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WORLD HEALTH ORGANIZATION
BACKGROUND GUIDE 2014

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NATIONAL MODEL UNITED NATIONS

NATIONAL COLLEGIATE CONFERENCE association™

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THE 2014 NATIONAL MODEL UNITED NATIONS

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30 Mar. – 3 Apr. (Conference A) & 13 - 17 Apr. (Conference B) • nmun.org

Dear Delegates,

Welcome to the 2014 National Model United Nations Conference and welcome to our committee, the World Health Organization (WHO). As members of the volunteer staff, we are excited to serve you as Directors and aim to facilitate your educational experience at the conference in New York. The Director for Conference A, Molly Deacon, holds a BA degree in International Studies from Wells College, and in 2015, she expects to receive her JD from SUNY Buffalo Law School. She volunteers her time at the Immigration Legal Services Program at Journey's End Refugee Services, an organization that assists refugees and their families in Western New York. This is her fourth year on staff. The Director for Conference B, Nyla Langford, graduated from Texas Christian University in 2010 and currently works for a consulting company that specializes in oncology clinical research and drug development. This is her third year on staff.

This year's topics under discussion for WHO are:

I. Improving Access to Mental Health Resources in Industrializing Countries
II. Strengthening Partnerships, Research, and Response Preparedness to Combat Pandemic and Resistant Disease
III. Improving Women's Health by Integrating Gender, Equity and Human Rights

Although WHO is an autonomous organization, it is the directing and coordinating authority for health within the United Nations system. Through WHO, governments can jointly tackle health problems to improve people's quality of life. Your creative ideas and innovative solutions, discussed and negotiated in the committee, can therefore contribute to human rights and security all over the world.

At NMUN•NY 2014, we are simulating the Executive Board of WHO in terms of composition and size, however delegates are not limited to the strict mandate of the Board in terms of its role as a budgetary and administrative body. On the contrary, for the purposes of NMUN•NY 2014, and in line with the educational mission of the conference, the committee has the ability to make programmatic and policy decisions on issues and topics within the mandate of WHO in line with the overall function of the organization.

This background guide is intended to provide you with an overview of the topics for discussion and a list of references to start your research as you prepare for the conference. This guide contains the most prominent developments related to WHO, but it is by no means exhaustive. Delegates are expected to conduct additional research in order to develop a comprehensive understanding of each topic as well as their respective delegations' positions and desired actions. For this reason, discussion questions may be found at the end of each topic guide to suggest possible directions for analysis and to stimulate dialogue at the conference.

In preparation of the conference, each delegation will be submitting a position paper. Please take note of the NMUN policies on the website and in the Delegate Preparation Guide regarding plagiarism, codes of conduct/dress code/sexual harassment, awards philosophy/evaluation method, etc.

If you have any questions concerning your preparation for the Committee or the Conference itself, feel free to contact the substantive staff listed below or the Under-Secretaries-General for the Department of Human Rights and Humanitarian Affairs, Meg Martin (Conference A) and Juliane Bade (Conference B): usg.hr_ha@nmun.org

We wish you all the best for your preparation for the conference!

Sincerely,

Conference A
Molly Deacon, *Director*
who.nya@nmun.org

Conference B
Nyla Langford, *Director*
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NMUN•NY Position Paper Guidelines

Due 1 March 2014

Each committee topic should be addressed in a succinct policy statement representing the relevant views of your assigned country, Non-Governmental Organization (NGO), or expert role. You should identify and address international and regional conventions, treaties, declarations, resolutions, and programs of action that are relevant to the policy of your country or NGO. You should also include recommendations for action to be taken by your committee. A delegate's role as a Member State, Observer State, or NGO should affect the way a position paper is written. To understand these differences, please refer to the Delegate Preparation Guide. It may also be helpful to view a Sample Position Paper.

A position paper should be submitted for each assigned committee.

- The two page position paper should cover all the topics in the background guide, not a separate paper for each topic.
- Do not submit papers for committees not assigned to your country/NGO (see matrix for Conf. A or Conf. B).
- No more than two delegates can represent a single country/NGO in a committee. If you assign two delegates to represent a country/NGO on a committee, they submit one position paper jointly, not separate position papers from each individual.

Please pay careful attention to the following guidelines when drafting and submitting your position papers. Only those delegations that follow the guidelines and meet the submission deadline will be eligible for position paper awards.

All papers must be typed and formatted according to the standards below:

- Length must not exceed two pages
- Margins must be set at 1 inch or 2.54 cm. for the whole paper
- Font must be Times New Roman sized between 10 pt. and 12 pt.
- Country/NGO name, school name, and committee name must be clearly labeled on the first page
- Agenda topics must be clearly labeled in separate sections
- National symbols (headers, flags, etc.) are deemed inappropriate for NMUN position papers

Please note that position papers must be comprised of entirely original writing. **The NMUN Conference will not tolerate plagiarism**, including copying from Committee Background Guides. Violation of this policy may result in dismissal from the conference. Although United Nations documentation is considered within the public domain, the conference does not allow the verbatim re-creation of these documents.

How to Submit Your Position Papers

Position papers need to be submitted by email in .pdf or .doc formats. As proof of submission, include yourself as an email recipient. Please use the committee name, your assignment, Conference A or B, and delegation/school name in both the email subject line and in the filename (example: GA1_Cuba_Conf A_State College).

1. Send one complete set of all position papers for each of your country/NGO assignments to the Deputy Secretary-General for the conference you are attending:

   Conference A: positionpapers.nya@nmun.org
   Conference B: positionpapers.nyb@nmun.org

2. Send a copy of your position paper for each assigned committee to the corresponding committee email address listed on the Committee Background Guides page.

Your delegation may wish to submit a copy of their position papers to the permanent mission of the country/NGO headquarters along with an explanation of the conference. This is encouraged if requesting a briefing.

Many, many papers will be read by the Secretariat. Your patience and cooperation in adhering to the above guidelines is greatly appreciated.

Abbreviations

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral treatment
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CSW	Commission on the Status of Women
DALY	Disability-Adjusted Life Year
DCE	Disease Control in Humanitarian Emergencies
ECOSOC	Economic and Social Council
EWARN	Emergency Warning and Response Network
GA	General Assembly
GAR	Global Alert and Response
GBD	Global Burden of Disease
GDP	Gross Domestic Product
GER	Gender, Equity and Human Rights
GIPC	Global Infection Prevention and Control
GOARN	Global Outbreak Alert and Response Network
GWH	Gender, Women and Health
GWHN	Gender, Women and Health Network
HIV	Human immunodeficiency virus
IHR	International Health Regulations
IMAGE	Intervention with Microfinance for AIDS and Gender Equity
MDG	Millennium Development Goals
MHTF	Maternal Health Thematic Fund
NGO	Non-Governmental Organization
NMHP	National Mental Health Programme
PED	Pandemic and Epidemic Disease
PHEIC	Public Health Emergency of International Concern
PIPF	Pandemic Infection Preparedness Framework
SAGE	Study on Global Ageing and Adult Health
SARS	Severe Acute Respiratory Syndrome
SHOC	Strategic Health Operations Centers
SUPRE	Suicide Prevention
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WER	Weekly Epidemiological Record
WHO	World Health Organization

Committee History

Introduction

The World Health Organization (WHO) was established in 1945 as the result of a meeting of the UN Conference on International Organizations.[1] The *Constitution of the World Health Organization* was approved the following year, and in 1948, the first session of the World Health Assembly convened to decide what the priorities of the organization would be.[2] Over the years, many of those priorities have remained on WHO's agenda - malaria, maternal health, and nutrition, for instance, and unfortunately, remain relevant to this day – alongside newly recognized public health challenges, such as mental health and HIV/AIDS.[3]

Since its inception, WHO has been successful in eliminating or making scarce numerous threats to global health.[4] Smallpox, once a worldwide epidemic, was last documented in 1977 thanks in large part to a program led by WHO.[5] A comparable campaign is still underway to eradicate polio, and although some milestones have not been met, the extent to which the disease is found throughout the world has diminished drastically.[6] The rates at which infants and children are vaccinated against potentially deadly diseases have climbed impressively since WHO first began its campaign to ensure childhood immunization in 1974.[7] These are among only a few of the Organization's accomplishments, and the list continues to grow.

> At NMUN•NY 2014, we are simulating the Executive Board of the WHO in terms of composition and size; however, delegates are not limited to the strict mandate of the Board in terms of its role as a budgetary and administrative body. On the contrary, for the purposes of NMUN•NY 2014, and in line with the educational mission of the conference, the committee has the ability to make programmatic and policy decisions on issues and topics within the mandate of WHO in line with the overall function of the organization.

Mandate

The mandate of the WHO can be read in the Organization's Constitution, which enumerates several general objectives and functions.[8] The Constitution empowers WHO to act in the interest of public health through research in health-related fields, promotion of preventative health care, provision of specialized aid and assistance in emergencies, and standardization of practices.[9] Mental health, maternal and child health, nutrition, and sanitation are all specifically mentioned in the Constitution, implying the special importance of these topics.[10] Some of WHO's other stated functions are to assist governments in building their health systems, to eradicate disease, to develop standards for food and pharmaceuticals, and to work vigorously toward the Organization's objective of "the attainment by all peoples of the highest possible level of health."[11]

Governance, Structure and Membership

The WHO is comprised of three primary organs. The World Health Assembly is its plenary, decision-making body. The Executive Board -which adopts resolutions and was created by the World Health Assembly- deals with the administrative functions of the organizations. The Secretariat is comprised of experts and other staff who work to facilitate WHO's work throughout the world.[12]

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[1] McCarthy, *A Brief History of the WHO,* 2002.
[2] Ibid.
[3] McCarthy, *A Brief History of the WHO,* 2002; WHO, *Health Topics*, 2013.
[4] Ibid.
[5] Ibid.
[6] Global Polio Eradication Initiative, *Data and Monitoring*, 2010; McCarthy, *A Brief History of the WHO,* 2002.
[7] McCarthy, *A Brief History of the WHO,* 2002; WHO, *Global Immunization Data*, 2013.
[8] WHO, *Constitution of the WHO,* 2006.
[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] WHO, *Governance*, 2013.

WHO's membership is comprised of 164 Member States, each of which may send delegations to meetings of the World Health Assembly.[13] The Executive Board's membership is drawn from the following regions: seven members from Africa; six from the Americas; three from South-East Asia; eight from Europe; five from the Eastern Mediterranean; and five from the Western Pacific.[14] The Executive Board includes 34 members who are elected for three-year terms.[15] These members are appointed by their respective Member States, and they meet twice annually.[16]

WHO is currently in the process of reforming its own structures in order to create a more efficient organization that is better integrated with other actors in the field of global public health. As part of this process, WHO is seeking input from non-state actors and the Executive Board's meetings regarding its partnerships and reassessment of its objectives into the next five years.[17] In 2013, WHO adopted its 2014-2019 work programme and its budget for the next year.[18] In 2014, WHO will discuss proposals for "streamlined reporting of Member States" and outcomes of efforts for financial reform.[19]

Powers & Functions

The WHO is governed, on its most basic level, by its Constitution.[20] WHO's Six Point Agenda also guides the Organization,, providing broad objectives through which the Organization will focus its work.[21] Guidelines approved by WHO govern its work and are aimed at improving Member States' national health policies, and by influencing action in that capacity, they influence the work of WHO as a whole.[22] WHO's Constitution also places a special emphasis on cooperation with similar organizations and agencies.[23] This cooperation is aimed at promoting preventive health measures, such as sanitation, nutrition, and shelter, and at partnering with scientists and specialists in order to advance technological, research, and policy goals for global health.[24]

The World Health Organization may adopt resolutions on agenda topics; this is the Organization's primary way of presenting recommendations relating to global public health.[25] The WHO Executive Board is responsible for the implementation of these resolutions.[26] The Executive Board may also address proposals made by Member States, establish new committees, delegate tasks to those committees, and make recommendations to Member States for the reformation of their own individual health policies.[27]

Special awareness campaigns and other targeted programs also make up a large part of WHO's work.[28] The Organization devotes specified days annually to topics such as tuberculosis, tobacco use, hepatitis, and malaria, among others.[29] These days focus on promoting awareness of the issues to which they are dedicated, forming new partnerships with donors, and stimulating the creation of work related to those issues.[30] Research is also one of WHO's crucial functions.[31] From research on specific pathogens and diseases, such as tropical disease and cancer, to research into what health care policies may be most effective for Member States, WHO plays a crucial role as a fact-finder.[32]

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[13] Ibid.
[14] WHO, *Composition of the Executive Board*, 2013.
[15] WHO, *Executive Board*, 2013.
[16] Ibid.
[17] WHO, *Governance Reform*, 2013.
[18] WHO, *Our Reform Story*.
[19] Ibid.
[20] WHO, *Constitution of the WHO,* 2006.
[21] WHO, *The WHO Agenda*.
[22] WHO, *WHO guidelines approved by the Guidelines Review Committee*, 2013.
[23] WHO, *Constitution of the WHO,* 2006.
[24] Ibid.
[25] WHO, *Governance*, 2013.
[26] WHO, *Executive Board*, 2013.
[27] Ibid.
[28] WHO, *Programmes and Projects*.
[29] Ibid.
[30] Ibid.
[31] Ibid.
[32] Ibid.

Recent Sessions

At the Sixty-sixth World Health Assembly, WHO's Member States drafted and approved plans to address mental health, meeting the Millennium Development Goals by 2015, the realization of universal health coverage, and preparedness for the possibility of an influenza epidemic.[33] These were only some of the topics discussed by the Assembly between 20 May and 27 May 27 2013.[34] These discussions indicate the objectives and priorities of WHO for coming years, and while some concerns, such as influenza and malaria, have been constant, others are new, such as the availability of information on the Internet.[35] At its most recent session, the Executive Board heard reports on autism spectrum disorders, LGBT health concerns, and WHO governance reform.[36]

In August, 2013, WHO also released its annual World Health Report.[37] This year, the report focuses on universal health coverage.[38] The report includes findings that more new research is coming from "emerging" countries, indicating the increased involvement of countries that have not always been fully engaged in the dialogue regarding global health.[39] More broadly, the report assesses how the body of research that already exists can be better put to use to attain the goal of universal access to care.[40]

Conclusion

The World Health Organization's history is long and eventful, dating back to the earliest days of the United Nations system.[41] While the Organization claims many successes, it faces new challenges in a world that is becoming increasingly globalized and connected.[42] WHO continues toward its objectives of research, cooperation, awareness, and facilitation, as well as the long-term goal of optimal global health. The issues on which WHO directs its resources may now be different than they were when the Organization was founded, but they are equally as urgent and relevant.[43] Now, by integrating emerging countries and NGO partners in its dialogue and solutions, its approaches to global public health may be strengthened and broadened.[44]

Annotated Bibliography

Charles, J. (1968). Origins, History, and Achievements of the World Health Organization. *British Medical Journal*, 2 (5600): 293-296.

This journal article captures the early history of the World Health Organization and traces the roots of the Organization back to the turn of the century. The article provides outside commentary on the early progress of WHO and provides specific examples of the beginnings of its involvement in shaping health policy around the world. This text captures WHO's initial priorities, and reading this article, delegates may compare and contrast those priorities with the topics that are in the spotlight today.

World Health Organization. (1958). *The First Ten Years of the World Health Organization*. Geneva: World Health Organization.

This publication, which the World Health Organization released after its first decade in operation, presents an organized guide to its early history and work. The WHO published three similar guides, and together, these document the first forty years WHO. For delegates, this publication will be instrumental to an understanding of how WHO came into existence and how its history led to the Organization in its present form.

[33] WHO, *Sixty-sixth World Health Assembly: Daily Notes on Proceedings*, 2013.
[34] Ibid.
[35] Ibid.
[36] WHO, *Executive Board 133rd Session Programme of Work*, 2013.
[37] WHO, *World Health Report 2013: Research for Universal Health Coverage*, 2013.
[38] Ibid.
[39] Ibid.
[40] Ibid.
[41] McCarthy, *A Brief History of the WHO*, 2002.
[42] WHO, Sixty-sixth World Health Assembly: Daily Notes on Proceedings, 2013.
[43] McCarthy, *A Brief History of the WHO*, 2002.
[44] WHO, *World Health Report 2013: Research for Universal Health Coverage*, 2013.

World Health Organization. (2013). *Composition of the Executive Board* [Website]. Retrieved 29 July 2013 from: http://www.who.int/governance/eb/eb_composition/en/index.html

As delegates will be emulating the WHO Executive Board at NMUN, this [Website] will be instrumental in building an understanding of the structure and function of this organ. From this [Website], delegates may access background information, documents, and decisions from the Executive Board that should guide work created by the committee.

World Health Organization. (2006). *Constitution of the World Health Organization*. Retrieved 4 July 2013 from: http://www.who.int/governance/eb/who_constitution_en.pdf
The Constitution of the World Health Organization is the primary document outlining the structure, mandate, and functions of the World Health Organization. Reading this document will be crucial to delegates' understanding of the purpose of the World Health Organization and its mandate. Delegates should bear this document in mind as they conduct their research and work on the issues presented at the conference.

World Health Organization. (2013). *Documentation: WHA 66* [Website]. Retrieved 1 August, 2013 from: http://apps.who.int/gb/e/e_wha66.html

This website serves as a guide to the most recent session of the World Health Assembly, which convened in May 2013. A log of the topics the Assembly addressed throughout the week may be of interest, as it gives an overview of WHO's most current priorities. Further, documents produced by the Assembly at its most recent session may be found here, and these provide further insight into the function of the Organization and the interpretation of its mandate and Constitution moving forward.

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I. Improving Access to Mental Health Resources in Industrializing Countries

Introduction

The World Health Organization (WHO)'s focus early in its history was to put an end to debilitating, communicable diseases, such as smallpox and polio.[45] Now, however, non-communicable and "invisible" diseases and disorders, including mental illnesses, have gained increased attention from the international community.[46]

Mental health, as defined by WHO, is "more than the mere lack of mental disorders."[47] WHO frames the subject holistically; a person who is mentally healthy will be healthier overall.[48] WHO also recognizes the damage that occurs when mental illness is not addressed appropriately.[49] These disorders can be the cause of unemployment, homelessness, and other hardships for individuals, but because they are so common, they have a massive effect on the communities in which they occur.[50] Mental illness may not always be easily recognized, especially in communities where access to even basic medical care is limited, but it is certainly not innocuous.[51]

Good mental health is recognized as a key contributor to overall wellness and longevity.[52] Despite this, woefully conspicuous gaps in care exist in this area, to the detriment of those who suffer from mental illness as well as those close to them.[53] This remains a problem in industrializing and industrialized countries, but industrializing countries face a distinct set of challenges when approaching the question of how best to promote mental health.[54] These challenges are financial, practical, and social in nature, and can be attributed in part to a lack of access to tangible and intangible medical resources.[55] While the path to mental health for industrializing countries may seem long and perilous, WHO has begun to work toward this immensely important global health goal, as have individual Member States and communities within those Member States.[56]

The Importance of Mental Health for Industrializing Countries

While mental health may be thought to be secondary to physical health, it is, in fact, a widespread cause of morbidity and mortality.[57] Some disorders, especially those that lead to suicide, can be deadly in and of themselves. Others, which can cause sufferers to engage in high-risk activities or to be unable to care for themselves, can lead to the development of chronic, physical ailments, such as heart disease and cancer.[58] Those suffering from depression, for instance, comprise a disproportionately high percentage of those also suffering from hypertension, epilepsy, diabetes, and HIV/AIDS.[59]

That is not to say that the high physical cost of mental illness is the only cost; in fact, the costs of mental illness frequently extend from the individual suffering to society as a whole.[60] According to WHO, "four of the six leading causes of years lived with disability," are due to mental illnesses, the most common one being depression, which has reached epidemic levels in many countries.[61] Untreated mental illness is also often linked with substance abuse, the

[45] WHO, *The First Ten Years of the WHO*, 1958.
[46] Levin, A., *WHO Plan Guides Nations on Improving Mental Health Care*, 2013.
[47] WHO, *Investing in Mental Health*, 2003.
[48] Ibid
[49] Ibid
[50] Ibid
[51] Ibid
[52] Ibid
[53] Saraceno, B., & M. van Ommeren, et. al., *Barriers to improvement of mental health services in low-income and middle-income countries*, 2007.
[54] WHO, Investing in Mental Health, 2003.
[55] Saraceno, B., & M. van Ommeren, et. al., *Barriers to improvement of mental health services in low-income and middle-income countries*, 2007.
[56] WHO, *mhGAP Mental Health Gap Action Plan: Scaling up care for mental, neurological, and substance use disorders*, 2008.
[57] WHO, *Investing in Mental Health*, 2003.
[58] Ibid
[59] Ibid
[60] Ibid
[61] Ibid

consequences of which are well recognized, and with high- risk behaviors, such as unprotected sex, which contributes to the transfer of sexually transmitted infections.[62] The burden poor mental health places on families is also severe.[63] Individuals afflicted with mental illness are subject to stigmatization and disconnection from society, and without a heightened awareness and sensitivity to these disorders, members of these individuals' families suffer as well.[64] Further, in areas where mental health care is not always available, families of those who are disabled by mental illness become caregivers, placing a significant financial and personal burden on them.[65] Suicide, which is frequently a consequence of many untreated mental illnesses, adds to that burden by placing emotional strain and distress on loved ones.[66]

In industrializing countries, many of which are already tasked with combating problems of poverty, relative political and institutional instability, and higher rates of unemployment, the burden of mental illness can be especially difficult to bear.[67] Without access to specialized care and without "safety nets" in place to assist those who become disabled by mental illness, the problems arising from the illness can be aggravated.[68]

International Framework

The work of WHO and its Member States in the area of mental health is guided not only by its own constitution, but also by certain key documents that relate either directly or indirectly to the issue.[69] Instruments related to mental health include the Principles for the Protection of Persons with Mental Illness (1991), the International Covenant on Economic, Social, and Cultural Rights (1966), the International Covenant on Civil and Political Rights (1966), and the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993).[70]

Recent Steps

Mental health has become a topic of recent interest for the World Health Organization for a number of reasons. As of October 2012, WHO estimated that 350 million people suffer from depression, and the number is rising, imposing an ever-greater burden on the world's health resources.[71] Additionally, concern over the omission of mental health as a Millennium Development Goal caused concern for public health experts.[72] These, and other factors, have driven mental health to the forefront of WHO's agenda.

At its sixty-sixth session, the World Health Assembly revised and approved the *Draft Comprehensive Mental Health Action Plan for 2013-2020*.[73] WHO plans to work to coordinate mental health services across various relevant sectors to promote mental health and wellness worldwide.[74] By partnering with other United Nations agencies, WHO intends to combat substance abuse and mental illness and to promote preventative measures to promote mental health.[75] The Action Plan addresses risk factors for mental illness while recognizing that mental illness can affect anyone, regardless of nationality or socioeconomic class.[76] The plan is guided by the *Convention on the Rights of Persons with Disabilities* (2006) and acknowledges mental illness as a major cause of disability globally.[77]

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[62] Ibid.
[63] Ibid.
[64] Ibid.
[65] Ibid.
[66] Ibid.
[67] Saraceno, B., & M. van Ommeren, et. al., *Barriers to improvement of mental health services in low-income and middle-income countries*, 2007.
[68] WHO, *Investing in Mental Health*, 2003.
[69] WHO, *The Role of International Human Rights in National Mental Health Legislation*.
[70] Ibid.
[71] WHO, *Depression* [Website], 2012.
[72] Saraceno, *Barriers to improvement of mental health services in low-income and middle-income countries*, 2007.
[73] WHO, *Draft Comprehensive Mental Health Action Plan for 2013-2020*, 2013.
[74] Ibid.
[75] Ibid.
[76] Ibid.
[77] Ibid.

This Action Plan specifically recognizes the need for improved mental health services in "low-income and middle-income countries," many of which are also industrializing countries.[78] The text of the plan notes that mental health framework established by legislatures only reach 36% of people living in low-income countries, leaving an extraordinarily large percentage of the population without access to care.[79] In order to ameliorate this gap, the Action Plan recommends an expansion of civil society movements, including non-governmental organizations (NGOs), which may provide needed assistance in this area.[80] One fundamental goal of the Action Plan is to reduce "the treatment and service gap for mental disorders […] by 20%."[81]

Emerging Opportunities

The effectiveness of mental health-related NGOs makes them valuable partners for WHO.[82] WHO's focus for the next seven years will be guided by the *Comprehensive Mental Health Action Plan*.[83] This means that WHO's objectives for mental health will be to facilitate actions by Member States to establish and improve mental health services, to bring mental health care to communities that were not reached previously, to plan for the prevention of mental illnesses, and to improve access to information regarding mental health.[84] Work is needed in all of these areas, especially in industrializing countries where the necessary structures may not yet be in place.[85]

mhGAP, which deals specifically with gaps in mental health care in low- and middle-income countries, will also guide WHO's work over the next several years.[86] Most recently, WHO's work related to this program has targeted personnel in industrializing and developing countries for training in mental health, and in order to ensure the adequacy of mental health services worldwide.[87] Substance abuse and autism were among specific issues that mhGAP addressed in recent months, and work to decrease stigma surrounding depression is ongoing.[88] Opportunities still exist for progress in all of these areas, and mhGAP's goal of improving services and access to those services in industrializing countries has still not been met.[89]

Role of the United Nations System

The obstacles to providing adequate mental health care in industrializing countries are numerous and relatively well-documented.[90] One such obstacle is the insufficiency of funding allocated to mental health and related initiatives.[91] This shortcoming can be explained in part by the low visibility of mental health as an agenda item until recent years.[92] On an international level, with mental health having been excluded as a Millennium Development Goal-related target, it has not received the attention of organizations and agencies concerned with meeting those goals by 2015.[93] On a national level, the governments of countries in which funding for health care is already slim are concerned with distributing the types of care deemed most necessary to the greatest number of people.[94] In these scenarios, mental health may not be prioritized.[95]

[78] Ibid.
[79] Ibid.
[80] Ibid.
[81] Ibid.
[82] Ibid.
[83] Ibid.
[84] Ibid.
[85] WHO, *mhGAP Newsletter*, 2013.
[86] WHO, *mhGAP Mental Health Gap Action Plan: Scaling up care for mental, neurological, and substance use disorders*, 2008.
[87] WHO, *mhGAP Newsletter*, 2013.
[88] Ibid.
[89] Ibid.
[90] Saraceno, *Barriers to improvement of mental health services in low-income and middle-income countries*, 2007.
[91] Ibid
[92] Ibid.
[93] Ibid.
[94] WHO, *Expert Opinion on Barriers and Facilitating Factors for the Implementation of Existing Mental Health Knowledge in Mental Health Services*, 2007.
[95] Ibid.

WHO is at the center of the efforts to surmount these obstacles; at times, however, the Organization must partner with other organizations or agencies within the UN system in order to act for the promotion of mental health.[96] Mental health intersects with the work of other agencies, including those whose work focuses on women, refugees and displaced persons, and youth.[97] While mental health may not be at the forefront of the agenda of the UN system as a whole, WHO's efforts to build partnerships with these aspects of the UN system have not slowed.

In 2007, WHO met with the UNFPA - which focuses on population issues and, in particular, maternal and reproductive health - to discuss mental health as it relates to mothers and their children.[98] The mental health needs of expecting and new mothers are unique, and when they are not adequately addressed, there are consequences for both mother and child.[99] Maternal depression, its effect on childhood development, and the comparative cost of intervention were all discussed and are outlined in a report produced by the two bodies.[100]

In 2013, the United Nations High Commissioner for Refugees (UNHCR) and WHO partnered to issue a new set of guidelines and protocols for dealing with post-traumatic stress disorder, a major mental health concern for refugees, many of whom have been subjected to torture, abuse, or other trauma.[101] In times of crisis, whether due to political instability, civil war, or environmental disaster, mental health needs may be neglected due to a dearth of care resources.[102] "Non-specialized" caregivers are often the first to respond in situations that displace populations, and it is for these workers that the UNHCR and WHO have created the new guidelines.[103] If those responding first are able to provide basic mental health care in addition to other forms of "first-aid," then the harm done to the mental health of those suffering may be reduced.[104]

National Mental Health Programs

Where industrializing countries do successfully create and operate centralized mental health care systems, they are sometimes at risk of failing to provide care to many of those who need it.[105] This can be due to inadequate resources to train mental health staff, or by an emphasis on institutionalization of those who are mentally ill rather than treatment and integration into society.[106] A failure to distribute psychotropic medications to facilities and health care providers away from urban centers may also contribute to the overall failure of centralized programs.[107] Further, attempts to centralize mental health and make mental health a part of basic medical care are often stalled by the complex process of training non-specialized staff to have a working understanding of the special needs of mentally ill patients.[108] These are only some of the hurdles in the path to centralized mental health care, and given the urgency of the need and the complexity of the steps needed to address these challenges, it has become necessary to find alternatives to the centralized model.[109]

However, in order to migrate to a decentralized or community-based approach to mental health, it will be necessary to break down services that are currently centralized in order to move them away from major metropolitan areas.[110] This will require each community to have its own structures and funding, and it will also require new mental health structures to form connections within the communities in which they work.[111]

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[96] WHO, *Maternal Mental Health and Child Health and Development in Resource- Constrained Settings*, 2007.
[97] WHO, *UN agencies release new guidelines on mental health care for trauma and loss*, 2013.
[98] WHO, *Maternal Mental Health and Child Health and Development in Resource- Constrained Settings*, 2007.
[99] Ibid
[100] Ibid
[101] WHO, *UN agencies release new guidelines on mental health care for trauma and loss*, 2013.
[102] Ibid
[103] Ibid
[104] Ibid
[105] Saraceno, *Barriers to improvement of mental health services in low-income and middle-income countries*, 2007.
[106] Ibid
[107] Ibid
[108] Ibid
[109] Ibid
[110] WHO, *Expert Opinion on Barriers and Facilitating Factors for the Implementation of Existing Mental Health Knowledge in Mental Health Services*, 2007.
[111] Ibid

Industrializing countries may also encounter some of the same obstacles as industrialized countries when building national mental health programs.[112] An emphasis on treatment by way of prescription drugs and an insufficient commitment to improving access to arguably more effective treatments, such as psychotherapy, has been ineffective in industrialized countries, including the United States.[113] Unmitigated cost is also a barrier preventing access to mental health care for many in the United States, a problem shared by many industrializing countries.[114] Where universal care does exist and where mental health is included, as in Canada, an overburdened system may cause mental health to fall by the wayside as more visible and physical concerns are prioritized; a scarcity of person-to-person support programs and lacking support for culturally-competent mental health services are symptoms of the problem.[115]

Awareness, Political Pressure, and Stigma

Perhaps one of the most immediate risks individuals face when seeking mental health treatment is separation from society as a result of social stigma surrounding mental illness.[116] Family members of individuals suffering from mental illness are also subject to this stigma, especially in the case of the severely mentally ill and, where the burden of caring for the elderly falls upon younger family members, in cases of dementia and other mental illnesses associated with old age.[117] This may prevent them from advocating for loved ones who cannot advocate for themselves due to disability arising from mental illness.[118] This leaves those most in need of treatment without a safe means of making their needs known, and without the means to communicate with those who are able to effect progress in the area of mental health, sufficient political pressure does not exist.[119]

Where stigma is a concern, awareness can be an important instrument in promoting progress. By promoting an understanding of what mental illness is, its prevalence, and its importance as a topic on national and international agendas, affected individuals may be able to break the silence surrounding their needs.[120] If mental health becomes a visible concern rather than a topic shrouded in mystery and misinformation, political and civil society will take notice.[121]

Depression and Suicide Prevention

As of late, the WHO has been working to raise awareness about the prevalence of depression.[122] Depression is listed as a "priority" in WHO's Mental Health Gap Action Programme (mhGAP), and through the Programme, WHO is working to equip non-specialists in the medical field to work with patients on this common and often debilitating condition.[123] Depression was also the subject of WHO's 2012 World Mental Health Day.[124] Still, this disorder is widespread, and as it may be fatal – leading to suicide – it has garnered much of WHO's attention in recent years.[125]

Suicide prevention has also become a priority on WHO's agenda.[126] WHO has been working to combat suicide by encouraging those already concerned to speak on the issue, by promoting initiatives that address the underlying risk factors for suicide, and by keeping decision-makers and professionals engaged with the issue.[127] Awareness has been

[112] WHO, *Expert Opinion on Barriers and Facilitating Factors for the Implementation of Existing Mental Health Knowledge in Mental Health Services*, 2007.
[113] Kliff, *Seven Facts About America's Mental Health-Care System*, 2012.
[114] Ibid
[115] Lurie, *10 Things To Do to Improve Mental Health in Canada*," 2008.
[116] Thara & Patel, *Role of non-governmental organizations in mental health in India*, 2010.
[117] Ibid
[118] Ibid
[119] Ibid
[120] Kumar, *Mental Health Services in Rural India: Challenges and Prospects*, 2011.
[121] *Where the mind is without fear*, 2008.
[122] WHO, *Depression* [Website], 2012.
[123] Ibid
[124] WHO, Depression is a Common Illness and People Suffering From Depression Need Support and Treatment, 2012.
[125] Ibid
[126] WHO, *Suicide Prevention (SUPRE)*, 2013.
[127] Ibid

a key tool in addressing the issue; however, increasing suicide rates over the past several decades would indicate that more work is needed in this area.[128]

Case Study: India

For many years, mental health was a neglected area of overall health care in India, a country that has industrialized relatively rapidly and that faces health challenges in both urban and rural areas.[129] In 1982, the government of India launched its National Mental Health Programme (NMHP) in order to generate awareness of the importance of mental health, alleviate the burden of care previously placed on families, and improve existing mental health facilities as a component of the country's centralized health system.[130] The implementation of this system has not been without flaws (inability to reach rural areas and inadequate or infrequent training of mental health care personnel, for instance).[131] However, NGOs that devote their resources to the improvement of mental health may be able to fill in some of the gaps.[132]

India's government commits a relatively low percentage of its GDP to fund health programs and services (4.16%).[133] The system currently in place has not successfully supplied enough support in terms of personnel equipped to address the needs of mental health patients.[134] The dynamic and episodic nature of certain mental illnesses have made tracking rates of mental illness over time a difficult task, and differences in researchers' definitions of "mental illness" have further complicated fact-finding.[135] One study, conducted in 2000, 18 years after India implemented its NMHP, reported a morbidity rate of 73 per 1000.[136]

Awareness has been a major factor in empowering Indian citizens to seek help and in rousing the government and non-government actors to action.[137] During the 1980s, substance dependency and abuse – particularly dependence upon and abuse of street drugs - became a subject that was heavily discussed in the media in India.[138] As citizens became concerned about what impact substance dependence had on society, numerous organizations were formed specifically to address this widespread issue, and existing organizations added substance abuse to their agendas.[139] The NGOs that arose from this public attention grew to a size where they were able to provide necessary treatment to individuals struggling with substance dependency, and they were able to reach regions of the country government health programs were unable to reach.[140]

More recently, mental health-related NGOs have been focusing on escalating suicide rates among young people (overall suicide rates are 12.2 per 100,000 for males and 9.1 per 100,000 for females).[141] These organizations have been responsible for raising awareness not only among the public, but in the professional medical community, where individuals are in a position to make recommendations and to make changes to their own priorities to reflect changing ideas about how mental health fits into overall wellness.[142] By focusing on smaller units – families and communities rather than provinces, regions, or an entire country – NGOs are often better able to put funding to use on a manageable level.[143] This approach may be better suited to countries with large populations and limited resources; this includes many industrializing countries.[144] NGOs focused on women have also been popular in recent

[128] Ibid
[129] Kumar, Mental Health Services in Rural India: Challenges and Prospects, 2011.
[130] Ministry of Health and Family Welfare of India, National Mental Health Programme (NMHP).
[131] Kumar, Mental Health Services in Rural India: Challenges and Prospects, 2011.
[132] Thara & Patel, Role of non-governmental organizations in mental health in India, 2010.
[133] WHO, *Mental Health Atlas: India*, 2011.
[134] Ibid
[135] Math & Srinivasaraju, *Indian psychiatric epidemiological studies: Learning from the past,* 2010.
[136] Ibid
[137] Thara & Patel, *Role of non-governmental organizations in mental health in India*, 2010.
[138] Ibid
[139] Ibid
[140] Ibid
[141] Thara & Patel, *Role of non-governmental organizations in mental health in India*, 2010; WHO, *Mental Health Atlas: India*, 2011.
[142] Thara & Patel, Role of non-governmental organizations in mental health in India, 2010.
[143] Ibid
[144] Thara & Patel, Role of non-governmental organizations in mental health in India, 2010.

years.[145] Organizations such as the Bapu Trust (which has funded community mental health projects in impoverished regions in India and which continued to advocate for the rights of those suffering from mental illness) promote equity and human rights in the form of appropriate mental health care, an area in which women are frequently at a disadvantage.[146] Community-based service programs address needs on a local level, including in rural areas, addressing a need not met by the Indian government's programs.[147] The role of NGOs in India has been a large one, and the mental health framework in that country has benefited greatly from the rise of those organizations.[148] By partnering with NGOs, professional organizations, and governments, WHO can lend its resources to effecting progress in other countries similar to that made in India.

Conclusion

Industrializing countries will face challenges in their journey to obtain optimal mental health for all people, but WHO's plans for the next several years are promising.[149] Stigma, unequal access to care, and geographic distribution of services all must be addressed, and this may be accomplished through partnerships between WHO and UN agencies and NGOs.[150] Conditions for mental health are improving in countries where attention has been paid to the issue by legislators and professionals; however, the issue must remain on the public health agenda if global progress is to be achieved.[151]

How can mental health be addressed in industrializing countries in particular, and what considerations should be taken into account with respect to the economies and cultures of these Member States? What more can the World Health Organization do to engage governments and NGOs in the promotion of mental health? How can the obstacles specific to industrializing countries be overcome? What successes can WHO look to as examples of effective mental health care systems? Can those examples be successfully applied to countries who face challenges such as growing populations, constrained resources, and a general lack of awareness surrounding mental health?

Annotated Bibliography

Marcus, Marina, M. Taghi Yasamy, Mark van Ommeren, Dan Chisholm, & Shekhar Saxena (2012). *Depression: A Global Public Health Concern* [Report]. Retrieved 7 July 2013 from: http://www.who.int/mental_health/management/depression/who_paper_depression_wfmh_2012.pdf

This guide frames depression, one of the most common and most frequently fatal mental illnesses, as a public health concern, providing the context necessary to begin to consider mental health as a health priority. While many delegates may already be familiar with what depression is and how it manifests, this document will introduce delegates to depression as a problem that is shared globally, but which may be effectively addressed at all levels: international, regional, national, and local. The guide also provides a snapshot of the prevalence of depression in several developing and industrializing countries.

Ministry of Health and Family Welfare of India. *National Mental Health Programme (NMHP)*. Retrieved 2 August 2013 from: http://mohfw.nic.in/WriteReadData/l892s/9903463892NMHP%20detail.pdf

This outline of India's National Mental Health Programme serves as an example of a national plan for mental health that was implemented in an industrializing country. While this plan was only marginally successful (in that it addressed some of the most obvious mental health concerns, even if it did leave many gaps to be filled), delegates may benefit from reading the summary of the plan to find areas that may be improved. This will help in building an understanding of how centralized health care plans frequently work in industrializing countries, as well as where the gaps in services are.

[145] Ibid
[146] *Where the mind is without fear*, 2008.
[147] Ibid
[148] Thara & Patel, Role of non-governmental organizations in mental health in India, 2010.
[149] WHO, *Draft Comprehensive Mental Health Action Plan for 2013-2020*, 2013.
[150] Ibid
[151] Thara & Patel, *Role of non-governmental organizations in mental health in India*, 2010.

Saraceno, Benedetto, Mark van Ommeren, Rajaie Batniji, Alex Cohen, Oye Gureje, John Mahoney, Devi Sridhar, & Chris Underhill (2007). "Barriers to improvement of mental health services in low-income and middle-income countries." *Lancet*, 2007;370: 1164-74. Retrieved 7 July 2013 from: http://www.basicneeds.org/download/EPUB%20-%20Lancet%202007%20-%20Barriers%20to%20improving%20mental%20health.pdf

This paper explores the challenges that advocates, health care workers, and other actors face while attempting to provide mental health care in developing countries. It emphasizes the importance of including mental health on the overall agenda for international public health and of reaching those who have not previously had access to care. By clearly explaining what the challenges are, this paper will help delegates organize their recommendations for addressing mental health in developing countries.

Thara, R. & V. Patel (2010). "Role of non-governmental organizations in mental health in India." *Indian J Psychiatry*, 52(Suppl1): S389-S395. Retrieved 8 July 2013 from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3146177/

This article outlines the changes to mental health services that occurred in India as a result of an increased presence of NGOs in the past several decades. The importance of mental health-related NGOs cannot be underestimated for industrializing countries, where governments have limited resources to tackle these widespread and often ignored issues without the assistance of independent actors. This example is helpful in understanding some of the problems that industrializing countries come across when attempting to build a framework for mental health as well as solutions facilitated by the international community.

World Health Organization. (2013). *Comprehensive Mental Health Action Plan 2013-2020* [Report]. Retrieved 7 July 2013 from: http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R8-en.pdf

WHO's Action Plan for mental health outlines the Organization's current approach to mental health. This important document will guide delegates' work as the committee strives to create recommendations that are in line with WHO's goals and current policy. The plan not only outlines WHO's recommendations, but also its methods of implementing the plan to reach its stated objectives.

World Health Organization. (2007). *Expert Opinion on Barriers and Facilitating Factors for the Implementation of Existing Mental Health Knowledge in Mental Health Services (WHO/NMH/MSD/07.1)* [Expert Opinion]. Retrieved 7 July 2013 from: http://www.who.int/mental_health/emergencies/expert_opinion_on_service_development_msd_2007.pdf

Recommendations regarding mental health are not useful if they cannot be implemented. This expert opinion will be useful in crafting realistic and actionable approaches to improving mental health in developing countries. The opinion addresses political obstacles to improving mental health, a set of obstacles that are frequently absent from dialogue on the subject. This document will assist delegates in forming more robust understandings of the topic's place on the international agenda.

World Health Organization. (2013). *Gender and Women's Mental Health* [Website]. Retrieved 3 August 2013 from: http://www.who.int/mental_health/prevention/genderwomen/en/

With the aim of providing equitable care in all areas, WHO has recognized the difference that exists in mental health needs for women. This fact sheet explains how this difference arises as a result of social status and differences in the way men and women are treated by society. Understanding how mental illness affects all people is important to understanding the topic as a whole, and as such, this fact sheet will be helpful.

World Health Organization. (2003). *Investing in Mental Health* [Report]. Retrieved 7 July 2013 from: http://www.who.int/mental_health/en/investing_in_mnh_final.pdf

This document explains what it would mean for WHO to invest in mental health, in terms of what would be required and what the outcome might be. The definition of "mental health" that guides WHO's work is given, and useful statistics that illustrate the impact of mental illness may also be found in this document.

Investing in Mental Health *is an excellent primer to this topic, as it provides insight into the nature of the problem and the direction that WHO will take as it addresses it.*

World Health Organization. (2013). *mhGAP Newsletter*. Retrieved 3 August 2013 from: http://www.who.int/mental_health/mhgap/mhGAP_nl_June_2013.pdf

mhGAP is WHO's program intended to facilitate the growth of frameworks for mental health in low- and middle-income countries, including industrializing countries. This plan was, in some ways, a jumping-off point for the Draft Comprehensive Mental Health Action Plan for 2013-2020, which is broader in its focus. This plan will be instrumental in gaining an understanding of how WHO approaches mental health in industrializing countries.

World Health Organization. (2013). *Suicide Prevention (SUPRE)*. [Website] Retrieved 7 July 2013 from: http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/

WHO's web page regarding suicide prevention presents useful information regarding mortality from suicide and a map that illustrates where suicide is most prevalent. In addition, the web page provides links to other helpful resources produced by WHO that will assist delegates in understanding this remarkably common cause of death. Preventing suicide, which accounts for a great number of deaths in young people worldwide, is a key part of improving mental health, and delegates should use this resource as a

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II. Strengthening Partnerships, Research, and Response Preparedness to Combat Pandemic and Resistant Diseases

"If we are unprepared, the next pandemic will cause incalculable human misery. Both directly from the loss of human life, and indirectly through its widespread impact on security. No society would be exempt. No economy would be left unscathed. This is a grim picture. But from the series of international meetings has come a truly global awareness of the importance of pandemic preparedness, and the role of international cooperation in responding to the pandemic threat."[152]

Introduction

According to the World Health Organization (WHO), an "infectious disease" is an infection "caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi; the diseases can be spread, directly or indirectly, from one person to another (…)."[153] A "disease outbreak" arises when this infectious disease occurs more times in a single area than would normally be expected, or when the disease differs from its usual epidemiological patterns.[154] When this outbreak achieves a global spread, it is identified by WHO as a "pandemic."[155] In contrast, a resistant disease is when the microorganism that causes the disease becomes resistant to the antibiotic that would have formerly been effective against it.[156] Usually this occurs when the microorganism mutates, making it invulnerable; and the fact that it no longer has a sensitivity to these antibiotics means that it can more easily spread among populations.[157] Furthermore, as this resistance increases, the number of antibiotics that can be used to combat it decrease. Both of these issues threaten global health by compromising quality and length of life, as well as access to effective healthcare, and are therefore a main area of focus for WHO.[158]

International Framework

Historically, humans have always fought pandemic diseases, and the aim of controlling pandemic diseases is therefore deeply rooted within the global narrative.[159] Dating back to the years of the Black Death ("the Great Plague"), which originated in 1334; doctors of the time would take to wearing heavy waxed leather cloaks and large masks reminiscent of bird-beaks with herbs in the nose, whenever visiting patients.[160] This was a rudimentary start to stopping contagion from spreading.[161] When the industrial revolution resulted in an increase in sea-faring merchants in the 1800's, harbours would quarantine international plague-bearing vessels, which, while a costly and largely ineffective process, likely somewhat prevented the spread of contagions on shore.[162] These attempts at quarantine also drew the attention of John Snow, an English scientist studying cholera, who then began theorizing on the idea of the diseases being able to spread through contamination and lack of sanitation.[163] Within the same decade, Edward Jenner, a scientist studying smallpox in England, came up with the first rudimentary vaccine, by inoculating people with cowpox, a much milder form of smallpox that builds up virus-resistant antibodies.[164]

In the mid-1900's, countries began to meet at International Sanitation Conferences, at first based solely in Europe and then expanding globally, and started to create international dialogue regarding the issue of pandemics.[165] The first convention on disease, specifically cholera, was signed at these Conferences; then, as World War I spread epidemics not previously encountered, these conventions conglomerated into the League of Nations Health

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[152] WHO, *Meeting on Avian Influenza and Pandemic Human Influenza* [Website], 2005.
[153] WHO, *Health Topics: Infectious Diseases* [Website], 2013.
[154] Ibid
[155] WHO, *What is a Pandemic*? [Website], 2012.
[156] WHO, *Antimicrobial resistance* [Website], 2013.
[157] Ibid
[158] WHO, *About WHO* [Website], 2013; WHO, *Working for Health: An Introduction to the World Health Organization* [Website], 2007; WHO, *Draft Twelfth WHO General Programme of Work.*, 2012.
[159] World Health Report, *Evolution of Public Health Security* [Website], 2007.
[160] United States Centers for Disease Control and Prevention, *Plague* [Website], 2012.
[161] World Health Report, *Evolution of Public Health Security* [Website], 2007.
[162] United States Centers for Disease Control and Prevention, *International Law and Infections Disease* [Website], 2010.
[163] World Health Report, *Evolution of Public Health Security* [Website], 2007.
[164] Ibid
[165] United States Centers for Disease Control and Prevention, *International Law and Infections Disease* [Website], 2010.

Organization.[166] This was the first international body on pandemic diseases; and when the League of Nations was replaced by the United Nations, the League of Nations Health Organization was renamed into the World Health Organization.[167] WHO then adopted the previous conventions on contagious diseases, including the work from the *International Sanitary Conferences* in Paris in 1851 and 1859, and the 1892 *International Sanitary Convention* in Venice, into their new policies and legislation, as a foundation for their future work on pandemic disease.[168] These were then replaced in 1969 by the *International Health Regulations* (IHR), which were signed during the Twenty Second World Health Assembly; and then modified by the Twenty-Sixth World Health Assembly in 1973, the Thirty-Fourth World Health Assembly in 1981, and the Fifty-Eighth World Health Assembly in 2005.[169]

It is important to note that the *International Health Regulations* are currently one of the more effective tools of WHO in creating legally-binding policies that can aid in putting WHO recommendations into action.[170] The goal of the IHRs is to help the "international community prevent and respond to acute public health risks that have the potential to cross borders and threaten people worldwide," and as such, WHO relies on these in times of international health crises, such as pandemics.[171] The IHRs came into international recognition as a powerful tool of WHO in July 2007 as a response to the SARS pandemic, and have remained a vital instrument of WHO during outbreaks since this point.[172] Since their creation, the IHRs have enabled the creation of emergency committees on pandemic diseases; continued international communication and surveillance on resistant diseases; and provided a forum for international capacity building within the global community regarding research and education on contagious diseases.[173]

Also important in the history of combatting contagious disease is the *International Covenant on Economic, Social, and Cultural Rights*, which was signed in January of 1976, around the same time as the IHRs were being modified.[174] Within this document the "right to health" is clarified by defining it as being dependant on the healthy development of the child; environmental and industrial hygiene; the prevention and control of diseases; and access to health care for all.[175] While this document also defines a number of important terms surrounding other human rights issues, it is particularly notable for its impact on the development of the Millennium Development Goals (MDGs); especially MDG 6, which is "to combat HIV/AIDs, malaria, and other diseases."[176] As the MDG's are the current international framework for working towards the rights of "the world's poorest peoples", all eight goals are scheduled to be met by 2015, meaning that current efforts to halt contagious diseases and provide healthcare are currently being prioritized in the international community.[177]

Role of the United Nations System

It is due to the uncontrollable nature of the timing of outbreaks, their severity, and their location that a cooperative globalized response is needed in order to contain the outbreak and limit the damage on human life.[178] In order to fully achieve these goals, the World Health Organization acts as a massive umbrella organization to consolidate all of the data and research of many sub-committees and organizations with the aim of "intensify[ing] communicable disease surveillance for early warning of outbreaks so that appropriate control measures can be implemented as soon as possible."[179]

Among the organizations that WHO coordinates, are the Department of Pandemic and Epidemic Disease (PED), the Pandemic Infection Preparedness Framework (PIPF), the Strategic Health Operations Centers (SHOC), the Global

[166] World Health Report*, Evolution of Public Health Security* [Website], 2007.
[167] Ibid
[168] Ibid
[169] World Health Report*, Evolution of Public Health Security* [Website], 2007; WHO, *International Health Regulations (1969)* [Website], 1983; WHO, *International Health Regulations (2005)* [Website], 2005.
[170] WHO, *What are the International Health Regulations (IHR)?* [Website], 2008.
[171] Ibid
[172] Ibid
[173] WHO, *Alert, Response, and Capacity Building under the International Health Regulations (IHR)* [Website], 2013.
[174] WHO, *The Right to Health* [Website], 2013.
[175] United Nations, *International Covenant on Economic, Social, and Cultural Rights* [Website], 2013.
[176] United Nations, *Millennium Development Goals* [Website], 2013.
[177] United Nations, *Goal 6: Combat HIV/AIDs, Malaria, and Other Diseases* [Website], 2013.
[178] WHO, *WHO Outbreak Communication Guidelines* [Website], 2012.
[179] WHO, *How does the WHO get information about disease outbreaks in infected countries?* [Website], 2005.

Outbreak Alert and Response Network (GOARN), and the Global Infection Prevention and Control (GIPC) Network.[180]

The Department of Pandemic and Epidemic Disease (PED) recently identified the major pandemic prevention goals of WHO in the *Twelfth General Programme of Work*, which was finalized 10-13 September 2012 in Malta by the Regional Committee for Europe.[181] The goal of this session was to redefine the concept of "health" through strategic imperatives that are newly adapted to a world recovering from an economic downturn.[182] One of the strategic imperatives created during this *Twelfth General Programme of Work* addresses the need to reduce the burden of communicable disease through increased surveillance and effective response to disease outbreaks, while identifying HIV, tuberculosis, and malaria as the three most prevalent threats to global security.[183] This document and its strategic imperatives became pivotal in the recent restructuring of the PED; and the PED now implements recommendations from the T*welfth General Programme of Work* throughout its 5 strategic imperatives of research, protection, preparedness, health care, and global response.[184]

The Global Outbreak Alert and Response Network (GOARN) is a collaboration of existing organizations that collects all the knowledge and resources within that network into an information pool to rapidly combat disease.[185] GOARN allows information sharing through a cooperative system of Member States and the United Nations, which is vital to pre-emptively predicting a disease and coordinating international effort when one occurs.[186]

In contrast to GOARN, the Pandemic Infection Preparedness Framework (PIPF) uses the information it gathers in order to "improve pandemic influenza preparedness and response, and strengthen the protection against the pandemic influenza by improving and strengthening WHO global influenza surveillance and response system."[187] This means that the majority of their work is based in global need for influenza immunization, to coordinate accurate reports and date, and in the creation of "Essential Regulatory Laboratories," which are WHO-approved research bases for research and production of influenza immunization.[188]

The Global Infection Prevention and Control (GIPC) Network was launched in June of 2011, and currently provides support to Member States through offering education on WHO policies and helping Member States develop their own effective national policies on disease prevention.[189] Furthermore, the network focuses on studying the education of both patients and health-care providers globally in order to address basic pandemic requirements, such as sanitation and the impact of disease on the patient's family.[190]

Finally, all of the information that is coordinated through these organizations is sent to the JW Lee Centre for Strategic Health Operations (SHOC), which is the center of WHO information of pandemic diseases.[191] It is "the hub of alert and response operations", and they are the center that will always make the final call on response to disease outbreaks.[192] It is through the collaboration of these organizations, and the consolidation of their data through SHOC, that the international community is able to stay informed of any information regarding pandemic disease.[193]

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[180] WHO, *Global Alert and Response* [Website], 2013.
[181] WHO Regional Committee for Europe, *WHO Reform* [Website], 2013.
[182] Ibid
[183] WHO, *PED: Pandemic and Epidemic Disease* [Website], 2013.
[184] Ibid
[185] WHO, *Global Alert and Response Network* [Website], 2013.
[186] WHO, *Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and access to Vaccines and other Benefits* [Website], 2011; WHO, *Global Alert and Response Network (GAR)* [Website], 2013; WHO, *Global Prevention and Control (GIPC) Network* [Website], 2011.
[187] WHO, *Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and access to Vaccines and other Benefits* [Website], 2013.
[188] WHO, *Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and access to Vaccines and other Benefits [Website],* 2011; WHO, *Global Alert and Response Network (GAR)* [Website], 2011; WHO, *Global Prevention and Control (GIPC) Network* [Website], 2011.
[189] WHO, *GIPC Network Launch Meeting and Next Steps* [Website], 2011.
[190] WHO, *Global Infection Prevention and Control Network (GIPC Network) Launched* [Website], 2011.
[191] Ibid
[192] WHO, *JW Lee Center for Strategic Health Operations (SHOC)* [Website], 2004.
[193] Ibid

Challenges of combating pandemic and resistant diseases

Despite all of the efforts by the international community and WHO, obstacles to combating pandemic and resistant disease still remain. Firstly, the effects of an outbreak are not limited to human health, but could affect socio-economic infrastructure and national security.[194] This is due to the fact that prevention and treatment of a pandemic requires existing healthcare, quarantine and border-monitoring infrastructure, which some Member States may not have access to.[195] WHO reflects this broad-reaching effect through the "Global Burden of Disease" project, which calculates the worldwide average human lifespan, taking into account shorter lifespans caused by disease.[196] This information is then interpreted to track risk factors in global health, and suggests recommendations to Member States so that they may set their health priorities accordingly.[197] While this is currently a helpful system for gathering information and informing countries, there has been studies stating that Member States are not currently required to follow these recommendations, and there is, therefore, a lack of accountability globally.[198]

Another significant challenge facing WHO is the availability of vaccines needed in order to treat pandemics effectively.[199] Often, low market demand prior to the outbreak means that supplies are not readily available or that the cost of the vaccine is so high that an average citizen cannot afford it.[200] As well, other health issues within a state may take research priority over vaccine production, meaning that a country is undersupplied when an outbreak occurs.[201] While WHO tries to aid funding issues as much as is feasible, they are also dependent on donor states for money, and have a limited budget to spread internationally to funding outbreak containment.[202] Furthermore, when the research on these medical treatments are finally underway, these vaccines will require extensive testing, and the time needed for testing will likely allow the disease to continue to spread.[203] Outside of these research and health care concerns, victims of pandemic disease are still struggling against discrimination and social stigma, and may not wish to identify themselves as having contracted the disease.[204] This is especially true in states where being infected is culturally constructed as being "shameful."[205] As a result, these citizens do not seek medical assistance, thus enabling the disease to spread further and creating a public health care issue.[206]

Finally, civil unrest can cause transportation issues with NGOs and WHO subsidiary bodies being unable to actually access victims of the disease.[207] As well, this civil unrest may cause a conflict between humanitarian aid and disease prevention when prioritizing programs within these countries.[208] In these cases, the health care system has deteriorated to point where providing treatment or meeting WHO recommendations is simply not viable.[209] It is in these situations where collaboration between UN bodies is especially important, as this is an area where humanitarian aid and peacekeeping missions, both of which are outside the WHO mandate, might be helpful.[210] As well, in developing nations, stagnant economic growth, exploding population levels, and governmental corruption have resulted in some countries being simply unable to support a health care system, treatment, or quarantine of any type.[211] These internal structural issues cannot simply be fixed with disease control measures, and are a significant obstacle to be addressed by WHO when creating new policies and treating outbreaks.[212]

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[194] WHO, *National and Global Responsibilities for Health* [Website], 2010.
[195] WHO, *Global Burden of Disease: 2004 Update* [Website], 2008.
[196] Health Statistics and Information Systems, *About the Global Burden of Disease (GBD) Project* [Website],
[197] WHO, *Global Burden of Disease: 2004 Update* [Website], 2008.
[198] Ibid
[199] Immunization, Vaccines, and Biologicals, *Questions and Answers on the Pandemic Influenza Vaccine* [Website], 2007.
[200] Ibid
[201] Ibid
[202] Ibid
[203] University of Kwazulu-Natal, *South Africa's Recent Achievement in Combating the HIV Epidemic* [Website], 2012.
[204] Ibid
[205] Ibid
[206] Ibid
[207] Global Philanthropy Partnership, *Philanthropy for Malaria* [Website], 2005.
[208] Ibid
[209] Ibid
[210] Ibid
[211] Ibid
[212] Ibid

Main Threats to International Health

Currently recognized by WHO as an international threat for becoming a disease outbreak are twenty-eight infectious diseases, including: African trypanosomiasis (sleeping sickness), Anthrax, Avian influenza ("bird flu"), Buruli ulcer disease, Cholera, Crimean-Congo haemorrhagic fever, Dengue and dengue haemorrhagic fever, Ebola haemorrhagic fever, Enteroviruses - non polio, Haemophilus influenza type B (HiB), Hendra virus, Hepatitis A, Hepatitis B, Hepatitis E, Influenza (Seasonal), Lassa fever, Legionellosis, Leprosy, Malaria, Marburg haemorrhagic fever, Measles, Meningococcal meningitis, Nipah virus, Plague, Poliomyelitis, Rift Valley fever, Smallpox, Tuberculosis, and Yellow fever.[213] Of these, three main diseases have had a profound impact on WHO's pandemic prevention and response projects: HIV/AIDS, H1N1, and SARS.[214]

HIV/AIDS

Human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) are retroactive autoimmune diseases that originated in west-central Africa during the early 20th century.[215] Symptoms are originally influenza-like, and devolve into wasting diseases and an increased risk of developing cancer.[216] HIV can be spread through three methods: sexual contact, exposure to infected body fluids, and from mother to child during pregnancy.[217] WHO first proposed a definition for AIDS in 1986.[218] AIDS was officially recognized in the 1980's by the World Health Organization, and since that point, WHO has thoroughly readdressed their policies regarding contagious diseases and pandemics.[219] With the AIDS pandemic, WHO transformed its approach from one of collecting information at a distance into taking action on the front lines by providing both aggressive antiretroviral treatment (ART) and new, consolidated international guidelines for the treatment of at-risk people.[220] These new programs were called the "Drug Access Initiative," universalizing the cost of the treatment drugs and encouraging nations to partner in research-based initiatives.[221] As a result, 9.7 million people in low- and middle-income countries were on treatment by the end of 2012, with a major focus in sub-Saharan Africa.[222] And within the last decade, WHO has narrowed down their focus from general treatment to at-risk groups, specifically mothers, sex workers, drug addicts, and children, in order to ensure equal access to treatment.[223] Also integrated into policies about the medical treatment of AIDS victims were UN recommendations to Member States regarding social issues impacted by the disease, such as discrimination and social stigma of the victims.[224] Due to these restructured initiatives, two-thirds of at-risk populations are receiving treatment, and the number of AIDS-related deaths within the last six years has reduced by almost a million deaths globally.[225]

SARS

In late 2002, Severe Acute Respiratory Syndrome (SARS), a viral respiratory disease, first appeared in Southern China and spread to 37 other countries within a matter of weeks.[226] Because of this, SARS had a 9.6% fatality rate, and was therefore unique in both its severity and its high rate of transmission.[227] Dr. Anarfi Asamoa-Baah, Assistant Director General, Communicable Diseases for WHO, identified SARS at the time as the first disease whose spread was likely due to the effects of globalization.[228] However, he assured WHO that previous methods of dealing with

[213] WHO, *Fact Sheet: Contagious Diseases* [Website], 2010.
[214] Ibid
[215] Sharp, Hahn, *Origins of HIV and the AIDS Pandemic* [Website], 2011.
[216] Vogel & Schwarze-Zander et al, *The Treatment of Patients with HIV* [Website], 2010.
[217] Markowitz, *Environmental and Occupational Medicine* [Website], 2010.
[218] WHO, *WHO case definitions of HIV for surveillance and revised clinical staging and immunological classification of HIV-related disease in adults and children* [Website], 2006.
[219]UNAIDS, *Accelerating Access Initiative: Widening Access to care and support for people living with HIV/AIDS* [Report], 2002.
[220] Ibid
[221] Ibid
[222] WHO, *15 Facts on HIV Treatment Scale-Up and New WHO ARVV Guidelines* [Website], 2013.
[223] Ibid
[224] Ibid
[225] Ibid
[226] WHO, *Summary of probable SARS cases with onset of illness from 1 November 2002 to 31 July 2003* [Website], 2003.
[227] Ibid
[228] Ibid

pandemics could be adopted to meet differing needs, and in June 2003,WHO held their first Global Conference on SARS in Kuala Lumpur, with the goal of creating an international scientific task force to combat SARS.[229]

As a result of this, in October of 2004, WHO released an official framework on risk assessment and preparedness entitled the *SARS Risk Assessment and Preparedness Framework* that was to be used at both the international and the national level.[230] For the first time when dealing with a pandemic disease, WHO had released a universal 6-step framework that would not only halt the impact of the SARS virus, but could also be applied to future disease outbreaks in order to curtail the epidemic.[231] In this framework, there was a focus on *Disease Outbreak News*, and the creation of the *Weekly Epidemiological Record* (WER) with the goal of constant, accurate disease data updates, two programs which would remain in place for all pandemics following SARS.[232] This framework, aside from encouraging open global communication on the disease, placed a large emphasis on revolutionary preventative measures, including preemptive medical supply bases, international surveillance and cooperation, increased research funding, and the institution of regional infection control plans.[233] It was a complete redesign of previous reactionary WHO pandemic responses, and generated a high success rate; as promised, WHO declared that the epidemic was over 28 days after the last reported case of SARS had been placed.[234] As of this point, the last SARS outbreak was in 2004 and there has been no SARS pandemic for over 9 years. [235]

H1N1

The H1N1 virus, an influenza A subtype colloquially known as "swine flu" which broke out in 2009, forced WHO to retract their previous reporting and data requirements for infectious diseases.[236] H1N1 could spread faster, when compared to most other viruses, in six weeks than most diseases could spread in six months.[237] In 2009, WHO released a pandemic briefing stating that they would change the data needed for risk assessment.[238] In this statement, they abstained from releasing global tables listing the statistics of the affected cases, and instead asked for weekly updates from Member States reporting primary cases and strain of the health care system.[239] WHO then issued nearly immediate consultations on restricting mass gatherings and shutting down classrooms.[240] The result was that while these measures were effective on a local level, they were expensive and did not prevent transmission on a large scale.[241] As well, issues of discrimination were present, and WHO began advising Member States that epidemiology should be their utmost priority above social and class separation concerns.[242] Member States in East Asia found that encouraging citizens to wear masks in public areas prevented disease spread, and that communication was key to ensuring that key transportation routes and borders could remain open.[243] There was an emphasis on encouraging citizens to remain calm despite a high number of outbreaks.[244] As well, they established the *WHO Study on Global Ageing and Adult Health (SAGE)*[245] as a primary advisor on immunization technology, all of which was regulated by WHO.[246] All of this was coordinated by an Emergency Committee, whose names were undisclosed until after H1N1 was no longer deemed a pandemic, marking this event as the first time that WHO has engaged in using a secret Emergency Committee for pandemic advising.[247] As a result of these combined initiatives, "pandemic influenza activity across the African continent is low or sporadic; data from West Africa indicates that

[229] WHO, *WHO Scientific Advisory Committee on Severe Acute Respiratory Syndrome (SARS) [Website],* 2003.
[230] WHO, *WHO SARS Risk Assessment and Preparedness Framework* [Website], 2004.
[231] Ibid
[232] WHO, *Weekly Epidemiological Report (WER)* [Website], 2009.
[233] WHO, *WHO SARS Risk Assessment and Preparedness Framework* [Website], 2004.
[234] Ibid
[235] WHO, *China's Latest SARS Outbreak has been Contained, but Biosafety Concerns Remain-Update 7* [Website], 2004; WHO, *Severe Acute Respiratory Syndrome (SARS) Index* [Website], 2004.
[236] WHO, *Changes in Reporting Requirements for Pandemic (H1N1) 2009 Virus Infection* [Website], 2009.
[237] Ibid
[238] Ibid
[239] Ibid
[240] Ibid
[241] Ibid
[242] Ibid
[243] Ibid
[244] WHO, *Summary of the Third Scientific Teleconference on Influenza A (H1N1)* [Website], 2009.
[245] WHO, *Study on Global Ageing and Adult Health (SAGE)* [Website], 2013.
[246] Global Alert and Response, *WHO Recommendations on pandemic (H1N1) 2009 Vaccines [Website]*, 2009.
[247] IHR, *List of Members of, and Advisors to, the International Health Regulations (2005) Emergency Committee Concerning Influenza Pandemic (H1N1)* [Website], 2005.

the active transmission of pandemic influenza virus has largely subsided after peaking during February and March 2010", and that globally "countries are not reporting increases in influenza activity above epidemic thresholds, or unusually early influenza activity…" proving WHO's new H1N1 policies as generally effective at reducing the global pandemic risk.[248]

Case Study: Situation With MERS-CoV

Currently, WHO is dealing with an emerging pandemic threat called Middle East Respiratory Syndrome Coronavirus (MERS-CoV), an avian flu that is spreading through the Middle East and Southern Europe with a fatality rate of 50%.[249] At the time that this guide was written, MERS-CoV has been seen in 9 countries, with cases increasing.[250] However, WHO has been utilizing their previously successful strategy of a secret Emergency Committee to combat the outbreak; and as it continues, they are consistently updating WHO with news and data.[251] WHO is also emphasizing global communication and collaboration, and has a strong emphasis on preventative measures, as according to the new policies implemented during the AIDS and SARS pandemics.[252] It is likely due to these preventative measures that on 17 July 2013, the Director-General of WHO has accepted the Emergency Committee's assessment that the current MERS-CoV situation is "serious and of great concern, but does not constitute a *Public Health Emergency of International Concern* (PHEIC) at this time."[253] This, above all other successes, proves the effectiveness of the recent restructuring of WHO policies, in that their new preventative measures have essentially averted MERS-CoV from being classified as a pandemic at this time.[254]

Conclusion

In conclusion, it is through the work of international subsidiary bodies under WHO, and through the recent global pandemics of HIV/AIDS, SARS, and H1N1 that WHO has been able to restructure their outbreak policies to ensure current and future pandemic-shutdown success.255 However, there are still areas left that are not addressed by the current policies that impede WHO from reaching full global success in combating pandemics and diseases, especially in social and political areas.256 These missing areas will need to be addressed in the immediate future with the increasing threat of a potential MERS-CoV pandemic in the Middle East currently proving to be of mounting concern for WHO.257

Moving forward, delegates should consider questions such as: How can existing flaws in the current international infrastructure be improved to aid in quicker response to potential outbreaks? What can be done to address the political and social issues affected by outbreaks, such as social stigma and political unrest? How can we encourage Member States to possess accountability for the Global Burden of Disease Project's suggestions? How should we analyze WHO's response to MERS-CoV, considering that it is a current outbreak? What can be done pre-emptively to aid in issues of low supply and high demand of vaccines during outbreaks? Although many aspects of this field have been addressed before, there are still challenges remaining in order to combat pandemic and resistant diseases.

Annotated Bibliography

Karns, M. & K. Mingst. (2004). International Organizations: The Politics and Processes of Global Governance. Lynne Rienner Publishing.

Karns and Mingst provide a comprehensive look at the international system and the variety of organizations that are part of international governance. This text looks at the various actors within global governance, including the UN, regional actors, non-state actors, and states. It also examines the need for global governance and uses a variety of case studies to illustrate this need.

[248] GAR, *Director-General Statement following the Eight Meeting of the Emergency Committee* [Website], 2010.
[249] GAR, *Frequently Asked Questions on Middle-East respiratory syndrome coronavirus (MERS-CoV)* [Website], 2013.
[250] International Travel and Health, *World-travel advice on MERS-CoV for pilgrimages* [Website], 2013.
[251] WHO, *WHO Statement on the Second Meeting of the IHR Emergency Committee concerning MERS-CoV* [Website], 2013.
[252] Ibid
[253] Ibid
[254] Ibid
[255] Ibid
[256] Global Philanthropy Partnership, *Philanthropy for Malaria* [Website], 2005.
[257] GAR, *Frequently Asked Questions on Middle-East respiratory syndrome coronavirus (MERS-CoV)* [Website], 2013.

World Health Organization. (2004). *JW Lee Center for Strategic Health Operations (SHOC)* [Website]. Retrieved 10 September 2013 from: http://www.who.int/csr/alertresponse/shoc/en/

This page is the introductory statement about the JW Lee Center for Strategic Health Operations (SHOC). It emphasizes the importance of the SHOC as the center for collecting all international disease information, as well as in cases of natural disaster or chemical emergencies. It covers SHOC's mandate as the hub of alert and response and their collaboration with the Global Outbreak Alert and Response Network (GOARN). Finally, it briefly details the history of the center, and its recent work on current crises and emergencies.

World Health Organization. (2005). *How does the WHO get information about disease outbreaks in infected countries?* [Website]. Retrieved 29 July 2013 from: http://www.who.int/features/qa/05/en/

This page covers basic information on how WHO will receive information for global pandemic outbreaks. It goes into what occurs at a micro-level, within community healthcare and with using NGOs, and how this information is filtered through to an international level, where the reports are collected by specific offices in South-East Asia and Geneva. Finally, this report explains how WHO assesses the information to accurately determine the state of emergency and establish further action.

World Health Organization. (2005). *WHO Outbreak Communication Guidelines* [Website]. Retrieved 1 August from: http://www.who.int/csr/resources/publications/WHO_CDS_2005_28en.pdf

This extensive document is pivotal in understanding the short-term and long-term reaction and goals of WHO when addressing a pandemic. It introduces the idea that while disease outbreaks are inevitable, public distress is not, and that the goal is to keep the public well-informed but not panicked. It has several main guidelines to follow, including trust, announcing early, transparency, and planning to ensure accurate communication. It works on a national level, and concludes with summarizing the international effects of this national communication, and reiterating the goal of global public health.

World Health Organization. (2008). *International Health Regulations (2005)* [Website]. Retrieved 24 July 2013 from: http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf

As delegates will essentially be discussing the effectiveness and restructuring of the International Health Regulations (IHR) that have been recently implemented, this document provides the most comprehensive coverage of these policies, as well as an in-depth examination of future examinations, scope of coverage, and sub-committees. It goes into the history of the IHRs, their existence as legally-binding regulations, and when they have historically been used to hold countries legally accountable for following WHO recommendations.

World Health Organization. (2012). *What is a Pandemic?* [Website]. Retrieved 29 July 2013 from: http://www.who.int/csr/disease/swineflu/frequently_asked_questions/pandemic/en/index.html

This is the most conclusive definition of a "pandemic" and is the official definition used by the World Health Organization when classifying an outbreak. It details what constitutes a pandemic virus, where these viruses come from, and how the target population will usually differ between a pandemic and an outbreak. Finally, it covers which seasons of the year WHO is more likely to see pandemic reports, and details the causes of these increases.

World Health Organization, Regional Office for Europe, Regional Committee for Europe, Sixty-second session. (2012). *WHO Reform (EUR/RC62/14)*. Retrieved 24 July 2013 from: http://www.euro.who.int/__data/assets/pdf_file/0019/170623/RC62wd14-Eng.pdf

This document covers the reform in policy that the World Health Organization has implemented over the past 10 years, especially with a focus in three areas: programs and priority-setting, governance and managerial reforms. The document also raises some challenges that WHO is facing, specifically in terms of funding and transparency, and the oversimplification of policies in the previous General Committee of Work. It also proposes a renewed focus on public health and specifically disease containment and prevention as priorities for the upcoming term.

World Health Organization, Unit on Disease Control in Humanitarian Emergencies (DCE). (2012). *Outbreak surveillance and response in humanitarian emergencies: WHO guidelines for EWARN Implementation* [Website]. Retrieved 10 September 2013 from: http://whqlibdoc.who.int/hq/2012/WHO_HSE_GAR_DCE_2012_1_eng.pdf

This is the most conclusive document on the Emergency Warning and Response Network (EWARN) for pandemic diseases, and also covers specific policies needed in areas of humanitarian aid and civil unrest. The report also includes an extensive list of priority diseases and alert thresholds, which provide technical information to back the over-arching policy reports. Finally, this document lists current priority diseases, definitions and treatment suggestions, and goes over what "alert level" these diseases qualify as, and defines the list of alert levels.

World Health Organization. (2013). *Health Topics: Infectious Diseases* [Website]. Retrieved 10 September 2013 from: http://www.who.int/topics/infectious_diseases/en/

This page is a compilation of all of WHO's existing information on pandemics and disease outbreaks. It focuses on WHO programs and activities, based on the region, and has specific sections for priority diseases, including HIV/AIDS, Malaria, and Tuberculosis. It also provides technical information for the neglected tropical diseases, pandemic disease definitions, and combating disease through health care training. Finally, it has both fact sheets and Q&As to cover basic information needed to understand disease outbreaks and pandemics.

World Health Organizations, Health Statistics and Information Systems. (2013). *About the Global Burden of Disease (GBD) Project* [Website]. Retrieved 24 July 2013 from: http://www.who.int/healthinfo/global_burden_disease/about/en/index.html

This report is the initial information on the Global Burden of Disease (GBD) project, and immensely important for considering the social impact of disease. This page defines the project, why there was an initial need for the project, and how the World Health Organization goes about collecting accurate information for the GBD's statistics. It also introduces the Disability-Adjusted Life Year (DALY) as a new metric and emphasizes the importance of this new framework..

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III. Improving Women's Health by Integrating Gender, Equity and Human Rights

"We now have an opportunity to achieve real, lasting progress – because global leaders increasingly recognize that the health of women and children is the key to progress on all development goals."[258]

Introduction

Health is a precondition for sustainable development.[259] Beyond this, it is a concern to all people and has influence on many fields, but it is also affected by various factors.[260] When it comes to the health situation of human beings, it makes a difference if one is male or female and the health of women and girls is of specific importance, because they are often victims of socio-cultural discrimination.[261] Some of the factors that influence the health situation of women are the unequal power relationships between men and women, the often worse access to education or the experience of physical, sexual or emotional violence.[262] Even factors that have an impact on both, men and women still often affect women more, for example, in the case of poverty and the ensuing malnutrition, which has an effect on a mother's feeding practices.[263]

Therefore, it is crucial to acknowledge the difference between men and women in terms of their sex and gender in order to achieve equity in health.[264] Gender equity as defined by the World Health Organization (WHO) refers to justice in the distribution of rights and responsibilities between males and females.[265] Health services, programmes or policies can only have a positive effect on women's health situations, when there is a focus on gender equality.[266] WHO has worked in the field of gender equality in health matters for decades now and has analyzed the various factors and challenges affecting it.[267]

International Framework

Article 25 of the *Universal Declaration of Human Rights* (1946) states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family (...)."[268] Besides this fundamental human right, there are several international documents that deal specifically with the topic of women's health. Among them is the *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW), adopted by the General Assembly (GA) in the annex to resolution 34/180 in 1979, which recognizes that in situations of poverty women often have the least access to health and other needs, even though they play a vital role in their communities.[269] Furthermore, the *Declaration on the Elimination of Violence against Women* adopted by General Assembly resolution in 1993 states in article 3 that women should be entitled to all human rights and fundamental freedoms including the "right to the highest standard attainable of physical and mental health."[270] The Committee on the Elimination of Discrimination against Women decided at its twentieth session in 1999 to develop a general recommendation on Article 12.[271] Recommendations for government actions included the implementation of national strategies in order to promote women's health and strengthen prevention and treatment as well as allocating appropriate financial, human and administrative resources for this work.[272]

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[258] UN Secretary-General, *Global Strategy for Women's and Children's Health*, 2010.
[259] UN General Assembly, *The future we want (Code),* 2012, para. 138.
[260] WHO, *Positioning Health in the Post-2015 development Agenda. WHO discussion paper*, 2012, p. 2.
[261] WHO, *Women's health*, 2013.
[262] Ibid
[263] Ibid
[264] WHO, *Gender, women and health: incorporating a gender perspective into the mainstream of WHO's policies and programmes (EB 116/13)*, 2005, para. 1.
[265] WHO, *WHO gender mainstreaming strategy*, 2013.
[266] WHO, *Gender Equality is good for health,* 2010.
[267] Ibid
[268] UN General Assembly, *Universal Declaration of Human Rights (A/RES/217 A(III)),* 1948, art. 25.
[269] UN General Assembly, *Convention on the Elimination of All Forms of Discrimination against Women (A/RES/34/180),* 1979.
[270] UN General Assembly, *Convention on the Elimination of All Forms of Discrimination against Women (A/RES/34/180),* 1979, art. 3; UN General Assembly, *Declaration on the Elimination of Violence against Women (A/RES/48/104)*, 1993.
[271] UN Committee on the Elimination of Discrimination Against Women, *CEDAW General Recommendation No. 24. Women and Health (Article 12),* 1999.
[272] Ibid.

The Fourth World Conference on Women, held in Beijing, China, in 1995, was one of the most influential of all international conferences focused on promoting women's rights.[273] In the outcome document, the *Beijing Platform for Action* (BPfA) (1995), there is a section on health issues, which states that women's health involves their emotional, social and physical well-being.[274] Furthermore, it discusses the challenges of health policies such as the failure of considering socio-economic disparities or the lack of autonomy of women when it comes to their health situation.[275] The report emphasizes the importance of women's health to a fulfilling life and the need for them to control all aspects of their health, especially considering their fertility as a requirement for their empowerment.[276]

Millennium Development Goals

One of the major international documents of the past decades was the *Millennium Declaration* (A/RES/55/2), which also recognized the importance of gender equality in all spheres of life, including access to health services.[277] The Millennium Development Goals (MDGs) also played a crucial role for the development of women's health as Goal 5 explicitly deals with improving maternal health and thus helped to raise awareness on the matter.[278] One of the targets of Goal 5 is to achieve universal access to reproductive health.[279]

Gender Mainstreaming

Economic and Social Council (ECOSOC) resolution 2012/24 requests the UN system including all its bodies and programmes continue mainstreaming issues of gender within their mandates and including a gender perspective in their work and policies.[280] Gender mainstreaming, was originally defined in ECOSOC resolution 1997/3, as:

> "The process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality."

What this concept effectively means in practice is that it is not enough to consider gender only superficially or casually in an ad-hoc manner in a project, but rather, the way in which a project influences and is influenced by gender, must be considered from the beginning.[281] In the context of health, all health professionals must be aware of the challenges for individuals based on gender and have profound knowledge in order to be able to address the gender issue where appropriate and make their work most effectively.[282]

Role of the United Nations System

Within the United Nations system, WHO is the primary entity responsible for health-related topics in both policy and practice, with additional work on specific health-related topics taken up by additional programmes and funds, including the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), and the United Nations Children's Fund (UNICEF). As health is a relevant topic across many issue areas, the General Assembly and Economic and Social Council both discuss health-related agenda items on an annual and ongoing basis, often assuming the role of developing coherence among various policy actors and reinforcing the work of entities with both knowledge-based and operational expertise, such as WHO.[283]

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[273] International Women's Health Coalition, *Fourth World Conference on Women, Beijing, 1995*, 2011.
[274] United Nations, *Report of the Fourth World Conference on Women (A/CONF.177/20/REV.1),* 1996, para. 89.
[275] Ibid., para. 90.
[276] Ibid, para. 92.
[277] WHO, *Gender, women and health: incorporating a gender perspective into the mainstream of WHO's policies and programmes*, 2005; UN General Assembly, *United Nations Millennium Declaration (A/RES/55/2)*, 2000.
[278] WHO, *Women and Health: today's evidence tomorrow's agenda*, 2009, p. XV.
[279] United Nations, *Goal 5: Improve maternal health.*
[280] United Nations Economic and Social Council, *Mainstreaming a gender perspective into all policies and programmes in the United Nations system,* 2012, operative 3.
[281] WHO, *What is "gender mainstreaming"?*, 2013.
[282] Ibid
[283] UN Economic and Social Council, *Improve Maternal Health: MDG 5* [Website]; UN Economic and Social Council, *2009 Annual Ministerial Review* [Website]*;* UN Economic and Social Council, *Universal Health Coverage at the center of*

WHO approaches this topic on a programmatic and policy level –through influencing the operations of regional and national health institutions and discussing within its governing bodies, such as the World Health Assembly.[284] Internally, there are two relevant departments: the Gender, Equity and Human Rights (GER) team and the Department of Gender, Women and Health (GWH).

The GER team, newly established in 2012, has adopted an approach to this topic, which includes a range of concrete actions including "technical cooperation, policy advice and dialogue, setting norms and standards, knowledge generation and sharing, convening stakeholders, and other enabling functions."[285] This work is carried out in large party via its Regional and Country Offices, which aim at supporting countries with integrating gender, equity and human rights into their national strategic health plans and policies.[286]

The second relevant section is the WHO Department of Gender, Women and Health (GWH), which works to create awareness, improve public understanding, increase knowledge and build capacities.[287] GWH works in various fields such as combating the spread of HIV/AIDS, fighting violence against women, addressing gender and malaria or dealing with food safety.[288] Its goal is to support policies and programmes that will contribute to the improvement of women's health by achieving gender equality and health equity.[289] To achieve this, GWH works with partners across the UN system, as well as on a bilateral basis with national development agencies.[290] In order to reinforce the health sector response in collaboration with national and local authorities, the Gender, Women and Health Network (GWHN) was created and supports Member States with implementing and evaluating their gender-focused health policies.[291]

Global Strategy for Women's and Children's Health

National and regional commitments made by governments and partners at various occasions such as the action surrounding and the outcome of the International Conference on Population and Development, the Fourth World Conference on Women or the ECOSOC Ministerial Review on Global Health have led to the development of the *Global Strategy for Women's and Children's Health*, which was developed under the auspices of the UN Secretary-General Ban Ki-moon and was launched in 2010.[292] The Strategy outlines the main areas where action is needed including support for country-led health plans, integrated delivery of health services and innovative approaches to financing of health services.[293]

The Strategy furthermore called upon WHO to determine the most effective institutional arrangements for ensuring global reporting and accountability on women's health, the outcome of which was the establishment of the Commission on Information and Accountability for Women's and Children's Health.[294] The accountability framework that was presented by the Commission included the tracking of results and resource flows at global and country levels and the investigation of opportunities for improvements in information technologies to receive more reliable information.[295] The final report of the Commission entitled "Keeping promises, measuring results", which was published in 2011 shows the challenges the international community still has to face in this matter and offers recommendations on how to continue the efforts.[296] It states that of the eight MDGs, the two that specifically deal with women's and children's health issues are those that are furthest from being achieved by 2015.[297]

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sustainable development: contributions of sciences, technology and innovations to health systems strengthening [Website]; UN WomenWatch, *Women and Health*.

[284] WHO, *World Health Assembly* [Website], 2013.
[285] WHO, *Gender, equity and human rights at the core of the health response*, 2012.
[286] Ibid.
[287] WHO Department of Gender, Women and Health, *Overview of Activities,* 2008.
[288] Ibid.
[289] WHO, Department of Women, Gender and Health, *Gender Equality is good for health,* 2010.
[290] WHO, *Gender Equality is good for health,* 2010.
[291] WHO, *The Gender, Women and Health Network*, 2013.
[292] UN Secretary-General, *Global Strategy for Women's and Children's Health*, 2010, p. 6.
[293] Ibid., p. 3.
[294] WHO, *Accountability Commission for health of women and children,* 2013.
[295] Ibid.
[296] WHO, *Keeping Promises, Measuring Results*, 2011, p. 4.
[297] Ibid., p. 3.

Other Relevant Entities

The United Nations Population Fund (UNFPA) is also very active in the field of women's health and especially improving reproductive health.[298] Working together with a range of partners including WHO, UNFPA aims at strengthening the prevention and care of sexually transmitted infections and promotes a better access to education and information.[299] One of the various initiatives of UNFPA is the Maternal Health Thematic Fund (MHTF), which was launched in 2008 to support safe motherhood by providing financial assistance.[300] The MHTF supported for example an assessment of the emergency obstetric care needs in Haiti after the earthquake in 2010, which will result in effective reconstruction.[301]

Another strong partner of WHO in the field of women's health is the United Nations Children's Fund (UNICEF), which worked together with WHO on the initiative "Making Pregnancy Safer."[302] The strategy of this initiative was to improve the capacity of health systems to support a better access to health services for mothers and neonates, especially in poor areas.[303] Furthermore, UNICEF works with governments and other partners in order to develop home-based maternal and newborn care programmes, establish community women's groups or promote a better access to education for girls, which can help them to strengthen their self-esteem.[304]

The Commission on the Status of Women (CSW) continuously deals with women's health issues, for example in its 43rd session, where it highlighted the importance of universal access to quality health care, expressed the need for a health sector reform in order to focus more on gender and promoted an improved international cooperation in this field.[305] Furthermore, CSW enhanced the role of the *Beijing Platform for Action*, which should implement measures to provide women with the necessary medical support and help to prevent maternal and child deaths.[306] In its 50th session, CSW stressed the enhanced participation of women in development and focused on achieving gender equality in the health sector.[307] It further pointed out how crucial it is to incorporate a gender perspective in all policies regarding health issues and called upon governments to take appropriate measures in this field and ensure women's and girl's access to education and health care.[308]

Within the General Assembly, the topic of health broadly is under the purview of the Third Committee, in the context of the general debate on "protection and promotion of human rights," discussing women's health often as a cross-cutting issue that is highlighted in the annual reports and briefings of its special rapporteurs.[309]

Reproductive and Maternal Health

Reproductive health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its function and processes."[310] Reproductive health thus means that people not only have the capability to reproduce, but also the ability to decide when and how often they want to.[311] It is vital that women have access to information on family planning, contraceptives and appropriate health care services such as antenatal and postnatal care.[312] Reproductive health, therefore, must be understood "in the context of relationships: fulfillment and risk; the opportunity to have a

[298] UNFPA, *About UNFPA* [Website].
[299] Ibid.
[300] UNFPA, *Maternal Health Thematic Fund* [Website].
[301] Ibid.
[302] UNICEF, *Maternal and newborn health* [Website], 21 June 2012.
[303] WHO, *Making pregnancy safer* [Website], 2013.
[304] UNICEF, *Maternal and newborn health* [Website], 21 June 2012.
[305] UN Commission on the Status of Women, *Agreed conclusions of the Commission on the Status of Women on critical areas of concern identified in the Beijing Platform for Action (1999/17),* 1999.
[306] Ibid.
[307] Ibid.
[308] UN Commission on the Status of Women, *Agreed conclusions enhanced participation of women in development: an enabling environment for achieving gender equality and the advancement of women, taking into account, inter alia, the fields of education, health and work*, 2006.
[309] UN General Assembly, *Allocation of agenda items to the Third Committee (A/C.3/68/1),* 2013.
[310] United Nations, *Report of the Fourth World Conference on Women (A/CONF.177/20/REV.1),* 1996, para. 94.
[311] Ibid., para. 94.
[312] United Nations, *Report of the Fourth World Conference on Women (A/CONF.177/20/REV.1),* 1996, para. 94; UN Secretary-General, *Global Strategy for Women's and Children's Health*, 2010, p. 7.

desired child or alternatively, to avoid unwanted or unsafe pregnancy."[313] Further, reproductive health "contributes enormously to physical and psychosocial comfort and closeness, and to personal and social maturation; poor reproductive health is frequently associated with disease, abuse, exploitation, unwanted pregnancy, and death." [314]

Poor reproductive health contributes to gender inequality.[315] Approximately 48 million women give birth without skilled assistance; around 150,000 women and 1.6 million children die each year during or within 48 hours after birth.[316] In sub-Saharan Africa, 1 out of every 26 women is at risk of dying while giving birth while in developed countries, it is 1 woman out of every 7,300.[317] The majority of cases of maternal death can be prevented.[318] Meeting the need for contraception could already reduce the number of maternal deaths worldwide by over 30%.[319] When women have better access to family planning and skilled birth attendance, rate of maternal death declines, which is shown in Jamaica, Malaysia or Tunisia, where the numbers could be halved within a decade.[320] In Sri Lanka, for example, maternal mortality was reduced by 87% in the last 40 years because 99% of the pregnant women receive four antenatal visits in a health facility and have the chance to give birth there, too.[321]

Another key factor is nutrition as it is crucial for health and even more beneficial for women that want to have children. Still, there are about 468 million women between 15 and 49 years of age that are thought to be anemic with the highest proportion of them (around 50%) living in Africa.[322] Anemia is associated with a lower physical capacity and increased susceptibility to infections and thus poses a risk to maternal health and often leads to low birth weight babies.[323] During pregnancy, it is especially important for women to uphold a healthy nutrition as women with a poor nutritional status are at higher risk of diseases or death.[324] Reasons for malnutrition are often the lack of availability of food or infestation with gastrointestinal parasites.[325]

In the *Five-Year Action Agenda of the United Nations Secretary-General*, as laid out on 25 January 2012, the need to improve the education regarding reproductive health is explicitly mentioned.[326] And in most regions, the access to reproductive health care has improved over the last years, although not fast enough to meet Millennium Development Goal 5.[327]

Violence Against Women and Girls

Violence against women is "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women and girls, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."[328] Violence against women often has consequences on the health of women, not only in the short term, but also in the long-term, for example, by affecting their reproductive health.[329] Thus, it is essential that States condemn violence against women and girls and take action at all levels in order to combat discrimination.[330] It is crucial to strengthen the implementation of legal frameworks and policies as well as improving the multi-sectoral services and programmes provided.[331]

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[313] POPIN, *Guidelines on Reproductive Health*.
[314] Ibid.
[315] UNDP, *Human Development Report 2011. Sustainability and Equity: A better future for all*, 2011, p. 61.
[316] Ibid., p. 61.
[317] WHO, *Women's Health in the WHO African Region: A Call for Action*, 2008, para. 4.
[318] United Nations, *Goal 5: Improve maternal health,* 2008.
[319] Ibid.
[320] Ibid.
[321] UN Secretary-General, *Global Strategy for Women's and Children's Health*, 2010, p. 7.
[322] WHO, *Nutrition of women in the preconception period, during pregnancy and the breastfeeding period,* 2012, para. 4.
[323] Ibid., para. 4.
[324] Ibid., para. 10.
[325] Ibid., para. 10.
[326] UN Secretary-General, *United Nations Secretary-General's Five-Year Action Agenda,* 2012, p. 10.
[327] UNDP, *Human Development Report 2011. Sustainability and Equity: A better future for all*, 2011, p. 61.
[328] UN Commission on the Status of Women, *Agreed conclusions on the elimination and prevention of all forms of violence against women and girls,* 2013, para. 11.
[329] Ibid.
[330] UN Commission on the Status of Women, *Agreed conclusions on the elimination and prevention of all forms of violence against women and girls,* 2013.
[331] Ibid.

Intimate partner violence
One of the major challenges in this field is the intimate partner violence, which is often associated with a woman's risk of contracting HIV, because in those situations women often do not have a chance to negotiate condom use and have a higher risk of tearing their vagina, which increases the chance of a transmission.[332] Furthermore, women that have been raped by their partner are less likely to get tested on HIV.[333] Violence during pregnancy can also cause maternal death.[334] A study in 400 villages in rural India, for example, has shown that 16 % of deaths among pregnant women resulted from partner violence.[335] Women that have experienced physical or sexual violence are also more likely to suffer from mental illnesses such as depression, suicide attempts, post-traumatic stress disorders, sleeping or eating disorders and have a higher risk of alcohol or drug abuse and other subsequent risk behaviors.[336]

Women's Health in Situations of Armed Conflict
In situations of armed conflict or other emergencies, women face specific challenges, as there is still a pattern of gender differentiation at all stages of disaster.[337] In those situations, women are at higher risk of suffering from sexual assault, rape or mass rape or they are forced to offer sex for exchange of survival, food or shelter.[338] The access to health services is often even more limited than normally and even if health care is available, women are often unable to find help due to cultural restrictions or their own household responsibilities.[339] Violence in conflict situations can have long-term effects on women's health on multiple levels, including, importantly psychosocial in regards particularly to isolation, marginalization and stigma which often affects all individuals in conflict situations, but particularly victims of violence.[340] Furthermore, situations of war have also a heavy influence on health systems in general as they are usually overstretched by the number of victims and parts of their infrastructure can be damaged.[341] Thus, it is crucial to train health systems in order to be able to better deal with those situations.[342]

Specific Challenges for Girls and Adolescents

Discrimination against girls in various fields such as access to health care services and nutrition is still a challenge in many societies around the world and often results from son preferences.[343] Furthermore, girls face many difficulties that pose severe health risks to them such as female genital mutilation or being forced into early marriage and child bearing.[344] Girls that experienced sexual abuse as children often engage in high-risk sexual behavior later in their lives including less condom use and multiple partners.[345]

Adolescent pregnancy
Girls are at higher risk of being sexually abused or forced into prostitution than boys with the consequence that they are more likely to get infected with HIV or other sexually transmitted diseases and often have to deal with unwanted pregnancies or unsafe abortions.[346] The reasons for adolescent pregnancy are multifaceted, but include early marriage, sexual coercion and a lack of access to contraception.[347] Roughly 38 % of girls in developing countries marry before the age of 18, 14 % even before the age of 15.[348] Young women between 15 and 19 years of age are twice as likely to die during pregnancy or while giving birth than women over the age of 20.[349] Young women in

[332] WHO, *Understanding and addressing violence against women: health consequences*, 2012, p. 4.
[333] Ibid., p. 4.
[334] Ibid., pp. 4-5.
[335] Ibid., pp. 4-5.
[336] Ibid., p. 5.
[337] WHO, *Women and Health: today's evidence tomorrow's agenda*, 2009, p. 11.
[338] WHO, *Violence against women. In situations of armed conflict and displacement,* 1997.
[339] WHO, *Women and Health: today's evidence tomorrow's agenda*, 2009, p. 11.
[340] WHO, *Violence against women. In situations of armed conflict and displacement,* 1997.
[341] Ibid.
[342] WHO, *Violence against women. In situations of armed conflict and displacement,* 1997.
[343] United Nations, *Report of the Fourth World Conference on Women (A/CONF.177/20/REV.1),* 1996, para. 93.
[344] Ibid, para. 93.
[345] WHO, *Understanding and addressing violence against women: health consequences*, 2012, p. 4.
[346] United Nations, *Report of the Fourth World Conference on Women (A/CONF.177/20/REV.1),* 1996, para. 93.
[347] WHO, *WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes Among Adolescents in Developing Countries*, 2011, p. 12.
[348] WHO, Women and Health: today's evidence tomorrow's agenda, 2009, p. 30.
[349] WHO, *WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes Among Adolescents in Developing Countries*, 2011, p. 2.

developing countries often do not use contraceptives because they lack information on how to use them or the reproductive health care services in their countries focus mainly on the needs of married women of reproductive age.[350] Therefore, each year approximately 2 - 4.4 million adolescents in developing countries have to face unsafe abortions, facing severe risks.[351] Even when these abortions do not result in death, they can still have long-term health consequences such as hemorrhage, reproductive tract infections or infertility.[352]

Female genital mutilation
One of the most severe damages to women's health, which is still common in many African countries, is the female genital mutilation. Female genital mutilations have severe health implications on girls and cause immediate bleeding, pain and the high-risk of infections.[353] Women who had a mutilation are more likely to experience pain during sex, have a significantly less sexual satisfaction and a higher risk of perinatal death.[354]

Lack of education
The health of women is affected by social and economic factors such as access to education and information.[355] Child mortality rates are highest in households where the level of education of the mother is lowest.[356] In order to improve the situation especially for young women, it is crucial to strengthen the sexuality education not only in schools, but also in out of school settings.[357] Furthermore, the provision of contraceptives is necessary and including life skills such as negotiations into sexuality education programmes could be beneficial.[358] Also, the role of parents and especially mothers should be addressed, as this often is a significant influence on adolescent girls.[359] However, not only women's education play a role, it is also due to a lack of education that young men often do not have an understanding of gender equality and do not respect women's self-determination or the importance of sharing responsibility when it comes to sexuality or reproduction.[360]

Women's Health in the Post-2015 Development Agenda

Priorities in the field of health seem to shift as non-communicable diseases play a greater role and it is more recognized how important it is for people to have access to all services they need including information on sexual and reproductive health.[361] Today, the focus is more on the economic, social and environmental determinants of health.[362] At the informal Member State Consultation on Health in the Post-2015 Development Agenda, it was discussed that health priorities should address the neglected elements of the MDGs such as girl's education, health equity and gender equality.[363] In the outcome of the United Nations Conference on Sustainable Development (Rio +20), entitled *The Future We Want* (A/RES/66/288), the necessity to strengthen health systems is mentioned.[364] In order to achieve this, a better cooperation between national and international levels is crucial and it is vital to improve the health infrastructure, increase health financing and guarantee access to safe and affordable medicines and vaccines.[365] Additionally, there must be access to information and contraceptives, as well as to timely emergency obstetric services.[366] Furthermore, it is fundamental to prevent child marriage and protect women from domestic violence and sexual abuse.[367]

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[350] WHO, *Women and Health: today's evidence tomorrow's agenda*, 2009, p. 31.
[351] WHO, *WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes Among Adolescents in Developing Countries*, 2011, p. 2.
[352] WHO, *Women and Health: today's evidence tomorrow's agenda,* 2009, p. 31.
[353] WHO, *Understanding and addressing violence against women: health consequences*, 2012, p. 3.
[354] Ibid., p. 3.
[355] WHO, *Women and Health: today's evidence tomorrow's agenda*, 2009, p. 2.
[356] Ibid., p. 11.
[357] WHO, *WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes Among Adolescents in Developing Countries*, 2011, p. 45.
[358] Ibid., p. 45.
[359] Ibid., p. 45.
[360] United Nations, *Report of the Fourth World Conference on Women (A/CONF.177/20/REV.1),* 1996, para. 93.
[361] WHO, *Positioning Health in the Post-2015 development Agenda. WHO discussion paper*, 2012, p. 2.
[362] Ibid., p. 2.
[363] WHO, *Informal Member State Consultation on Health in the Post 2015 Development Agenda*, 2012, p. 2.
[364] UN General Assembly, *The future we want (A/RES/66/288) [Resolution]*, 2012. para. 139.
[365] Ibid., para. 143.
[366] United Nations, *Goal 5: Improve maternal health*, 2008.
[367] Ibid.

Case Study: South Africa

In South Africa, the Johannesburg University of the Witwatersrand, the London School of Hygiene and Tropical Medicine and a microfinance provider started a joint initiative called the "Intervention with Microfinance for AIDS and Gender Equity (IMAGE) Study," which took five years and involves around 850 women and 4,000 young people from the rural district of South Africa's Limpopo province.[368] The programme aimed to address the effect of women's social and economic vulnerability on gender-based violence and HIV transmission.[369] IMAGE offers rural women access to microfinance in order to support them with starting their own businesses to become economically independent.[370] Furthermore, IMAGE provides gender and HIV education in order to enable women to better negotiate sexual relationships and recognize their rights.[371]

Among women who participated in the project, the experience of physical or sexual violence was reduced by half over the past year compared to women not taking part in the project.[372] The improvement of the social empowerment of women lead to a change in their behavior, for example by using condoms more often, taking voluntary tests or improving the communication about HIV/AIDS.[373] This shows that self-confidence, financial independence and education have a significant impact on women's empowerment and also on their health situation.[374] WHO has declared the IMAGE project as a best practice model for HIV prevention at their Dakar Conference in 2008 and has made it one of its ten global case studies for the Commission on the Social Determinants of Health.[375]

Conclusion

Throughout the last years, there has been progress in the field of women's health by recent initiatives such as the UN Secretary-General's *Global Strategy for Women's and Children's Health* (2010), the Millennium Development Goals (particularly Goal 5) or the establishment of two new commissions, the Commission on Information and Accountability and the Commission on Life-Saving Commodities.[376] In the midterm review of its gender strategy, WHO discovers that even though it has implemented a far-reaching gender-mainstreaming program, the impact on every-day work has still been limited.[377] Therefore it is necessary to focus on new strategies such as a more systematic capacity development, improved accountability mechanisms and targets within each Strategic Direction that need to be met.[378] The international community must understand the importance of implementing sexual and reproductive health programmes, strengthening the health systems in all Member States and investing more in policies and programmes that improve women's health situations worldwide.[379] There are several aspects that need to be further discussed and addressed by WHO such as the severe consequences of sexual violence to girls and women, the stronger involvement of men in reproductive health or the need to enable women to exercise their rights in this field.[380]

Delegates should ask themselves what the situation of women's health in their countries is like and what projects or initiatives have been launched there. Can any of the experiences made be used as examples for other countries? How

[368] National Prosecution Authority of South Africa & UNICEF, *Compendium of Case Studies. Mapping & Review of Violence Prevention Programmes in South Africa,* 2008, pp. 5-6.
[369] GBV Prevention Network, *Intervention with Microfinance for AIDS and Gender Equity (IMAGE)*, 2009.
[370] National Prosecution Authority of South Africa & UNICEF, *Compendium of Case Studies. Mapping & Review of Violence Prevention Programmes in South Africa,* 2008, pp. 5-6.
[371] Ibid., pp. 5-6.
[372] Ibid., pp. 5-6.
[373] GBV Prevention Network, *Intervention with Microfinance for AIDS and Gender Equity (IMAGE)*, 2009.
[374] National Prosecution Authority of South Africa & UNICEF, *Compendium of Case Studies. Mapping & Review of Violence Prevention Programmes in South Africa,* 2008, pp. 5-6.
[375] GBV Prevention Network, *Intervention with Microfinance for AIDS and Gender Equity (IMAGE)*, 2009.
[376] Bustreo & Hunt, *Women's and children's health: evidence of impact of human rights* [Report], 2013, p. 6.
[377] WHO, *Gender mainstreaming in WHO: What* is next? [Report], 2011, p. 2.
[378] Ibid., p. 2.
[379] UN Commission on the Status of Women, *Follow-up to the Fourth World Conference on Women and to the twenty-third special session of the General Assembly, entitled "Women 2000: gender equality, development and peace for the twenty-first century" (E/CN.6/2010/NGO/15),* 2009.
[380] Ibid.

did the government implement gender, equity and human rights in their own health policies? What international measures or strategies should be further strengthened and how can better accountability be achieved?

Even though, there has been progress, many challenges remain and they often begin with interventions in childhood or adolescence.[381] This often has an effect on women's lives later, not only on health matters but also on social factors such as equality and discrimination.[382] Thus, these are not only health challenges; these are also human rights challenges that need to be addressed by the committee.[383]

Annotated Bibliography

GBV Prevention Network. (2009). *Intervention with Microfinance for AIDS and Gender Equity (IMAGE)* [Website]. Retrieved 7 September 2013 from: http://www.preventgbvafrica.org/featured-member/intervention-microfinance-aids-and-gender-equity-image

This web site gives information on a specific project in South Africa that offers women microfinance in order to empower them by making them economically independent. Together with a strengthening of health education, this led to an improved situation for women. This shows how gender equality, women's empowerment and health are connected. Delegates can take this as an example for possible strategies and projects.

United Nations. (1996). *Report of the Fourth World Conference on Women (A/CONF.177/20/REV.1)* [Report]. Beijing, 4-15 September 1995. Retrieved 6 September 2013 from: http://www.un.org/womenwatch/daw/beijing/pdf/Beijing%20full%20report%20E.pdf

The report includes a section on women and health, which emphasizes women's rights regarding health decisions and highlights health as a human right. For delegates this source can be helpful in order to put gender mainstreaming into a bigger context as the Fourth World Conference on Women played a decisive role in that matter. The report also touches the various challenges women face and offers detailed recommendations on actions to be taken.

United Nations, Department for Public Information. (2008).*Goal 5: Improve maternal health* [Fact Sheet]. Millennium Development Goals. End Poverty 2015. Retrieved 7 September 2013 from: http://www.un.org/millenniumgoals/2008highlevel/pdf/newsroom/Goal%205%20FINAL.pdf

This fact sheet will give delegates facts and numbers on the situation of maternal health and the challenges of achieving MDG 5. It also provides delegates with success stories from different countries that better illustrate the efforts made. At the end, there are recommendations on what still needs to be done in the field. Overall, it is an excellent overview for delegates on this subject.

United Nations, Secretary-General. (2010). *Global Strategy for Women's and Children's Health*. Retrieved 6 September 2013 from: http://www.who.int/pmnch/topics/maternal/20100914_gswch_en.pdf

This source will give delegates an excellent overview of the topic. In the strategy, the challenges women face are introduced, and the importance of working together is highlighted. Furthermore, there are sections on the financial gap and accountability. At the end, there are recommendations for the various actors in the field that will also be an excellent orientation for delegates.

World Health Organization. (1997). *Violence against women. In situations of armed conflict and displacement.* Retrieved 7 September 2013 from: http://www.who.int/gender/violence/v7.pdf

This source will help delegates to get a better overview on the health situation of women in violent conflicts. It shortly explains the challenges they face and also deals with the impacts of violent conflict on the health system in general. A second part of the source deals with the specific challenges of the girl child.

[381] Bustreo & Hunt, *Women's and children's health: evidence of impact of human rights* [Report], 2013, p. 6.
[382] Ibid., p. 6.
[383] Ibid, p. 6.

World Health Organization. (2009). *Women and Health: today's evidence tomorrow's agenda* [Report]. Retrieved 6 September 2013 from: http://whqlibdoc.who.int/publications/2009/9789241563857_eng.pdf

This report is a comprehensive overview of the health situation of women today. It touches various salient aspects such as the specific challenges of the girl child and the adolescent girl as well as the importance of maternal health. Furthermore, it deals with the reproductive health, the connection to HIV/AIDS and the psychological effects such as depression. Delegates can find profound background knowledge on women's challenges here.

World Health Organization. (2012). *Understanding and addressing violence against women: health consequences* [Fact Sheet]. Retrieved 7 September 2013 from: http://apps.who.int/iris/handle/10665/77431

This source explains many serious health consequences that result from the various challenges women have to face and thus will provide delegates with comprehensive knowledge of the multifaceted factors on women's health. It covers a wide range of topics including femicide, female genital mutilation or unsafe abortions. Delegates will find useful information for their further research.

World Health Organization, Department of Gender, Women and Health. (2008). *Overview of Activities.* Retrieved 7 September 2013 from: http://www.who.int/gender/GHW_overview_EN.pdf

The Overview of Activities will give delegates an insight into the work of the Department. It describes what and how the department does in order to address the issue of gender within health policy. It also explains tools, which could be helpful for delegates. The country specific examples show the regional work of certain organizations and governments.

World Health Organization, Department of Women, Gender and Health. (2010). *Gender Equality is good for health.* Retrieved 6 September 2013 from: http://www.who.int/gender/about/about_gwh_20100526.pdf

This source explains the connection between gender equality and health and the effects disparities in this field have. It stresses the importance of cooperation and global partnership in order to find solutions and strengthen the existent policies and programmes. For delegates, this is a brief overview that will give them a better understanding of why the topic is of importance.

World Health Organization. (October 2012). *Positioning Health in the Post-2015 Development Agenda. WHO discussion paper.* Retrieved 7 September 2013 from: http://www.who.int/topics/millennium_development_goals/post2015/WHOdiscussionpaper_October2012.pdf

This source will give delegates an understanding of the necessary changes in the focus of addressing women's health in the Post 2015 Development Agenda. It explains the shortcomings of the MDGs and offers recommendations to change that. For delegates, this is vital in order to see in what direction the future strategies and policies should go. It will help them in their discussions at the conference.

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Rules of Procedure of the World Health Organization (WHO)

Introduction

1. These rules shall be the only rules which apply to the Executive Board of the World Health Organization (hereinafter referred to as "the Board") and shall be considered adopted by the Board prior to its first meeting.

2. For purposes of these rules, the Director, the Assistant Director(s), the Under-Secretaries-General, and the Assistant Secretaries-General, are designates and agents of the Secretary-General and Deputy Secretary-General, and are collectively referred to as the "Secretariat."

3. Interpretation of the rules shall be reserved exclusively to the Deputy Secretary-General or her/his designate. Such interpretation shall be in accordance with the philosophy and principles of the National Model United Nations (NMUN) and in furtherance of the educational mission of that organization.

4. For the purposes of these rules, "President" shall refer to the chairperson or acting chairperson of the Board, which can be any member of the Secretariat or their designate.

5. The practice of striving for consensus in decision-making shall be encouraged. NMUN also acknowledges it may sometimes be necessary for a Member State to abstain or vote against a resolution it cannot support for policy reasons.

I. SESSIONS

Rule 1 - *Dates of convening and adjournment*

The Board shall meet every year in regular session, commencing and closing on the dates designated by the Secretary-General.

Rule 2 - *Place of sessions*

The Board shall meet at a location designated by the Secretary-General.

II. AGENDA

Rule 3 - *Provisional agenda*

The provisional agenda shall be drawn up by the Deputy Secretary-General and communicated to the members of the Board at least sixty days before the opening of the session.

Rule 4 - *Adoption of the agenda*

The agenda provided by the Deputy Secretary-General shall be considered adopted as of the beginning of the session. The order of the agenda items shall be determined by a majority vote of those present and voting.

> *The vote described in this rule is a procedural vote and, as such, observers are permitted to cast a vote. For purposes of this rule, those present and voting means those Member States and observers, in attendance at the meeting during which this motion comes to a vote. Should the Board not reach a decision by conclusion of the first night's meeting, the agenda will be automatically set in the order in which it was first communicated.*

Rule 5 - *Revision of the agenda*

During a session, the Board may revise the agenda by adding, deleting, deferring or amending items. Only important and urgent items shall be added to the agenda during a session. Debate on the inclusion of an item in the agenda shall be limited to three speakers in favor of, and three against, the inclusion. Additional items of an important and urgent character, proposed for inclusion in the agenda less than thirty days before the opening of a session, may be placed on the agenda if the Board so decides by a two-thirds majority of the members present and voting. No additional item may, unless the Board decides otherwise by a two-thirds majority of the members present and voting, be considered until a commission has reported on the question concerned.

> *For purposes of this rule, the determination of an item of an important and urgent character is subject to the discretion of the Deputy Secretary-General, or his or her designate, and any such determination is final. If an item is determined to be of such a character, then it requires a two-thirds vote of the Board to be placed on the agenda. The votes described in this rule are substantive votes, and, as such, observers are not permitted to cast a vote. For purposes of this rule, ―the members "present and voting" ― means members (not including observers) in attendance at the session during which this motion comes to vote.*

Rule 6 - *Explanatory memorandum*

Any item proposed for inclusion in the agenda shall be accompanied by an explanatory memorandum and, if possible, by basic documents.

III. SECRETARIAT

Rule 7 - *Duties of the Secretary-General*

1. The Secretary-General or her/his designate shall act in this capacity in all meetings of the Board.

2. The Secretary-General, in cooperation with the Deputy Secretary-General, shall provide and direct the staff required by the Board and be responsible for all the arrangements that may be necessary for its meetings.

Rule 8 - *Duties of the Secretariat*

The Secretariat shall receive and distribute documents of the Commission to the Members, and generally perform all other work which the Board may require.

Rule 9 - *Statements by the Secretariat*

The Secretary-General or her/his designate, may make oral as well as written statements to the Board concerning any question under consideration.

Rule 10 - *Selection of the President*

The Secretary-General or her/his designate shall appoint, from applications received by the Secretariat, a President who shall hold office and, *inter alia*, chair the Board for the duration of the session, unless otherwise decided by the Secretary-General.

Rule 11 - *Replacement of the President*

If the President is unable to perform her/his functions, a new President shall be appointed for the unexpired term at the discretion of the Secretary-General or her/his designate.

IV. LANGUAGE

Rule 12 - *Official and working language*

English shall be the official and working language of the Board during scheduled sessions (both formal and informal) of the Board.

Rule 13 - *Interpretation (oral) or translation (written)*

Any representative wishing to address any body or submit a document in a language other than English shall provide interpretation or translation into English.

> *This rule does not affect the total speaking time allotted to those representatives wishing to address the body in a language other than English. As such, both the speech and the interpretation must be within the set time limit. The language should be the official language of the country you are representing at NMUN.*

V. CONDUCT OF BUSINESS

Rule 14 - *Quorum*

The President may declare a meeting open and permit debate to proceed when representatives of at least one-third of the members of the Board are present. The presence of representatives of a majority of the members of the Board shall be required for any decision to be taken.

> *For purposes of this rule, members of the Board means the total number of members (not including observers) in attendance at the first night's meeting (session).*

Rule 15 - *General powers of the President*

In addition to exercising the powers conferred upon him or her elsewhere by these rules, the President shall declare the opening and closing of each meeting of the Board, direct the discussions, ensure observance of these rules, accord the right to speak, put questions to vote and announce decisions. The President, subject to these rules, shall have complete control of the proceedings of the Board and over the maintenance of order at its meetings. He or she shall rule on points of order. The President may propose to the Board the closure of the list of speakers, a limitation on the speakers time and on the number of times the representative of each member may speak on an item, the adjournment or closure of the debate, and the suspension or adjournment of a meeting.

> *Included in these enumerated powers is the power to assign speaking times for all speeches incidental to motions and amendment. Further, the President is to use her/his discretion, upon the advice and at the consent of the Secretariat, to determine whether to entertain a particular motion based on the philosophy and principles of the NMUN. Such discretion should be used on a limited basis and only under circumstances where it is necessary to advance the educational mission of the Conference and is limited to entertaining motions.*

Rule 16 - *Authority of the Board*

The President, in the exercise of her or his functions, remains under the authority of the Board.

Rule 17 - *Voting rights on procedural matters*

Unless otherwise stated, all votes pertaining to the conduct of business shall require a favorable vote by the majority of the members "present and voting" in order to pass.

> *For purposes of this rule, the members present and voting mean those members (including observers) in attendance at the meeting during which this rule is applied. Note that observers may vote on all procedural votes; they may, however, not vote on substantive matters (see Chapter VI). Every delegation must cast a vote in procedural votes. Further, there is no possibility to abstain or pass on procedural votes*

Rule 18 - *Points of order*

During the discussion of any matter, a representative may rise to a point of order, and the point of order shall be immediately decided by the President in accordance with the rules of procedure. A representative may appeal against the ruling of the President. The appeal shall be immediately put to the vote, and the President's ruling shall stand unless overruled by a majority of the members present and voting. A representative rising to a point of order may not speak on the substance of the matter under discussion.

> *Such points of order should not under any circumstances interrupt the speech of a fellow representative. They should be used exclusively to correct an error in procedure. Any questions on order arising during a speech made by a representative should be raised at the conclusion of the speech, or can be addressed by the President, sua sponte (on her/his own accord), during the speech. For purposes of this rule, the members present and voting mean those members (including observers) in attendance at the meeting during which this motion comes to vote.*

Rule 19 - *Speeches*

No representative may address the Board without having previously obtained the permission of the President. The President shall call upon speakers in the order in which they signify their desire to speak. The President may call a speaker to order if his remarks are not relevant to the subject under discussion.

> *In line with the philosophy and principles of the NMUN, in furtherance of its educational mission, and for the purpose of facilitating debate, the Secretariat will set a time limit for all speeches which may be amended by the Board through a vote if the President, at his or her discretion, decides to allow the Board to decide. In no case shall the speakers time be changed during the first scheduled session of the Board. Consequently, motions to alter the speaker's time will not be entertained by the President. The content of speeches should be pertinent to the agenda as set by the Board.*

Rule 20 - *List of Speakers*

Members may only be on the list of speakers once but may be added again after having spoken. During the course of a debate, the President may announce the list of speakers and, with the consent of the Board, declare the list closed. Once the list has been closed, it can be reopened upon by a vote of the Board. When there are no more speakers, the President shall declare the debate closed. Such closure shall have the same effect as closure by decision of the Board.

> *The decision to announce the list of speakers is within the discretion of the President and should not be the subject of a motion by the Board. A motion to close the speakers list or reopen (if the list has already been closed) is within the purview of the Board and the President should not act on her/his own motion.*

Rule 21 - *Right of reply*

If a remark impugns the integrity of a representative's State, the President may permit that representative to exercise her/his right of reply following the conclusion of the controversial speech, and shall determine an appropriate time limit for the reply. No ruling on this question shall be subject to appeal.

> *For purposes of this rule, a remark that impugns the integrity of a representative's State is one directed at the governing authority of that State and/or one that puts into question that State's sovereignty or a portion thereof. All interventions in the exercise of the right of reply shall be addressed in writing to the Secretariat and shall not be raised as a point of order or motion. The reply shall be read to the Board by the representative only upon approval of the Secretariat, and in no case after voting has concluded on all matters relating to the agenda topic, during the discussion of which, the right arose. The right of reply will not be approved should it impugn the integrity of another State.*

Rule 22 - *Suspension of the meeting*

During the discussion of any matter, a representative may move the suspension of the meeting, specifying a time for reconvening. Such motions shall not be debated but shall be put to a vote immediately, requiring the support of a majority of the members present and voting to pass. Delegates should not state a purpose for the suspension.

> *This motion should be used to suspend the meeting for lunch or at the end of the scheduled board session time. Delegates should properly phrase this motion as "suspension of the meeting," and provide a length of time when making the motion.*

Rule 23 - *Adjournment of the meeting*

During the discussion of any matter, a representative may move to the adjournment of the meeting. Such motions shall not be debated but shall be put to the vote immediately, requiring the support of a majority of the members present and voting to pass. After adjournment, the Board shall reconvene at its next regularly scheduled meeting time.

> *As this motion, if successful, would end the meeting until the Board's next regularly scheduled session the following year, and in accordance with the philosophy and principles of the NMUN and in furtherance of its educational mission, the President will not entertain such a motion until the end of the last meeting of the Board.*

Rule 24 - *Adjournment of debate*

During the discussion of any matter, a representative may move the adjournment of the debate on the item under discussion. Two representatives may speak in favor of, and two against, the motion, after which the motion shall be immediately put to the vote. The President may limit the time to be allowed to speakers under this rule.

Rule 25 - *Closure of debate*

A representative may at any time move the closure of debate on the item under discussion, whether or not any other representative has signified her/his wish to speak. Permission to speak on the motion shall be accorded only to two representatives opposing the closure, after which the motion shall be put to the vote immediately. Closure of debate shall require a two-thirds majority of the members present and voting. If the Board favors the closure of debate, the Board shall immediately move to vote on all proposals introduced under that agenda item.

Rule 26 - *Order of motions*

Subject to Rule 18, the motions indicated below shall have precedence in the following order over all proposals or other motions before the meeting:

1. To suspend the meeting;
2. To adjourn the meeting;
3. To adjourn the debate on the item under discussion;
4. To close the debate on the item under discussion.

Rule 27 - *Proposals and amendments*

Proposals and amendments shall normally be submitted in writing to the Secretariat. Any proposal or amendment that relates to the substance of any matter under discussion shall require the signature of twenty percent of the members of the Board [sponsors].

The Secretariat may, at its discretion, approve the proposal or amendment for circulation among the delegations. As a general rule, no proposal shall be put to the vote at any meeting of the Board unless copies of it have been

circulated to all delegations. The President may, however, permit the discussion and consideration of amendments or of motions as to procedure, even though such amendments and motions have not been circulated.

If the sponsors agree to the adoption of a proposed amendment, the proposal shall be modified accordingly and no vote shall be taken on the proposed amendment. A document modified in this manner shall be considered as the proposal pending before the Board for all purposes, including subsequent amendments.

> *For purposes of this rule, all proposals shall be in the form of working papers prior to their approval by the Secretariat. Working papers will not be copied, or in any other way distributed, to the Board by the Secretariat. The distribution of such working papers is solely the responsibility of the sponsors of the working papers. Along these lines, and in furtherance of the philosophy and principles of the NMUN and for the purpose of advancing its educational mission, representatives should not directly refer to the substance of a working paper that has not yet been accepted as a draft resolution during formal speeches. After approval of a working paper, the proposal becomes a draft resolution and will be copied by the Secretariat for distribution to the Board. These draft resolutions are the collective property of the Board and, as such, the names of the original sponsors will be removed. The copying and distribution of amendments is at the discretion of the Secretariat, but the substance of all such amendments will be made available to all representatives in some form. Should delegates wish to withdraw a working paper or draft resolution from consideration, this requires the consent of all sponsors.*

Rule 28 - *Withdrawal of motions*

A motion may be withdrawn by its proposer at any time before voting has commenced, provided that the motion has not been amended. A motion thus withdrawn may be reintroduced by any member.

Rule 29 - *Reconsideration of a topic*

When a topic has been adjourned, it may not be reconsidered at the same session unless the Board, by a two-thirds majority of those present and voting, so decides. Reconsideration can only be moved by a representative who voted on the prevailing side of the original motion to adjourn. Permission to speak on a motion to reconsider shall be accorded only to two speakers opposing the motion, after which it shall be put to the vote immediately. The President may limit the time to be allowed to speakers under this rule.

Rule 30 - *Invitation to silent prayer or meditation*

Immediately after the opening of the first plenary meeting and immediately preceding the closing of the final plenary meeting of each session of the General Assembly, the President shall invite the representatives to observe one minute of silence dedicated to prayer or meditation.

VI. VOTING

Rule 31 - *Voting rights*

Each member of the Board shall have one vote.

> *This rule applies to substantive voting on amendments, draft resolutions, and portions of draft resolutions divided out by motion. As such, all references to member(s) do not include observers, who are not permitted to cast votes on substantive matters.*

Rule 32 - *Request for a vote*

A proposal or motion before the Board for decision shall be voted upon if any member so requests. Where no member requests a vote, the Board may adopt proposals or motions without a vote.

> *For purposes of this rule, proposal means any draft resolution, an amendment thereto, or a portion of a draft resolution divided out by motion. Just prior to a vote on a particular proposal or motion, the President may ask if there are any objections to passing the proposal or motion by acclamation, or a*

member may move to accept the proposal or motion by acclamation. If there are no objections to the proposal or motion, then it is adopted without a vote. Adoption by "acclamation" or "without a vote" is consistent not only with the educational mission of the conference but also the way in which the United Nations adopts a majority of its proposals.

Rule 33 - *Majority required*

1. Unless specified otherwise in these rules, decisions of the Board shall be made by a majority of the members present and voting.

2. For the purpose of tabulation, the phrase "members present and voting" means members casting an affirmative or negative vote. Members which abstain from voting are considered as not voting.

   All members declaring their representative States as "present and voting" during the attendance roll-call for the meeting during which the substantive voting occurs, must cast an affirmative or negative vote, and cannot abstain on substantive votes.

Rule 34 - *Method of voting*

1. The Board shall normally vote by a show of placards, except that a representative may request a roll-call, which shall be taken in the English alphabetical order of the names of the members, beginning with the member whose name is randomly selected by the President. The name of each member shall be called in any roll-call, and one of its representatives shall reply "yes," "no," "abstention," or "pass."

   Only those members who designate themselves as present or present and voting during the attendance roll-call, or in some other manner communicate their attendance to the President and/or Secretariat, are permitted to vote and, as such, no others will be called during a roll-call vote. Any representatives replying pass must, when requested a second time, respond with either a yes or no vote. A pass cannot be followed by a second pass for the same proposal or amendment, nor can it be followed by an abstention on that same proposal or amendment.

2. When the Board votes by mechanical means, a non-recorded vote shall replace a vote by show of placards and a recorded vote shall replace a roll-call vote. A representative may request a recorded vote. In the case of a recorded vote, the Board shall dispense with the procedure of calling out the names of the members.

3. The vote of each member participating in a roll-call or a recorded vote shall be inserted in the record.

Rule 35 - *Explanations of vote*

Representatives may make brief statements consisting solely of explanation of their votes after the voting has been completed. The representatives of a member sponsoring a proposal or motion shall not speak in explanation of vote thereon, except if it has been amended, and the member has voted against the proposal or motion.

All explanations of vote must be submitted to the President in writing before debate on the topic is closed, except where the representative is of a member sponsoring the proposal, as described in the second clause, in which case the explanation of vote must be submitted to the President in writing immediately after voting on the topic ends. Only delegates who are sponsors of a draft resolution that has been adopted with an unfriendly amendment, whom subsequently voted against the draft resolution may explain their vote.

Rule 36 - *Conduct during voting*

After the President has announced the commencement of voting, no representatives shall interrupt the voting except on a point of order in connection with the actual process of voting.

For purposes of this rule, there shall be no communication among delegates, and if any delegate leaves the Board room during voting procedure, they will not be allowed back into the room until the Board has convened voting procedure. Should a delegate who is also serving as Head Delegate leave the room, they may reenter but they may not retake their seat and participate in the vote.

Rule 37 - *Division of proposals and amendments*

Immediately before a proposal or amendment comes to a vote, a representative may move that parts of a proposal or of an amendment should be voted on separately. If there are calls for multiple divisions, those shall be voted upon in an order to be set by the President where the most radical division will be voted upon first. If an objection is made to the motion for division, the request for division shall be voted upon, requiring the support of a majority of those present and voting to pass. Permission to speak on the motion for division shall be given only to two speakers in favor and two speakers against. If the motion for division is carried, those parts of the proposal or of the amendment which are approved shall then be put to a vote. If all operative parts of the proposal or of the amendment have been rejected, the proposal or amendment shall be considered to have been rejected as a whole.

> *For purposes of this rule, most radical division means the division that will remove the greatest substance from the draft resolution, but not necessarily the one that will remove the most words or clauses. The determination of which division is most radical is subject to the discretion of the Secretariat, and any such determination is final.*

Rule 38 - *Amendments*

An amendment is a proposal that does no more than add to, delete from, or revise part of another proposal. Permission to speak on the amendment shall be given only to two speakers in favor and two speakers against.

> *An amendment can add, amend, or delete entire operative clauses, but cannot in any manner add, amend, delete, or otherwise affect preambular clauses or sub-clauses of operative clauses. The President may limit the time to be allowed to speakers under this rule. These speeches are substantive in nature.*

Rule 39 - *Voting on amendments*

When an amendment is moved to a proposal, the amendment shall be voted on first. When two or more amendments are moved to a proposal, the amendment furthest removed in substance from the original proposal shall be voted on first and then the amendment next furthest removed there from, and so on until all the amendments have been put to the vote. Where, however, the adoption of one amendment necessarily implies the rejection of another amendment, the latter shall not be put to the vote. If one or more amendments are adopted, the amended proposal shall then be voted on.

> *For purposes of this rule, furthest removed in substance means the amendment that will have the most significant impact on the draft resolution. The determination of which amendment is furthest removed in substance is subject to the discretion of the Secretariat, and any such determination is final.*

Rule 40 - *Order of voting on proposals*

If two or more proposals, other than amendments, relate to the same question, they shall, unless the Board decides otherwise, be voted on in the order in which they were submitted.

Rule 41 - *The President shall not vote*

The President shall not vote but may designate another member of her/his delegation to vote in her/his place.

VII. CREDENTIALS

Rule 42 - *Credentials*

The credentials of representatives and the names of members of a delegation shall be submitted to the Secretary-General prior to the opening of a session.

Rule 43 - *Authority of the General Assembly*

The Board shall be bound by the actions of the General Assembly in all credentials matters and shall take no action regarding the credentials of any member.

VII. PARTICIPATION OF NON-MEMBERS OF THE COMMITTEE

Rule 44 - *Participation of non-Member States*

The Board shall invite any Member of the United Nations that is not a member of the Board and any other State, to participate in its deliberations on any matter of particular concern to that State.

A sub-board or sessional body of the Board shall invite any State that is not one of its own members to participate in its deliberations on any matter of particular concern to that State. A State thus invited shall not have the right to vote, but may submit proposals which may be put to the vote on request of any member of the body concerned.

> *If the Board considers that the presence of a Member invited, according to this rule, is no longer necessary, it may withdraw the invitation. Delegates invited to the Board according to this rule should also keep in mind their role and obligations in the Board that they were originally assigned to. For educational purposes of the NMUN Conference, the Secretariat may thus ask a delegate to return to his or her board when his or her presence in the Board is no longer required. Delegates may request the presence of a non-member of their board simply by informing the President that this is the desire of the body, there is no formal procedural process.*

Rule 45 - *Participation of national liberation movements*

The Board may invite any national liberation movement recognized by the General Assembly to participate, without the right to vote, in its deliberations on any matter of particular concern to that movement.

> *National liberation movements are only represented at NMUN in two ways: (1) if their delegation has been assigned explicitly the national liberation movement itself; or (b) should the Security Commission wish to hear from a representative of the movement in their deliberations, the Secretariat shall provide the appropriate representative.*

Rule 46 - *Participation of and consultation with specialized agencies*

In accordance with the agreements concluded between the United Nations and the specialized agencies, the specialized agencies shall be entitled: a) To be represented at meetings of the Board and its subsidiary organs; b) To participate, without the right to vote, through their representatives, in deliberations with respect to items of concern to them and to submit proposals regarding such items, which may be put to the vote at the request of any member of the Board or of the subsidiary organ concerned.

> *NMUN does not assign delegations to Specialized Agencies.*

Rule 47 - *Participation of non-governmental organization and intergovernmental organizations*

Representatives of non-governmental organizations/intergovernmental organizations accorded consultative observer status by the Economic and Social Council and other non-governmental organizations/intergovernmental organizations designated on an ad hoc or a continuing basis by the Board on the recommendation of the Bureau, may participate, with the procedural right to vote, but not the substantive right to vote, in the deliberations of the Board on questions within the scope of the activities of the organizations.

> *NMUN will assign delegations an NGO instead of a Member State upon request.*