfire and killed or wounded. Others fleeing the fighting become internally displaced persons (IDPs), living in camps, or refugees.

The health care issues in areas of conflict extend beyond combat injuries. Residents, IDPs, and refugees often lack access to adequate food, water, and basic medicine. Humanitarian aid convoys are often stripped away of supplies such as medical and food aid, resulting in malnutrition, starvation, and preventable deaths of civilians. The victims are also susceptible to outbreaks of disease such as cholera. Women are unable to access reproductive and maternal care. Victims suffer from increasing incidence of mental health issues due to stress from being in a combat environment or forced to leave their homes.

The problem is compounded by violence against healthcare personnel and medical facilities. Doctors,

nurses, emergency medics, and healthcare administrators can also be killed or injured, either through deliberate attacks or as "collateral damage." According to WHO, in 2016 there were 302 attacks on medical workers, causing 372 deaths across 20 countries.[2] Hospitals, clinics, laboratories, and medical vehicles such as ambulances are destroyed by shelling or incapacitated due to the lack of electricity or water. As a result, victims are often unable to get timely access to medical care, and may have to walk for days -- waiting at checkpoints and roadblocks -- in order to reach regional hospitals or camps where health care is available.



2016 Attacks on Healthcare Workers

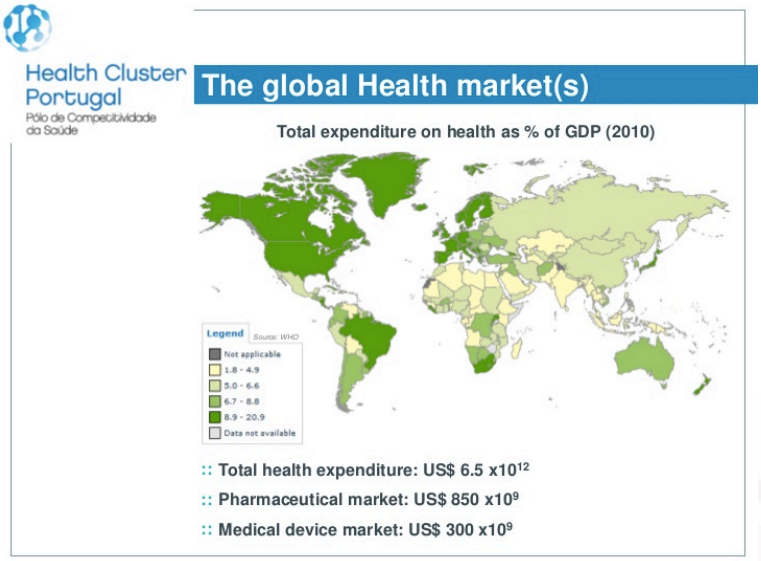
http://www.who.int/emergencies/attacks-on-health-care/attacks-on-health-care-2016.pdf?ua=1

There is an urgent need to better protect the wounded and sick, medical professionals, and healthcare facilities and equipment during conflicts. Violence against civilians and healthcare workers, and obstruction of access to proper medical care, are serious violations of both International Human Rights Law (IHRL) and International Health Law (IHL). The international community needs to cooperate to get all parties to abide by IHRL and IHL, which require access to medical care and protection for those who provide it.[3] Delivering medical aid in areas of conflict is both an important international human rights obligation and a crucial step towards lasting peace. WHO works with government agencies and other organization to provide health care to residents, IDPs, and refugees in armed conflicts throughout the world. This committee should look to solve the issue of aid worker safety and develop ideal responses in high-danger areas in order to ensure medical aid in areas of conflict.

History

Historically, WHO has been more involved in the regulation, prevention, and eradication of widespread diseases, but the Organization has also delivered aid in some of the most deadly conflicts, including the war in Iraq. The goal of WHO intervention in areas of conflict is to reduce avoidable loss of life by responding to emergencies and delivering timely, efficient aid. WHO responds to emergencies with networks for Emergency Risk Management and Humanitarian Response, as well as the Global Health Cluster, an

initiative that WHO heads. The Global Health Cluster coordinates worldwide information and resources for maximizing ability to respond to emergencies, and currently covers over 70 million people in 24 countries. In organizing



Impact of Global Health Cluster

https://image.slidesharecdn.com/hcpbeta-trends20120905luissoares-120906092649-phpapp02/95/health-cluster-sector-lus-soares-2-728.jpg?cb=1346924317

responses to emergencies, WHO also works with the Inter-Agency Standing Committee (IASC), a body that develops and protects humanitarian goals in emergencies.[4]

WHO has attempted to carry out the duty to deliver medical aid in areas of conflict in accordance with IHL and IHRL. IHL dictates a right to life, IHRL a right to health, and IHL requires all parties to a conflict, even non-state actors, to provide medical attention to those in need without delay. Together, these internationally approved codes dictate that aid shall be non-discriminatory, attacks or the use of force on wounded or aid workers is prohibited under normal circumstances, and access to health facilities shall not be denied under normal circumstances. Furthermore, parties to a conflict are obligated to protect the wounded and sick and healthcare personnel from

interference, probably by means of a third party.[5]

Current Situation

WHO ranks health concerns, crises and emergencies to determine the response. Ungraded countries of concern have experienced an event that is being monitored but currently requires no WHO response. Grade 1 is a single or multiple country event with minimal public health consequences that requires a minimal response from the country office or WHO. Grade 2 is a single or multiple country event with moderate public health consequences, and Grade 3 is the most severe event with significant public health consequences. The response to these emergencies is led by a country office and/or WHO and coordinated by an Emergency Support Team in a regional office. Emergency responses are thoroughly outlined by WHO, but logistics and finance need to be coordinated in each case.

WHO is currently leading the response to Grade 3 crises in six countries: Ethiopia, Iraq, Nigeria, South Sudan, Syrian Arab Republic and Yemen. In three of these countries, Iraq, Syrian Arab Republic and Yemen, the emergencies and the resulting public health crises are the direct result of conflict. A recent Red Cross report, "I Saw My City Die," found that between 2010 and 2015, nearly half of all civilian war deaths worldwide occurred in these three countries. The fighting is especially deadly in cities such as Mosul, Iraq and Raqqa, Syria. More than 17 million Iraqis, Syrians and Yemenis have fled the fighting — a level of displacement that the Red Cross says has not been seen since World War II.[6]

Mosul Crisis in Iraq

In 2014, Sunni militants closely aligned with the Islamic State of Iraq and Syria (ISIS) spilled over the border from Syria and captured Iraq's second-largest city, Mosul, from the fleeing Iraqi Army. After a brutal eight-month battle, Iraqi forces, with support from American airstrikes and advisors, have now nearly retaken Mosul from the Islamic State (IS). But as Iraqi forces move west through the old city, the remaining Islamic State militants are putting up fierce resistance. As of July 2017, 920,000 residents have fled the fighting while an estimated 15,000 remain trapped in a small pocket of the city that perhaps 150 remaining Islamic State militants are barely holding.[7]

In a recent statement, the Red Cross said the fighting in Mosul, as well as Raqqa, Syria, has left "people caught between a rock and a hard place, desperate to stay alive under a deluge of airstrikes, sniper fire, shelling, and bombs." The organization said its doctors at Mosul General Hospital, near the frontline of fighting, have treated hundreds of civilians with terrible injuries including many small children.[8]

When Iraqi forces began their offensive in the fall of 2016, the UN warned of a major crisis if even a fraction of the city's residents were to flee. "In a worst-case scenario, we're literally looking at the single largest humanitarian operation in the world in 2016," said Lise Grande, the UN's humanitarian coordinator in Iraq.[9] According to the WHO's latest situation report, more than 13,000 injured civilians have been treated in hospitals, more than 7,650 trauma patients have been

treated at trauma stabilization points, more than 860,000 people have been displaced from Mosul (half of which are living in camps in Ninewa and neighboring governorates of Erbil and Dahuk), and a total of 2.7 million people are in need of health services.[10] In addition to conflict-related trauma, major health issues include cholera outbreaks, acute respiratory infections, acute diarrhea and suspected scabies, and most recently foodborne illness. Overall, in Iraq, more than four million Iraqis are currently displaced -- including 1.1 million living in camps and emergency sites -- and 10.3 million people in need of health humanitarian assistance.[11]

WHO Aid in Mosul
http://www.who.int/hac/crises/irq/iraq-mosul-report-17June2017.jpg

Syrian Arab Republic

The conflict in the Syrian Arab Republic is complex and multi-sided. What began as another Arab Spring uprising against an autocratic ruler in 2011 has become a brutal proxy war that has drawn in regional and world powers. Violent clashes between pro-democracy protesters seeking the removal of President Bashar al-Assad and government security forces sparked a civil war. By 2012 fighting between newly formed rebel brigades and government forces had reached the capital of Damascus and the city of Aleppo. The political battle is complicated by the fact that there are several rebel groups, often competing with one another, as well as the sectarian

nature of the conflict, pitting the country's Sunni majority against al-Assad's Shia Alawite sect.

The Islamic State (IS) capitalized on the instability in the region to seize large swathes of Syria and Iraq, where it proclaimed the creation of a "caliphate" in June 2014. In Syria, these IS militants have been fighting the government, rebel forces, rival jihadists from the al-Qaeda-affiliated Nusra Front, and Kurdish People's Protection Units (YPG) seeking more autonomy. Russia, Iran, and Lebanon's Shia Hezbollah movement have been backing Assad's Alawite government; the US, UK, France, Turkey, Saudi Arabia, Qatar, and Jordan support the Sunni rebels.

The civil war in Syria is "the worst humanitarian disaster of our time," according to the Safeguarding Health in Conflict Coalition. In its March 2016 report, the coalition estimated that 400,000 people had died during the conflict, over half of the country's 22 million people had been displaced, and 13.5 million people were left in need of humanitarian assistance. Since then, the situation has worsened. Physicians for Human Rights (PHR), which tracks and reports on attacks on health, documented 365 attacks on 259 medical facilities and recorded the deaths of 757 health care workers as of June 2016. Attacks on health facilities occurred every 17 hours in Aleppo by August, and in September, an aid convoy was attacked and destroyed, killing 20 aid workers and preventing the delivery of vital supplies. In October, Médecins Sans Frontières/ Doctors Without Borders (MSF) reported that there were only 11 ambulances left in Aleppo. By the end of the

year, the intense bombings in Aleppo left remaining hospitals on the rebel-held side of the city so badly damaged they were forced to stop providing care.[12] In Raqqa in the northeast, WHO reports that 150,000 people have been displaced by fighting so far this year -- many living in camps with limited access to food, water and medicine -- and all four national hospitals in the governorate are only partially functioning and facing shortages in health staff, medicine, electricity and water.

There are global governance efforts focusing on health care in conflict. UN Security Council Resolution 1998, unanimously adopted in July 2011, focuses on the protection of children, schools and hospitals in armed conflicts. The World Health Assembly's 2012 Resolution called for leadership from WHO to collect and disseminate data on attacks on health care in humanitarian emergencies. Security Council Resolution 2286, unanimously adopted in May 2016, focused on health care in armed conflict. In recent years, WHO has been testing a system for collecting data on attacks on health care in Central African Republic, the Syrian Arab Republic, and the West Bank and Gaza Strip in Israel.

On a more practical level, WHO provides medical consultations in health facilities in areas of conflict, distributes diagnostic kits for communicable diseases to health care facilities, distributes emergency medical supplies and equipment to partners in camps and hospitals, and trains health workers to diagnose and treat mental and substance abuse disorders. In March, WHO supported a campaign that

provided polio vaccinations to 45,187 children under the age of five in Ar-Raqqa. WHO and partners monitor the situation in areas where the need for shelter, food, water and health care is most acute and pushes for increased access to meet these urgent needs.

Possible Solutions

Improvements to delivering aid in areas of conflict can be made in two main ways: developing ideal emergency response procedures for high-danger situations and ensuring the safety of aid workers. Basic measures can be taken to maximize safety and effectiveness of medical aid in armed conflicts. Safety and security procedures can be drawn up for each individual situation, with contingency plans that are drilled including necessary supplies and services in the case of emergency. Walled perimeters controlling access and entry points, designated security, and early warning systems have proved indispensable.[13] Preventive measures have also proved effective, including strategic location choice and placement of windows, fire-resistant building materials, and sufficiently high boundary walls. It is important for the international community to hold warring parties accountable for considering effects on health in acts of war. The use of explosives should be avoided in densely populated areas or cities both for the human concern and for the effects on important infrastructure. Healthcare aid should, whenever possible, protect urban life-support systems from the destruction of war, as water, electrical, and sanitation services are key to the

health of the population. Medical aid can also assist in the reconstruction process of cities and infrastructure, which is proven to be important in health recovery.[14] Finally, the system of protective emblems for medical aid workers should be expanded and its effectiveness guaranteed by regulating misuse and addressing violations.[15]

Red Cross Emblem
http://www.redcross.lk/wp-content/uploads/2012/01/Emblem_08.jpg

As far as ensuring the safety of aid workers, a primary step could be to have all member-states agree to align their domestic legislation to abide by the obligations held under IHL and IHRL. Specifically, this plan would require the recognition of violence against aid workers and the wounded and sick as a war crime and commitment to the obligation to provide protection to aid workers. Additionally, despite all the data the UN keeps on war victims, refugees, IDPs, and other aspects of humanitarian crises, until recently there was nearly no tracking of health-specific attacks. Poor records have led to poor accountability and poor compliance. For obvious reasons of great involvement with healthcare in armed conflict, WHO is in an ideal position to keep this data, analyze it, and provide reports on these attacks.[16] WHO has kept data on attacks recently, but significantly more can be done in identifying the perpetrators, motives, modus operandi, and reporting on these findings. Furthermore, these findings can

be presented to the Security Council with suggested repercussions for greater accountability.

Bloc Positions

The international community generally agrees upon the necessity of ensuring access to healthcare during armed conflict and safeguarding medical aid workers, so this issue is not a particularly divisive one. However, many members have current armed conflicts or have experienced recent attacks on aid workers, and they may have specific concerns they want to address. In 2016, attacks on health workers occurred in 23 countries: Afghanistan, Armenia, Central African Republic, Democratic Republic of the Congo, Egypt, Ethiopia, Iraq, Israel and the Occupied Palestinian Territory, India, Libya, Mali, Mozambique, Myanmar, Niger, Nigeria, Pakistan, Somalia, South Sudan, Sudan, Syria, Turkey, Ukraine, and Yemen.[17] In addition, some countries are more receptive than others to international involvement or intervention, and may push for consensus on steps to provide medical aid and protect workers to different degrees. Beyond the policy of the general region, delegates are strongly encouraged to research their individual country's policy.

Western Hemisphere and Asia

In 2016, none of the 302 attacks on medical aid workers occurred in the Western Hemisphere or Eastern Asia.[18] Members from North and South America and East Asia will likely look to find ways to make sure International Humanitarian Law is enforced with regards to healthcare in armed conflict, and, with variation depending on political sides in individual conflicts, take a tougher line against the violations perpetrated by warring parties.

Middle East and Africa

The vast majority of recent conflicts and attacks on healthcare workers has occurred

in the Middle East and Africa.[19] Countries in these regions will generally be less concerned with the rights and protection of medical aid workers as they are with their interests of fighting in the conflicts. Therefore, these countries are less receptive to legislation or action to protect medical aid workers or increase accountability for violations of IHL or IHRL. However, the humanitarian governments of these regions will still look for ways to ensure healthcare is delivered in areas of conflict.

Questions to Consider

1. What environment-related health effects are present in your country? Has your country taken any action against them?
2. What is your country's stance towards recognizing/addressing climate change? What is your country's history with international intervention/aid?
3. How can solutions address specific regions, specific problems, and varying degrees of vulnerability?
4. How can UNEP work with the private sector to reduce anthropogenic emissions harmful to health and utilize NGOs?
5. What is your country's response protocol for natural disasters, epidemics, or outbreak of disease? Does your country work internationally on health issues?
6. How can solutions keep watch over the effects of climate change on human health and mitigate its effects in the long term?

SOURCES

[1] http://www.who.int/en

[2] http://www.who.int/emergencies/response-plans/2017/iraq/en

[3] http://www.who.int/emergencies/attacks-on-healthcare/en/

[4] http://www.who.int/hac/en

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[6] https://www.icrc.org/en/document/iraq-syria-and-yemen-five-times-more-civilians-die-city-offensives-new-report-finds

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[11] http://www.who.int/emergencies/response-plans/2017/iraq/en

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[19] https://www.safeguardinghealth.org/sites/shcc/files/SHCC2017final.pdf