Dear Delegates,

Welcome to the 2020 National Model United Nations New York Conference (NMUN•NY)! We are pleased to introduce you to our committee, the World Health Organization (WHO). This year’s staff is: Directors Aidan Killackey (Conference A) and Ben Wrigley (Conference B). Aidan works at a mid-sized law firm in Seattle, United States. Ben is studying for his master’s degree in economic policy at the University of Siegen.

The topics under discussion for the World Health Organization are:

1. Universal Health Coverage: Leaving No One Behind
2. Addressing Vaccine Hesitancy

WHO is an autonomous organization that directs and coordinates international healthcare issues within the United Nations (UN) system with the aim of attaining the highest possible level of health for all people. At NMUN•NY 2020, we are simulating the Executive Board of WHO as regards to its size and composition. However, the body may address all topics within the mandate of WHO. Delegates should work to promote multilateral negotiations, which are inclusive and consider health as a human right for all under the Universal Declaration of Human Rights. Proper simulation is key in WHO in order to successfully complete the agenda and create resolutions that are succinct and effective.

This Background Guide serves as an introduction to the topics for this committee. However, it is not intended to replace individual research. We encourage you to explore your Member State’s policies in depth and use the Annotated Bibliography and Bibliography to further your knowledge on these topics. In preparation for the Conference, each delegation will submit a Position Paper by 11:59 p.m. (Eastern) on 1 March 2020 in accordance with the guidelines in the Position Paper Guide and the NMUN•NY Position Papers website.

Two resources, available to download from the NMUN website, that serve as essential instruments in preparing for the Conference and as a reference during committee sessions are the:

1. NMUN Delegate Preparation Guide - explains each step in the delegate process, from pre-Conference research to the committee debate and resolution drafting processes. Please take note of the information on plagiarism, and the prohibition on pre-written working papers and resolutions. Delegates should not start discussion on the topics with other members of their committee until the first committee session.
2. NMUN Rules of Procedure - include the long and short form of the rules, as well as an explanatory narrative and example script of the flow of procedure.

In addition, please review the mandatory NMUN Conduct Expectations on the NMUN website. They include the Conference dress code and other expectations of all attendees. We want to emphasize that any instances of sexual harassment or discrimination based on race, gender, sexual orientation, national origin, religion, age, or disability will not be tolerated. If you have any questions concerning your preparation for the committee or the Conference itself, please contact the Under-Secretaries-General for the Human Rights and Humanitarian Affairs Department, Tobias Dietrich (Conference A) and Estefani Morales (Conference B), at usg.hr_ha@nmun.org.

We wish you all the best in your preparations and look forward to seeing you at the Conference!

Sincerely,

Conference A
Aidan Killackey, Director

Conference B
Ben Wrigley, Director
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United Nations System at NMUN-NY

This diagram illustrates the UN system simulated at NMUN-NY and demonstrates the reportage and relationships between entities. Examine the diagram alongside the Committee Overview to gain a clear picture of the committee’s position, purpose, and powers within the UN system.
Committee Overview

Introduction

The World Health Organization (WHO) is the directing and coordinating authority on international healthcare issues within the United Nations (UN) system, promoting the attainment of the highest possible level of health by all people.¹ WHO intervenes within six intersecting areas of work to assist its 194 Member States in the development of their respective health systems; the eradication of non-communicable diseases; the promotion of good lifelong health; the prevention, treatment, and care of communicable diseases; the preparedness, surveillance, and response with respect to international health emergencies; and the extension of corporate services to the organization’s public and private partners.²

After a complete breakdown of international health cooperation during the Second World War, an Interim Commission continued the activities of existing health institutions such as the Health Organisation of the League of Nations.³ During the San Francisco Conference in 1945, which set the foundation for the UN, various states proposed creating a new international health organization.⁴ In July 1946, 51 UN Member States and ten additional states signed the Constitution of the World Health Organization, which entered into force in April 1948.⁵ The Constitution outlines the guiding principle that health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.⁶ The World Health Assembly (WHA), the organization’s decision-making body comprised of all WHO Member States, convened in Geneva for the first time on 24 June 1948.⁷ Although WHO had largely remained a driving force for health research throughout its first decade, its operative programs gradually expanded in the following years.⁸ Its first global immunization campaign began when WHA adopted a resolution on a “Smallpox Eradication Programme,” which eventually succeeded in eliminating the disease in 1980.⁹ Another defining moment for WHO was the 1978 International Conference on Primary Health Care, which declared access to primary health care for all as the organization’s key strategic objective and linked health to social and economic development.¹⁰

Governance, Structure, and Membership

194 states, including all UN Member States except for the Cook Islands and Nieu, are members of WHO.¹¹ While its secretariat is located in Geneva, Switzerland, WHO maintains a worldwide presence, staffing six regional offices across the globe and operating a total of 150 country offices and decentralized

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² WHO, What We Do, 2019.
⁴ Ibid.
⁵ Ibid.
⁶ Ibid.
⁷ Ibid.
⁸ Ibid.
¹⁰ Ibid., pp. 303-304.
sub-offices.\textsuperscript{12} WHO’s constitution assigns its executive functions to its Executive Board, which comprises 34 experts in the field of health, each appointed for a three-year term by a WHO Member State elected by WHA with respect to population per region proportions.\textsuperscript{13} The board’s key policymaking functions include the drafting of multiannual programs of work as well as submitting draft resolutions to WHA for consideration.\textsuperscript{14} In formulating WHO policies, the Executive Board’s Programme, Budget and Administration Committee (PBAC) plays an important role, as it makes recommendations with regards to planning, monitoring, and evaluating WHO programs, and the organization’s financial and administrative management.\textsuperscript{15} The PBAC consists of 14 board members, with two members from each region elected by the Executive Board for a two-year period.\textsuperscript{16} Furthermore, the Executive Board endorses decisions and policies of WHA and coordinates response efforts to international health emergencies.\textsuperscript{17} The Executive Board meets at least twice a year, once in January and once in May after WHA’s annual convention.\textsuperscript{18} The Board also holds special sessions in the event of an international health emergency or issue of international importance, most recently in an effort to work on the draft \textit{Thirteenth General Programme of Work 2019–2023} (GPW13), which it later adopted.\textsuperscript{19}

In addition to the determination of WHO’s policies, the Assembly supervises the organization’s financial policies, adopts its budget, and appoints the Director-General on the nomination of the Executive Board.\textsuperscript{20} WHO’s Director-General acts as chief technical and administrative officer with the support of the secretariat’s administrative staff.\textsuperscript{21} The Director-General also serves as the \textit{ex officio} secretary of WHA, the Executive Board, as well as the organization’s commissions and committees, and is responsible for submitting WHO’s financial statements and budget estimates to the Executive Board.\textsuperscript{22} Dr. Adhanom Ghebreyesus is the current Director-General of WHO, succeeding Dr. Margaret Chan who had held the position during the previous ten years.\textsuperscript{23} Before the end of her term as WHO’s Director-General, Dr. Chan published a report titled \textit{Ten Years in Public Health 2007-2017}, which addresses the setbacks, achievements, and progress during her time in office.\textsuperscript{24} The current Director-General’s vision reinforces the importance of the Sustainable Development Goals (SDGs) in improving global health and well-being by focusing on health rights for all people and by giving health the central role in international agendas.\textsuperscript{25}

WHO’s biennial program budgets derive from its multiannual programs of work, and are funded through a combination of assessed and voluntary contributions.\textsuperscript{26} Assessed contributions are those coming from dues paid by Member States in order to keep their membership status.\textsuperscript{27} Voluntary contributions are made by state and non-state contributors, such as non-governmental organizations (NGOs), the private sector, philanthropic foundations, and academic institutions.\textsuperscript{28} Historically, assessed contributions have constituted most of WHO’s funding, but voluntary contributions have increased since 1990 and now

\begin{thebibliography}{99}
\bibitem{13} WHO, \textit{The Executive Board}, 2019.
\bibitem{15} WHO, \textit{Revised Terms of Reference for the Programme, Budget and Administration Committee of the Executive Board (EB131.R2)}, 2012, p. 3.
\bibitem{16} Ibid.
\bibitem{18} Ibid.
\bibitem{21} Ibid., p. 9.
\bibitem{22} Ibid., pp. 9-10.
\bibitem{23} WHO, \textit{Dr Tedros Takes Office as WHO Director-General}, 2017.
\bibitem{27} WHO, \textit{Assessed Contributions}, 2019.
\end{thebibliography}
represent the majority of WHO’s income. Under GPW13, planned spending over the 5 years from 2019–2023 is $1.2 billion greater than from 2014-2019.

In May 2011, the Executive Board launched a Member State led reform to transform WHO into a more effective and efficient, transparent, and accountable organization. The reform addressed three core areas – programs and priority setting, governance, and management – and tackles a wide range of issues relating to accountability, human resources, evaluation, and communication. The governance reform examined WHO’s governing bodies’ working methods, engagement practices with external stakeholders, and ultimately the organization’s governance role in the global community on issues related to health. In terms of the financial reform, the Programme Budget 2018-2019 replaced preapproved funding for crisis response with planning and budgeting at the time of emergency, and adjusted resource allocation for areas that attract less donor interest. WHO is currently drafting its 2020-2021 biennial budget to continue these reforms and to realize measurable improvements in universal health coverage (UHC), addressing health emergencies, and population health.

**Mandate, Functions, and Powers**

WHO’s constitution established the organization as a specialized agency of the UN in accordance with Article 57 of the *Charter of the United Nations* (1945). Notwithstanding its status as an autonomous organization within the UN system, WHO operates within the purview of the UN Economic and Social Council (ECOSOC). Accordingly, WHA reports to ECOSOC concerning any agreement between the organization and the UN. Furthermore, WHO’s Director-General is the official representative of international health efforts across a broader range of policy areas. As such, the Director-General is a key member of the UN System Chief Executive Board for Coordination, which comprises the 29 executive heads of the UN including its funds and programs, the specialized agencies, and subsidiary bodies.

Article 2 of WHO’s constitution mandates the organization to foster mental, maternal, and child health, and to provide information, counsel, and assistance in the field of health. The mandate defines WHO’s role in advancing the eradication of diseases, coordinating and directing international health programs and projects, as well as improving nutrition, sanitation, and other conditions. WHO is also responsible for advancing medical and health-related research; promoting scientific collaboration; improving standards of training in health, medical, and related professions; as well as developing international standards for food, biological, pharmaceutical, and similar products.

WHO carries out various projects, campaigns, and partnerships, addressing a wide range of health topics. Furthermore, WHO’s programs may operate on global, regional, and country levels simultaneously. WHO plays an important role in resolving crises of Member States, offering support at

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29 Ibid.
32 Ibid.
33 Ibid.
39 UN CEB, *Who We Are*, 2016.
40 Ibid.
41 Ibid., p. 2.
42 Ibid., p. 3.
levels of country offices, regional offices, and headquarters through the network for Emergency Risk Management and Humanitarian Response. WHO’s activities during outbreaks are also often complemented by the work of the Global Outbreak Alert and Response Network, a coalition of Member States’ scientific institutions, medical and surveillance initiatives, regional technical networks, the United Nations Children’s Fund (UNICEF), the Office of the United Nations High Commissioner for Refugees, the International Committee of the Red Cross, and other humanitarian NGOs.

WHO also assumes a norm- and standard-setting function to help states prevent the outbreaks of public health emergencies, most notably via promoting the implementation of the International Health Regulations (IHR), which were adopted by WHA resolution 58.3 “Revision of the International Health Regulations” on 23 May 2005. The need for strengthening states’ diseases surveillance capacities has become salient following a resurgence of several epidemic diseases in the 1990s such as cholera and plague. The IHR legally binds 196 states, including all WHO Member States, setting standards for the prevention and response to acute, cross-border public health risks.

The promotion of health-related research plays a central role in advancing global health and provides benefits across WHO’s work areas. Acknowledging this, WHA adopted the WHO Strategy on Research for Health (2012), which aims to enhance cooperation between WHO’s secretariat, Member States, health practitioners, and researchers to reinforce research on Member States’ priority health needs and strengthen national capacities for health research. Another key contribution by WHO is the systematic collection, analysis, and interpretation of health-related data via the organization’s Global Health Observatory Data Repository and its annual World Health Statistics Reports.

In order to promote international health, WHO partners with other UN bodies such as the Joint United Nations Programme on HIV/AIDS (UNAIDS), as well as external public entities, NGOs, and private sector actors. Most notably, WHO leads the Global Health Cluster (GHC), which comprises 48 partners, including UN bodies as well as public stakeholders and academic institutions. Aiming to minimize the health impacts of humanitarian emergencies, GHC partners collaborate to foster global capacities for emergency preparedness, response, and recovery from humanitarian health crises. WHO also sustains different approaches, initiatives, alliances, and global networks that target different areas of life-course issues such as health of women before, during, and after pregnancy; health of newborns, children, adolescents, and older people; and environmental risks to health.

Recent Sessions and Current Priorities

In 2018, WHA adopted GPW13, the organization’s first multiyear agenda to align itself with the 2030 Agenda for Sustainable Development (2030 Agenda) (2015), namely SDG 3 (good health and well-being). GPW13 emphasizes three interconnected goals to realize SDG 3: 1 billion more people

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49 WHO, Frequently Asked Questions About the International Health Regulations (2005), 2009.
54 WHO, Partnerships, 2019.
57 WHO, Partnerships, 2019.
benefitting from UHC, 1 billion more people protected from health emergencies, and 1 billion more people enjoying better health and well-being.\textsuperscript{59}

In March 2018, WHO co-hosted with the governments of Fiji, Mauritius, and Grenada the Third Global Conference on Climate and Health to accelerate health efforts in Small Island Developing States, who are especially vulnerable to climate change impacts.\textsuperscript{60} In 2017, the president of the UN Climate Change Conference (COP23) requested that WHO deliver a special report on climate change and health at COP24, which it did in December 2018.\textsuperscript{61} The report called for stronger action to mitigate the effects of climate change to protect human health.\textsuperscript{62}

The 144\textsuperscript{th} and 145\textsuperscript{th} sessions of the Executive Board, held in January and May 2019, respectively, included conversations on polio eradication, implementing the 2030 Agenda, and the involvement of non-state actors in WHO governance.\textsuperscript{63} During the 144\textsuperscript{th} session (EB144), the Director-General reported that WHO will extend its polio eradication efforts, which are currently organized under the Polio Eradication and Endgame Strategic Plan 2013–2018 (Endgame Plan), into at least 2023 due to difficulties in eradicating the virus by 2019.\textsuperscript{64} In a separate report to the Executive Board, the Director-General also summarized the progress on achieving the 30-plus health-related sustainable development targets.\textsuperscript{65} To achieve further progress, and in light of GPW13, the report noted that WHO needs to continue building Member State capacity; facilitating North-South, South-South, and triangular cooperation; and promote inter-agency cooperation within the UN.\textsuperscript{66} EB145 included a focus on ongoing governance reforms.\textsuperscript{67} WHO’s current manner of non-state participation in its governance is to allow NGOs to comment at the end of debates of the Executive Board and WHA.\textsuperscript{68} However, the dramatic increase in NGO participation in debate since the 2000s has made the current practice ineffective, and the Director-General invited the Executive Board to model the involvement of non-state actors in WHO after other UN bodies and intergovernmental organizations.\textsuperscript{69}

At the 72\textsuperscript{nd} session of the WHA (WHA72) in May 2019, the Assembly adopted various resolutions on UHC, patient safety, and the pricing of health care products.\textsuperscript{70} WHA72 also considered a report by the Director-General on implementing the 2030 Agenda.\textsuperscript{71} The report details WHO’s work on reproductive health, infectious diseases, and environmental health risks, amongst other topics, in regards to their respective sustainable development targets.\textsuperscript{72} WHA resolution 72.4 directed the Director-General to submit a technical report on UHC to the General Assembly to support the High-Level Meeting on Universal Health Coverage (HLM-UHC), held on 23 September 2019.\textsuperscript{73} WHA72 also made patient safety – limiting and remedying harm – a strategic priority for WHO through resolution 72.6, which called for

\textsuperscript{59} Ibid.
\textsuperscript{60} WHO, Third Global Conference on Health and Climate, 2019.
\textsuperscript{61} WHO, COP24 Special Report: Health & Climate Change, 2018, p. 2.
\textsuperscript{62} Ibid., p. 8.
\textsuperscript{63} WHO, Provisional Agenda (EB144/1 (Annotated)), 2018, p. 2; WHO, Provisional Agenda (EB145/1 (Annotated)), 2019, p. 1.
\textsuperscript{64} WHO, Report by the Director-General: Polio: Eradication (EB144/9), 2018, p. 1.
\textsuperscript{66} WHO, Report by the Director-General: Implementation of the 2030 Agenda for Sustainable Development (EB145/1 Rev.1), 2018, pp. 7-15.
\textsuperscript{67} WHO, Provisional Agenda (EB145/1 (Annotated)), 2019, p. 1.
\textsuperscript{68} WHO, Report by the Director-General: WHO Governance Reform Processes: Involvement of Non-State Actors (EB145/5), 2019, p. 2.
\textsuperscript{69} Ibid., pp. 3-4.
\textsuperscript{70} WHO, WHA72, 2019.
\textsuperscript{71} WHO, Report by the Director-General: Implementation of the 2030 Agenda for Sustainable Development (A72/11 Rev.1), 2019.
\textsuperscript{72} Ibid.
\textsuperscript{73} WHO, Preparation for the High-level Meeting of the United Nations General Assembly on Universal Health Coverage (WHA72.4), 2019.
empowering patients and their families, the use of new technologies to surveil risks, and the creation of a “safety culture” within medicine. To address financial harm or barriers to patients, WHA resolution 72.8 called on Member States to better track and share the net price of health products, such as vaccines and medicines, to reduce costs and thereby improve access.

During the last year, WHO has been at the frontline of addressing and providing aid in different areas to assist Member States affected by different disease outbreaks and other pressing international crises that have taken place all around the world. Diseases that had been nearly eradicated and could be preventable through vaccines, such as diphtheria and cholera, have made a comeback and threaten the lives of millions of people around the globe, especially those in vulnerable communities. Another serious challenge faced by the international community and WHO has been the resurgence of the Ebola virus disease (EVD) in the Democratic Republic of the Congo, where WHO has reported 3,091 cases of EVD during the first 9 months of 2019. WHO works closely with the UN peace operation in the country, the UN Organization Stabilization Mission in the Democratic Republic of the Congo. Malnutrition, natural hazards, and access to health in situations of conflict are other threats to global health that have predominated recently. As outbreaks and epidemics keep occurring all over the world, WHO continues working to keep the world safe from health threats, especially those who are most vulnerable.

Conclusion

WHO is the coordinating authority on international healthcare issues within the UN system. As the executive body responsible for the formulation and review of WHO’s policies, the Executive Board assumes a key responsibility in addressing current health priorities through the preparation of draft resolutions considered by WHA. The global state of health is ever-changing and increasingly complicated, requiring strategic, creative, and unique solutions that adapt to local conditions and situations. WHO continues to reform itself to adapt to changes in global governance and make better use of its financial and human resources so that it can address acute health crises and establish norms that promote human health more broadly. In light of persistent challenges across the priorities highlighted above, delegates are expected to develop effective solutions to address challenges to health, and to achieve the health objectives set forth by the SDGs.

Annotated Bibliography

This document published by WHO compiles the organization’s founding documents and accompanying legal provisions. It includes WHO’s constitution, provides information on its governing bodies’ rules and procedures, and specifies WHO’s agreements with other

75 WHO, Improving the Transparency of Markets for Medicines, Vaccines, and Other Health Products (WHA72.8), 2019.
76 Ibid.
80 WHO, Managing Epidemics: Key Facts About Major Deadly Diseases, 2018.
84 WHO, Provisional Agenda (EB144/1 (Annotated)), 2018, p. 2; WHO, Provisional Agenda (EB145/1 (Annotated)), 2019, p. 1.
85 WHO, WHO Director-General, 2019.
intergovernmental and NGOs. Furthermore, the document specifies the legal provisions on WHO's financial administration. The document provides delegates with an encompassing overview of WHO's legal framework and details on the formal mandate for the organization’s operations. While the 49th edition has not been published, WHO has provided some updates to Basic Documents on its website at: https://apps.who.int/gb/bd/.

This report offers a summary of WHO’s budget for the current biennial term, as well as how the funds and contributions will be allocated depending on health topics, categories, and regions of work. It provides an overview on the different areas where financial support has increased or decreased, and what areas of work/regions need the most help. This document will be helpful for delegates seeking to gain a broader understanding of WHO’s current priorities and allocation of its funds.

This section of WHO’s website provides delegates with access to comprehensive information on the organization’s history and structure, WHO’s main areas and fields of operation, as well as background information on its governing bodies and WHO’s cooperation with other organizations. The website represents a key resource for delegates to get a quick overview not only on WHO’s formal structures and history, but also on its role in the UN system and its work with Member States. While information provided on the website is mostly general, its sub-sections contain helpful links to more specific sources of information on the topics outlined above.

During its 72nd session, WHA approved GPW13. GPW13 emphasizes how the current WHO strategic priorities are linked to the SDGs, such as advancing UHC, addressing health emergencies, and promoting healthier populations. The program also outlines the role, that different levels of WHO’s operation – headquarters, regional offices, and country offices – and WHO’s partners, such as the World Bank, have in achieving the three strategic priorities. This source will serve as a great foundation for delegates in their research when it comes to understanding WHO’s importance and relevant areas of work concerning the topics discussed at the conference.

This website provides a list of the outcome documents and resolutions of the 72nd World Health Assembly (WHA72), which took place between 20 and 28 May 2019 in Geneva, Switzerland. This list includes resolutions, such as one on antimicrobial resistance, and reports, including one concerning the IHR. It further contains an action plan related to WHO’s current priorities, which will be relevant during the conference and useful for delegates throughout their research.

Bibliography


I. Universal Health Coverage: Leaving No One Behind

“And let us remember: just as peace is not simply the absence of conflict, so is health not just the lack of illness. Our goal is not only a band-aid or a single dose of medicine, important as those are. Our goal must be overall well-being, physically and mentally for everyone in all countries. Let us move ahead with ambitious action to ensure health systems that deliver for everyone, everywhere.”  

Introduction

The World Health Organization (WHO) defines health as, “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.” The goal of Universal Health Care (UHC), which is achieved when “all individuals and communities receive the health services they need without suffering financial hardship,” works in the service of health by ensuring that all people can realize the high standard of well-being envisioned by WHO. UHC’s tenants did not arise spontaneously, but rather grew out of another concept, primary health care (PHC), that remains an important step towards UHC. The WHO’s definition of health along with the concept of PHC form a basis upon which UHC has been built. PHC has experienced a shift in definition over the years since its introduction, first defined as universally accessible, essential health care services at an affordable cost and now emphasizing the necessity of treatment and prevention that occurs as early as possible. While PHC focuses on the development and delivery of services, UHC focuses on the equitable access to services. In that sense, PHC operates as a ground-level element ensuring that when communities need access to health care, the services they need are available. Further, WHO does not define UHC as free or exhaustive health care, recognizing that entirely free health services are often unsustainable. No Member State has, to this point, successfully achieved the goal of UHC.

The importance of UHC is enshrined in one of the current guiding tenants of the United Nations (UN), Sustainable Development Goal (SDG) 3 (good health and well-being), and specifically target 3.8. UHC is vital to the full achievement of SDG 3 because it provides the means through which advances in prevention and treatment reach all people. Moreover, to get an adequate understanding of progress towards UHC’s twin goals, appropriate health services and the financial capacity sufficient to ensure the receipt of services, Member States and the UN system alike must ensure that data is properly collected and assessed. In doing so, Member States may make more informed decisions about their health care systems and ensure that no one is left behind.

87 UN Secretary-General, Remarks at the Universal Health Coverage Forum, 2017.
94 Ibid., p. 21.
98 Global Conference of Primary Health Care, Declaration of Astana, 2018, p. 5.
100 UN General Assembly, Transforming Our World: The 2030 Agenda for Sustainable Development (A/RES/70/1), 2015, p. 12.
Currently, UHC’s implementation is severely restricted by the unequal access to resources across Member States.101 Many low-income countries lack appropriate medical personnel: 90% of low-income states have fewer than ten doctors per ten thousand people.102 While in many cases, determinants of health have improved since the start of the century, they are far from achieved.103 UHC represents the future of health coverage for all Member States and improving their health capacity will help to ensure that the well-being envisioned by SDG 3 becomes a reality for all people.104 However, achievement of UHC is barred by a number of factors, including the availability of data on health care systems and the ability of Member States to develop strong financial backing for their health care systems.105 This guide will examine one of the main problems with assessing the implementation of UHC, the lack of reliable data indicators to track progress, followed by the steps Member States may take to increase their health care systems’ financial capacities.106

**International and Regional Framework**

The 1948 *Universal Declaration of Human Rights* (UDHR) and the 1966 *International Covenant on Economic, Social and Cultural Rights* (ICESCR) are among the first documents which presented UHC as a goal of the international community.107 Article 25 of the UDHR specifically enshrines the right of “adequate […] medical care” to ensure a proper standard of living, while Article 12 of the ICESCR states that its States parties recognize the right to the highest attainable standard of health.108 While the *Constitution of the World Health Organization*, adopted in 1946, includes no specific mention of UHC, the repeated emphasis on the “highest attainable standard of health” for all peoples shows a commitment to the goal of UHC from the foundation of WHO.109 Prior to UHC becoming an explicit goal of the UN, the international community recognized the importance of establishing solid outcomes for health through documents such as the 1978 *Alma-Ata Declaration* and the 1986 *Ottawa Charter for Health Promotion*.110 The *Alma-Ata Declaration* was the first WHO document to outline the importance of PHC as a goal for Member States, setting the stage for the eventual turn to UHC.111 The Ottawa Charter commits states to the additional goal of health promotion, which recognizes that individuals have more control over their health when living in a state of peace, financial and physical security.112

The *2030 Agenda for Sustainable Development* (2015) brought the goal of UHC to the fore in both WHO and the broader UN system through SDG 3 (good health and well-being).113 Concurrently with the SDGs, the 2015 *Addis Ababa Action Agenda* took specific note of UHC, citing the importance of development partnerships and WHO leadership in addressing health care inadequacies across Member States.114 The Action Agenda is a document dedicated to the financing of development efforts across all Member States, setting the stage for the SDGs to be adopted in the 70th session of the General Assembly.115 The Action

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102 Ibid., p. 56.
103 Ibid., p. 69.
115 Ibid., pp. 1-2.
Agenda recognizes the central role that WHO plays in achieving UHC, including the necessity of strengthening national health systems, along with tracking health risks, increasing health care workers, and mobilizing financial and human resources.116

In 2018, worldwide stakeholders convened in Astana, Kazakhstan to update the original commitment to PHC made in 1978 at the Alma-Ata Conference to include the tenants of UHC.117 Taking place on the 40th anniversary of Alma-Ata, the Astana Conference led to a document of recommittal to the goals of PHC, as well as recognizing the need for building capacity through financing Member States’ health care systems and empowering communities: the Declaration of Astana.118 This Declaration outlines the envisioned future for health care, with specific emphasis towards adopting multilateral and diverse solutions to strengthening health care, as well as recognizing the importance of traditional remedies, civil society involvement, gender-sensitivity, and other considerations.119

Role of the International System

In 2017, the General Assembly underscored the importance of UHC, by adopting resolution 72/139 on “Global Health and Foreign Policy: Addressing the Health of the Most Vulnerable for an Inclusive Society”, which highlights the importance of a significant number of UHC goals, including prevention, financing, global partnerships and sets the stage for the 2019 High-Level Meeting (HLM) on UHC (HLM-UHC).120 The HLM-UHC, which took place on 23 September 2019, is the latest step in the General Assembly’s work supporting UHC.121 HLM-UHC’s theme, “Universal Health Coverage: Moving Together to Build a Healthier World,” was adopted in resolution 73/131 (2018) on “Scope, modalities, format and organization of the high-level meeting on universal health coverage” and embodies the General Assembly’s and WHO’s joint commitment to securing political and financial commitments from Member States towards the advancement of UHC.122 Within the UN system, there are several other organizations strongly committed to UHC, including the United Nations Development Programme (UNDP) and the World Bank.123 UNDP recognizes that UHC is a key to realizing the development necessary to fully attain the SDGs.124 As an investment that will save significant financial and human capital in the long run, UHC represents an opportunity to recoup lost economic potential, thus furthering the goal of UNDP to eradicate poverty and reduce inequalities.125 A further stakeholder in UHC is the World Bank, which co-sponsors multiple health partnerships with WHO, especially in terms of financing.126 In 2019, the World Bank released its most recent document on UHC, High-Performance Health Financing for Universal Health Coverage, which focuses on the financing weaknesses of health care systems across Member States and provides a roadmap for success to strengthen the capacity of those systems.127 In this report, the World Bank cites efforts such as, an approach to financing that involves multiple areas of government, taxing health-damaging products and reassessing the allocation of funds towards health services.128 As a whole, the UN system strongly supports WHO’s efforts in the achievement of UHC, delivering significant

116 Ibid., pp. 22-23.
117 Global Conference of Primary Health Care, Declaration of Astana, 2018.
118 Ibid.
119 Ibid.
121 World Health Organization, UN High-Level Meeting on Universal Health Coverage, 2019.
122 Ibid.
125 Ibid.
126 Primary Health Care Partnership Initiative, About PHCPI, 2018; World Bank, High-Performance Health Financing for Universal Health Coverage, 2019.
128 Ibid., pp. 43, 46.
support, both in terms of providing service and enhancing the financial capacity of health care systems across Member States.\(^{129}\)

Moreover, the decision-making body of WHO, the World Health Assembly (WHA), has released a number of resolutions directly addressing the goals of PHC.\(^{130}\) Utilizing the definition of PHC outlined in the Alma-Ata Declaration, WHA resolution 62.12 (2009) on “Primary Health Care, Including Health System Strengthening” urged Member States to build PHC local and regional systems through locally trained health workers, as well as monitoring systems to gather data.\(^{131}\) WHA also recognized the necessity of transitioning to a system of universal coverage prior to its enshrinement in the SDGs.\(^{132}\) WHA resolution 58.33 on “Sustainable Health Financing, Universal Coverage and Social Health Insurance”, adopted in 2005, urges Member States to begin planning the transition away from solely PHC, in favor of universal coverage that would better meet the needs of all populations.\(^{133}\)

WHO is the driving force behind the achievement of UHC, implementing the 2030 Agenda and using its resources to track UHC’s achievement.\(^{134}\) With partnerships from a variety of regional and non-governmental organizations (NGOs), WHO is able to provide Member States with various resources to help develop health care capacities, such as country specific reports, plans for health systems development, and data measurement.\(^{135}\) One such organization is UHC2030, an NGO that works with WHO to achieve UHC.\(^{136}\) UHC2030 is a services platform working to increase collaboration between Member States across the global community with a specific focus on political commitment to UHC and knowledge sharing.\(^{137}\) In 2017, UHC2030 released its guideline paper towards UHC, titled *Healthy Systems for Universal Health Coverage - A Joint Vision for Healthy Lives*.\(^{138}\) This report speaks to the importance of strengthening health systems through service delivery, health systems financing, and health-minded governance so that the goals of UHC may be achieved in an equitable manner for all people.\(^{139}\) Both WHO and the World Bank have seats on the UHC2030 Steering Committee.\(^{140}\) The Primary Health Care Partnership Initiative (PHCPI), founded in 2015, which includes the Bill & Melinda Gates Foundation, WHO, and the World Bank as shareholders, focuses specifically on strengthening the capacity of primary health care systems to achieve UHC through collection of health care data, improvement of PHC systems and service delivery, and engagement with the global community.\(^{141}\) These NGOs are coordinated through the joint efforts of WHO and the World Bank and represent specifically focused efforts at achieving the determinants of UHC, receiving quality financial services and sustainable financing.\(^{142}\) As a founding stakeholder in PHCPI, WHO has continued to be a leader of the partnership, working to bring Member States and other groups together to strengthen PHC.\(^{143}\)


\(^{137}\) Ibid.


\(^{139}\) Ibid., p. 7.


Regionally, a number of groups work towards the achievement of UHC.\textsuperscript{144} The Alliance for Health Policy and Systems Research (HPSR) works specifically in low- and middle-income Member States to research better health outcomes and surrounding health systems.\textsuperscript{145} HPSR focuses on researching how societies work to achieve health goals in order to help Member States achieve more resilient health care systems.\textsuperscript{146} The Alliance also recognizes the importance of UHC and incorporates it within their mission as a tool to build Member States’ resilience against external or unanticipated shocks that threaten the security of their health systems.\textsuperscript{147} Additionally, UHC2030 has a country-level policy resource for Member States based in Western Europe, the European Union-Luxembourg-WHO Partnership for UHC, which brings together a number of countries with the European Union to cooperate in the achievement of UHC.\textsuperscript{148}

**Increasing Availability and Reliability of Health Care Data**

The use of data to understand how health care is implemented on the ground level in Member States is vital to the full and nuanced achievement of UHC.\textsuperscript{149} For example, the use of gender and income disaggregated data can point to specific challenges in the health of underserved portions of the population, providing Member States with the ability to target specific weaknesses in their systems.\textsuperscript{150} There is significant room for improvement on this front, as up to half the indicators are missing underlying data in many Member States, making the actual ability of WHO, Member States, and other stakeholders to determine progress towards UHC much more difficult.\textsuperscript{151} Moreover, those Member States with less available or reliable data also tend to be those with the least resources and the greatest need for improvement in their health care systems.\textsuperscript{152} As with many UN initiatives, the ability to accurately assess the efficacy in achieving UHC is heavily dependent on gathering, assessing, and synthesizing data, both during and following the implementation of actions.\textsuperscript{153} Following the introduction of the SDGs in 2015, data reporting became a main focus of the international community in order to promote accountability toward achieving goals, including UHC.\textsuperscript{154}

Directly linked to the definition of UHC outlined by WHO, data aggregation efforts such as the 2017 *Global Monitoring Report* generally separate available data according to the essential elements of UHC, health coverage and health financing.\textsuperscript{155} The *World Health Statistics Report 2019* articulates one problem with the reliability of health care data: Member States use outdated or unrelated data to develop “comparable estimates” about health care, which are modeled from comparisons between countries rather than direct measure of health statistics.\textsuperscript{156} For example, on average Hepatitis B prevalence data is five years out of date before it can be used to make an assessment of Hepatitis B rates in a Member State.\textsuperscript{157} Additionally, current health care data uses indirect measures to assess underlying services, such as the outcome of a given service to measure the effectiveness of that service, which is less reliable than direct measures.\textsuperscript{158} The combined prevalence of comparable estimates and indirect measures articulate clearly that data remains a significant gap in understanding health services, which impedes the full achievement of UHC.\textsuperscript{159}
Finally, Member States must prioritize data in terms of its ability to improve health care outcomes; data must be synthesized to identify gaps in service coverage and efficiently allocate resources to reduce inequalities in health care outcomes. Improving data by increasing its volume, relevance, and reliability, as well as the ability to use it to make appropriate judgments about how to improve health care systems would create a direct path to UHC’s full achievement. Member States must recognize their own financial and systemic limits and operate in conjunction with WHO and NGOs in order to improve those data shortcomings where limited resources prevent data collection from becoming a priority.

**Strengthening the Financial Capacity of Health Care Systems**

To achieve the holistic healthcare solutions that SDG 3 calls for, it is necessary to focus on building strong systems that can appropriately finance the care UHC envisions, instead of solely focusing on the number of treatments available or the eradication of particular diseases. To help establish a strong UHC system, Member States must recognize the importance of building their financial capacity, as the financial capacity of systems determines if Member States can develop services and if people can afford to use them. To this end, WHO has recently refocused on sustainable development indicator 3.8.2, which concerns the percentage of health care costs borne by households, by releasing documents such as *The World Health Report: Health Systems Financing: The Path to Universal Coverage*, which speaks to the ability to finance health care in terms of the proportion of household spending required to attain services.

WHO identifies catastrophic spending, defined as out-of-pocket health care expenses comprising at least 10% of household spending, as a significant barrier to households’ financial security. One of UHC’s goals is to reduce these levels of catastrophic spending, not to entirely eliminate private spending on health care services or require that all health care be provided for free; rather that households can seek and receive health care without being forced into poverty. In recent years, the international community has experienced an overall decline in out-of-pocket spending, instead favoring public health spending and deemphasizing payments made at the point-of-service.

Since the financial crisis of the mid-2000s, worldwide economic recovery has led to increased spending on health care. However, the unequal distribution of spending has exacerbated inequality, with high-income countries spending up to 80% of the worldwide total, despite faster economic growth in low and middle-income Member States. While this increase is positive, many Member States do not place priority on public health spending, leaving political and economic space for Member States to increase public spending on health care systems. This inequity shows that health care is still regarded as a luxury item for government expenditure, rather than a priority item to guarantee the health of populations. This mentality is exacerbated by external aid, which has a tendency to crowd out public spending and deemphasize the necessity of government building capacity internally. Currently, the only

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clear trend is that higher income positively correlates with higher spending on health. Understanding how and why Member States invest in health care at particular rates is a key to unlocking the full potential of all health care systems.

Health care systems fail the most vulnerable people when they require direct payments made at points of service. Direct payments (that is, payments made at the time health services are received) disproportionately disadvantage households living near the poverty line, as they may be forced to choose between health and other necessities such as food, or be driven below the poverty line. Direct payments are the principal form of spending on health care throughout the world for various reasons, including political unwillingness for public spending, lack of government resources, or corruption. For example, in areas that receive little financial support from governments, such as rural areas or war zones, communities are forced to rely on direct payments since they have no alternatives. Moreover, a further reduction in direct payments must be associated with an increase in financial and structural resources that ensure comparable support for staff, equipment, medicine, and care.

To guide Member States on financing issues, the UN system has adopted a number of resolutions designed to help with the implementation of UHC financing goals. General Assembly resolution 67/81 on “Global Health and Foreign Policy”, adopted in 2012, encourages Member States to mainstream inclusive financing policies, sensitive to cultural and economic factors unique to each. Bolstered by WHA resolution 58.33 (2005) on “Sustainable Health Financing, Universal Coverage and Social Health Insurance”, which also identifies the need for culturally sensitive reforms, it is clear that the effective implementation of UHC requires transitions from direct payments towards public spending. Financial reforms can be achieved through partnerships with international organizations, including WHO, over direct financing, technical sharing, and cooperation programs, coupled with a mainstreamed national focus on health care outcomes.

**Conclusion**

Since the establishment of the SDGs in 2015, UHC has advanced from an idea less important than PHC and capacity building to one of the defining goals of WHO. To help achieve this goal, WHO has identified two necessary components of UHC: effective service coverage for all individuals and the financial security to pursue those resources without the fear of falling into deep debt or poverty. As such, health care reforms must emphasize the most vulnerable populations, especially those in low-income countries, in order to reduce service inequities and achieve target 3.8 of the SDGs.

Additionally, tracking successful programs and allocating resources efficiently requires that WHO and Member States have access to current, reliable, and complete data. Lack of data is especially prevalent in low-income areas and the low availability of data in those areas means that the vulnerable populations who live there have access to less services, often of lower quality. Moreover, the World

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174 Ibid., p. 17.
175 Ibid., p. 23.
177 Ibid., p. 64.
178 Ibid., p. 65.
179 Ibid., p. 65.
180 Ibid., pp. 68-69.
182 Ibid., p. 5.
189 Ibid.
Health Statistics 2019: Monitoring Health for the SDGs report identifies that many Member States lack the underlying data indicators necessary for accurate health care reporting, especially in terms of important demographics such as sex and economic status.\textsuperscript{190} UDHR and SDGs require that affordable, effective health care be provided to all people.\textsuperscript{191} Nowadays, UHC is continually coming closer to fruition, yet many Member States lag behind and none have fully implemented it.\textsuperscript{192} However and despite the clear struggles to full achievement of UHC, positive trends such as the rapidly increasing pace of public health spending and access to services bode well for UHC.\textsuperscript{193} WHO strong commitment to UHC attainment is clear, its partnerships with NGOs and the outcomes from the HLM-UHC represent the desire to bring Member States as stakeholders for the full achievement of SDG 3.\textsuperscript{194}

Further Research

When researching the topic and preparing for the conference, delegates may consider questions such as: How can national systems strengthen their capacity in order to achieve the goals of UHC by 2030? What data indicators lack the sophistication or quantity to be informative for Member States, and how can this data be improved? What is the future of health care systems financing? What is the role of regional-specific partnerships in financing and capacity building? How can WHO partner with NGOs, intergovernmental organizations, and other UN organs to assist Member States in developing a plan for reaching UHC?

Annotated Bibliography


The Declaration of Astana builds upon the 1978 Alma-Ata Declaration and the 2030 Agenda for Sustainable Development to provide a consensus declaration that outlines a future for providing PHC to underserved populations. The Declaration reaffirms healthcare as a human right and establishes a commitment to primary health care by all stakeholders, as well as outlining the necessary drivers for PHC: capacity building, human resources, technology, and financing. The Declaration closes with a reiteration of the importance of achieving UHC. Delegates will find this source useful in understanding the current focus of WHO on UHC.


This report focuses primarily on the financial aspects of achieving universal health coverage, providing specific recommendations for Member States to modify existing health systems to achieve UHC. Among these modifications are: increasing health care funding, eliminating point-of-service payments, and improving efficiency and equity. The report includes specific recommendations to achieve each of these three goals, such as changes in taxation, risk-pooling, international donations, and adapting systems to address specific and unique concerns. Member States, both rich and poor, have improved their health care financing. Delegates will find this source useful in contextualizing UHC’s achievement in relation to other SDG 3 targets and understanding the gaps in health care across Member States.

\textsuperscript{190}Ibid.

\textsuperscript{191} UN General Assembly, Universal Declaration of Human Rights (A/RES/217 A (III)), 1948; UN General Assembly, Transforming Our World: The 2030 Agenda for Sustainable Development (A/RES/70/1), 2015, p. 16.

\textsuperscript{192} WHO, World Health Statistics 2019: Monitoring Health for the SDGs, 2019, p. 69.

\textsuperscript{193} WHO, Public Spending on Health: A Closer Look at Global Trends, 2018, p. 5.

\textsuperscript{194} WHO, UN High-Level Meeting on Universal Health Coverage, 2019.

Compiled in 2017 by WHO and a number of auxiliary contributors, this report assesses healthcare outcomes in relation to SDG 3 and its target 3.8, achieving UHC. The report is divided into two parts: coverage of essential health services and financial protection. In its first part, the report utilizes indicators from data reported to WHO to assess health outcomes from service. In the second part, it uses various consumption measures in relation to standard poverty indices. As in the first part, a key stumbling block for measurement is the lack of data, specifically as it relates to disaggregated data that focuses on specific groups to complement national regional statistics. Delegates should recognize this source as a comprehensive overview of UHC progress and may utilize it to recognize global trends in UHC.


This report is specifically geared towards the overall levels of health spending across the world, linking it with health outcomes. It analyzes new data measures in PHC and specific disease intervention, providing insight into health care spending. The report includes a number of key findings, but most relevantly a global trend towards increased health care funding, outstripping global gross domestic product increases, albeit with significant inequities and no clear overall plan to achieve UHC. Delegates may use the information in this paper to understand Member States’ current financing trends and what is necessary moving forward in order to achieve UHC.


As a comprehensive overview of the progress towards SDG 3, this yearly report provides data and conclusions regarding the current state of health services across the world. The report specifically discusses the existing and expected shortfalls in health care workers, as well as cost and availability of medicine. The report also links target 3.8 with other SDGs. In its overall conclusions, it cites increased access to health services through greater capacity in national health systems as a significant area of growth. Delegates may rely on this source to understand what data is currently collected by the UN in health care and where that data is lacking and needs improvement.

Bibliography


II. Addressing Vaccine Hesitancy

Introduction

Vaccines are defined as “a biological preparation that improves immunity to a particular disease.”195 They are one of the most potent and cost-effective health interventions, and prevent 2 to 3 million deaths per year.196 The World Health Organization (WHO) has been heavily involved in promoting immunization throughout its history; one of the first interventions was the successful campaign to eradicate smallpox from 1966 to 1980.197 WHO has recently directed immunization promotion efforts through strategic frameworks, the first of which was the 2006 Global Immunization Vision and Strategy (GIVS).198 The successor framework, the Global Vaccine Action Plan (GVAP), contains a commitment to 90% national vaccination coverage by 2020.199

In order for outbreaks of communicable diseases to be prevented, it is necessary to maintain herd immunity.200 Herd immunity refers to when a sufficiently large proportion of the population is vaccinated.201 The precise percentage depends upon the infectiousness of the disease.202 Once attained, herd immunity protects unvaccinated individuals, which is especially important for those who are unable to be vaccinated for medical reasons.203 Vaccine hesitancy has resulted in the loss of herd immunity to various diseases within regions with sufficient access to vaccines.204 WHO’s Strategic Advisory Group of Experts (SAGE) on Vaccine Hesitancy defines vaccine hesitancy as: “delay in acceptance or refusal of vaccines despite availability of vaccination services.”205

In developed states, most vaccine-preventable diseases, such as measles and diphtheria, are thought to have been eradicated through vaccination.206 However, vaccine hesitancy is starting to reverse these gains.207 Throughout 2018, outbreaks of measles were reported across the world.208 WHO estimated a 300% increase in infections of measles compared with the previous year.209 These outbreaks occurred in countries in which access to the measles vaccine was widely available, including the United States and Ukraine.210 In 2000, measles had been eliminated from the United States, whereas 2019 saw the largest outbreak of measles since 1994 with over 1,000 people becoming infected.211 This reemergence of measles was attributed to vaccine hesitancy.212 The growing tendency within certain Member States towards vaccine hesitancy has lowered the proportion of the population that was vaccinated to be below the level required for herd immunity.213 This has made their populations vulnerable to outbreaks of infectious diseases.214

195 WHO, Vaccines.
196 WHO, Immunization Coverage.
197 WHO, Smallpox.
201 Ibid.
202 Ibid.
203 Ibid.
205 Ibid., p. 7.
207 France24, Fight Vaccine Hesitancy as ‘Contagious Disease’, UN Meeting Told, 2019.
208 Ibid.
209 Ibid.
212 Ibid.
One attempt to measure the scale of vaccine hesitancy across the world was within the Wellcome Global monitor survey which was carried out in 2018 among 140,000 people across 140 countries. The survey used the SAGE’s definition of vaccine hesitancy to measure global attitudes toward vaccination and the results have shown that there are wide disparities in peoples’ trust of vaccines between regions. While the majority of unvaccinated people reside in conflict stricken areas, levels of trust in vaccination are lowest in developed countries, particularly those in Eastern Europe. In some states, the levels of trust in vaccinations are as low as 50% because of decreasing trust in institutions and misplaced fears about vaccine safety. These low levels of trust have resulted in many people choosing not to have themselves or their children vaccinated.

Vaccinations prevent infectious diseases and also benefit education and economic development. According to WHO, if levels of vaccine hesitancy continue to grow, then the international community’s efforts to overcome more traditional barriers to vaccines, such as cost or distribution, will be compromised. WHO recognized the severity of this issue when it named vaccine hesitancy as one of the ten threats to global health in 2019. Universal vaccination could save as many as 8.7 million lives by 2020 and is a necessary prerequisite to accomplish the vision set out within the 2030 Sustainable Development Agenda. Two of the most effective interventions to address vaccine hesitancy are to work to counter misinformation which causes doubt as to whether vaccines are safe and effective, and to work closely with those healthcare professionals administering vaccinations so as to develop methods to reassure those who otherwise may be reluctant to receive vaccinations. This guide will focus on tackling vaccine hesitancy through countering vaccine misinformation and program interventions. Afterwards, there will be a case study examining the recent outbreak of measles. To this end, foundational international and regional frameworks together with the most important actors for countering vaccine hesitancy will be presented.

International and Regional Framework

The right to health has been expressed throughout numerous documents since the UN establishment, including the Universal Declaration of Human Rights (UDHR) adopted in 1948 by the General Assembly. This declaration defines fundamental human rights to be enjoyed by all, regardless of one’s personal background. Article 25 of the UDHR explicitly states that well-being and access to medical care are fundamental human rights. Member States committed towards realizing this right within the International Covenant on Economic, Social, and Cultural Rights (ICESCR), which was ratified by 169 Member States in total and came into force in 1976. Article 12 not only reiterates the importance of good health and well-being, but also explicitly states that the prevention, treatment, and control of infectious diseases are necessary to achieve good health.

References:

216 Ibid., pp. 6-7.
217 Ibid.
218 Ibid.
219 Ibid.
220 WHO. Immunization.
222 Ibid.
223 Bill and Melinda Gates Foundation, Bill and Melinda Gates Pledge $10 Billion in Call for Decade of Vaccines, 2010.
225 OCHR, Right to Health: Factsheet no 31.
226 UN General Assembly, Universal Declaration of Human Rights (A/RES/217 A (III)), 1948, art. 25.
227 Ibid.
229 Ibid.
WHO’s constitution, signed in 1946, states WHO’s objective to be “the attainment by all peoples of the highest possible level of health,”230 It furthermore establishes that this objective is to be accomplished through different health-related measures, including the eradication of infectious diseases.231 WHO’s responsibilities include ensuring that the general public is adequately informed on health matters, and developing international standards with regard to health products.232 The WHO’s constitution was the first UN document to establish the right to health on a legal basis.233

Vaccination was included as an integral part of the Millennium Development Goals (MDGs).234 The percentage of one-year old children immunized against measles was an indicator for MDG4: Reduce Child Mortality. Vaccination also featured prominently within MDG 6: Combat HIV/AIDS, malaria and other diseases.235 The importance of health was expanded further within the Sustainable Development Goals (SDGs) as outlined within the 2030 Agenda.236 In SDG 3 (Good Health and Well-being), target 3.B. explicitly states support for the research and development of vaccines and promotes the provision of universal access to vaccinations.237 Indicator 3.B. establishes that the “proportion of the population with access to affordable medicines and vaccines on a sustainable basis” be provided.238 However, progress towards this goal has been insufficient.239 The percentage of children receiving a vaccine preventing diphtheria, tetanus, and pertussis remained unchanged between 2015 and 2017.240

Role of the International System

WHO established the SAGE on Immunization in 1999 to monitor and advise the WHO’s progress toward disease control goals, such as those contained within the GVAP, and the provision of universal access to vaccines.241 This group, in turn, created a working group to examine the drivers of vaccine hesitancy, the findings of which were released in a 2014 report titled Strategies for addressing Vaccine Hesitancy – A Systemic Review.242 As mentioned earlier, the report introduced the definition of vaccine hesitancy which is now widely utilized across the UN, and the report concluded by placing the drivers of vaccine hesitancy into three categories.243 These categories are confidence, complacency, and convenience.244 Confidence refers to the belief that vaccines are ineffective or even harmful.245 Complacency refers to people being unfamiliar with the devastating effects of the diseases against which vaccinations protect.246 As a result of this, populations become complacent about vaccination.247 Convenience describes occasions in which

231 Ibid.
233 Ibid.
234 WHO, Millennium Development Goals (MDGs), 2018.
236 UN General Assembly, Transforming Our world: the 2030 Agenda for Sustainable Development (A/RES/70/1), 2015.
238 UN General Assembly, Transforming Our world: the 2030 Agenda for Sustainable Development (A/RES/70/1), 2015, pp. 16-17.
239 UN General Assembly, Transforming Our world: the 2030 Agenda for Sustainable Development (A/RES/70/1), 2015.
243 Ibid., p. 7.
244 Ibid., pp.11-12.
245 Ibid.
246 Ibid.
247 Ibid.
people would not be vaccinated due to some kind of barrier, such as a lack of mobility or long waiting times.248

Moreover, WHO has worked to promote vaccination through the creation of the GIVS framework with the United Nations Children's Fund (UNICEF) in 2006.249 The GIVS framework guided progress toward several immunization-related goals, including 90% vaccination coverage across countries, a 90% decrease in measles mortality, and a decrease in Child Mortality caused by vaccine-preventable diseases by two-thirds, compared with 2000.250 In order to realize this vision and to build upon the GIVS, the World Health Assembly established the GVAP in 2011.251 The GVAP contains six strategic objectives to be accomplished by 2020.252 These objectives entail a strong commitment to immunization from states, civil society and communities, strengthening health systems and immunization programs, and ensuring that the benefits of immunization reach everyone, including traditionally underserved communities.253 The second strategic objective explicitly mentions that the general public must be better informed as to the benefits of vaccines so that they view it as an inalienable human right integral to their health.254

Regional bodies have also worked to promote vaccination and to counter growing hesitancy.255 At the 28th African Union Summit in 2016, African Union Member States acknowledged that vaccination underpins wider advances in sustainable development.256 They pledged to overcome barriers for the poorest in society to access vaccines and also to build coalitions between civil society, community leaders, and political representatives to ensure support for universal access to vaccines.257 The European Union (EU) parliament, amidst measles outbreaks and growing mistrust in the safety of vaccines, adopted a resolution on 18 April 2018 titled *Vaccine hesitancy and drop in vaccination rates in Europe.*258 It contained measures to alleviate public concerns about the testing of vaccines, such as countering misinformation spreading through unreliable news sources, and reaffirms the necessity of engaging with civil society and national and regional governments to counteract these concerns.259

NGOs also play an important role in encouraging vaccination.260 During the 2010 World Economic Forum, the Bill and Melinda Gates Foundation called for the 2011-2020 period to be the decade of vaccines, and pledged $10 billion toward accomplishing universal vaccine coverage by 2020.261 The Vaccine Alliance (Gavi) supports countries with lower rates of vaccination through increased funding and coordination efforts.262 One of its priorities has been to help increase the demand for vaccination in places where it is relatively low.263 This is accomplished in part through the overcoming of social, gender, and cultural barriers.264 Another prominent NGO is The Vaccine Confidence Project, which closely monitors public

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250 Ibid.
253 Ibid., pp. 30-31.
254 Ibid., pp. 38-42.
256 Ibid.
257 Ibid.
258 Ibid.
263 Ibid.
264 Ibid.
sentiment about vaccines to ensure that falsehoods about vaccines that begin to spread can be detected and counteracted as fast as possible.

**Countering vaccine misinformation**

**Community outreach**

Community outreach is a priority for WHO. Engagement with communities can allow for the promotion of vaccination to disseminate throughout society, and to reach parts of society which are unable or reluctant to participate in national vaccination programs. To do this effectively, WHO adapts its communication strategies to different cultures and beliefs while being careful to ensure that it remains a two-way conversation. WHO utilizes data collected about the community and its concerns to better inform them through different forms of media, ranging from more traditional ones such as the radio, to online sources. UNICEF is one of the UN bodies most active in the promotion of vaccination. In 2007, UNICEF recognized the state of Georgia in the Caucasus as having one of the lowest rates of vaccination due to vaccine hesitancy. UNICEF worked with the Georgian government to launch a campaign informing parents about vaccines and their potential to save lives. The campaign had “Timely immunization is your child’s bodyguard,” as its main slogan. In response to the recent outbreaks of measles, UNICEF has also launched a publicity campaign in schools and clinics based within the region of Lviv in Ukraine, one of the regions most afflicted by measles due to vaccine hesitancy.

**Online Media**

One prominent source of misinformation with regard to vaccination has been social media. Therefore UN bodies have created online awareness campaigns in order to share the positive benefits of vaccination. One such campaign is the World Immunization Week, a public information campaign coordinated by WHO to fight misconceptions about vaccines such as better hygiene being sufficient to prevent outbreaks of infectious disease, or that giving a child multiple vaccines could overwhelm their immune system. World Immunization Week 2019 took place from 24 to 30 April. Throughout this campaign, WHO, together with UNICEF, the Bill and Melinda Gates Foundation, and Gavi, coordinated across social media through the hashtag #vaccineswork. The Bill and Melinda Gates Foundation offered to give up to $1 million US dollars by donating a dollar toward UNICEF’s vaccination efforts each time a post featuring this hashtag was shared or liked throughout the week. The campaign was hugely successful with 3.1 million engagements on social media, and the maximum total being donated by the foundation. Another way this campaign engages people with the benefits of vaccination is through vaccine heroes. The vaccine heroes consisted of people from across the world in a wide range of occupations, including medical professionals, activists, and those involved in the distribution of...
vaccines.\textsuperscript{283} The campaign shared stories of them, talking about their personal experiences and how vaccination has impacted their communities.\textsuperscript{284}

WHO has also worked directly with online platforms such as Facebook, Pinterest, and Instagram, to look at how search results for terms such as vaccination are generated.\textsuperscript{285} Instead of allowing for potentially false information to be listed within the top results, these kinds of searches instead directly link to trusted bodies, ensuring that false information about vaccination is not allowed to spread through these platforms.\textsuperscript{286}

\textit{Countering misinformation in public}

Another, more traditional way of misinformation being spread, is through oral rhetoric. To counteract this, the WHO Regional Office for Europe created a guidance document on “How to respond to vocal vaccine deniers in public.”\textsuperscript{287} This document contains psychological and persuasive guidance for communicating with a vaccine denier, a person who refuses to accept the scientific evidence that vaccines are safe and effective.\textsuperscript{288} There is a spectrum of vaccine hesitancy, ranging from reluctance through to vocal denial, and individuals on this spectrum will have different reasons as to why they reject vaccination.\textsuperscript{289} When addressing an audience there are many things to be aware of in order to engage in a constructive discussion.\textsuperscript{290} For example, audiences will often display a negativity bias and will be quicker to trust negative information than positive information.\textsuperscript{291} Traditional ways of trying to debunk myths will often backfire, repeating a false myth while trying to debunk it will often result in an audience’s belief in the myth growing stronger due to the familiarity effect.\textsuperscript{292} The familiarity effect has been examined in psychological studies which have revealed that many people will commonly believe something if they have heard it repeated many times over.\textsuperscript{293} There also exists a narrative bias.\textsuperscript{294} Statistics and facts will often be ineffective in the face of false information which forms a coherent narrative because a narrative will often speak to a person’s emotional state of being.\textsuperscript{295} The document produced by the WHO European Office discusses multiple approaches for a speaker to overcome these biases and to present facts in a way which will make the audience receptive to the scientific consensus.\textsuperscript{296} Examples include packaging statistics into personal anecdotes or metaphors, asking rhetorical questions of the audience in order to allow them to start to question previously held beliefs, and to convey confidence and charisma while speaking about vaccination.\textsuperscript{297}

\textit{Program interventions}

\textit{The Role of Health Workers}

Health workers find themselves on the front line of vaccination efforts and their interactions with patients have significant impacts upon future willingness to accept vaccines.\textsuperscript{298} They are well placed to work

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\bibitem{285} UN DGC, \textit{UN Health Agency Welcomes Facebook Pledge to Stop Vaccine Misinformation From Going Viral}, 2019; The Guardian, \textit{Pinterest’s new Vaccine Search Will Offer Something Rare on Social Media: Facts}, 2019.
\bibitem{286} Ibid.
\bibitem{287} WHO Regional Office for Europe, \textit{How to Respond to Vocal Vaccine Deniers in Public}, 2017, pp. 5-11.
\bibitem{288} Ibid.
\bibitem{289} Ibid.
\bibitem{290} Ibid., pp. 14-16.
\bibitem{291} Ibid., p. 15.
\bibitem{292} Ibid.
\bibitem{293} Ibid.
\bibitem{294} Ibid.
\bibitem{295} Ibid.
\bibitem{296} Ibid., p. 20.
\bibitem{297} Ibid.
\end{thebibliography}
closely with communities to build trust and to reach people who are less engaged with, or more doubtful of, traditional and online information sources. WHO helps health workers to address vaccine hesitancy through training modules which discuss how to communicate differently with patients depending upon their levels of trust toward vaccines.

One of these WHO training modules is called “Conversations to build trust in vaccination” and considers how health professionals can communicate most effectively with concerned parents. It advises health workers to start the conversation with a presumptive statement, talking about vaccination as the default option, and to then assess whether the patient is accepting, reluctant, or a vaccine skeptic. If the individual is hesitant, then the technique used to persuade them is motivational interviewing which includes acknowledging their concerns and responding to them with open-ended questions affirming the positive benefits of vaccination while building a rapport. If this conversation is unsuccessful at persuading the parent to vaccinate their children, then the health worker should try to be understanding while reminding the parent of their responsibility toward their child, but trying to ensure that the parent comes away from the conversation receptive to further attempts at persuasion. Another example of how health workers have achieved a positive impact is through WHO’s work with the National Primary Healthcare Development Agency in Nigeria. Together they have developed a Community Engagement Framework in which community leaders are empowered to register and monitor the vaccination status of all the children born in their community. They then refer unvaccinated children to their local health center for immunization.

**Tailoring Immunization Programmes (TIPS)**

TIPS were created by WHO Regional Office for Europe to strengthen public immunization programs across the region in order to achieve the GVAP targets. In doing so it assists Member States in maintaining high immunization rates through successful national immunization programs which are tailored toward childhood and infant vaccinations. WHO works closely with national immunization programs of a country to identify segments of their population vulnerable to vaccine hesitancy, identify the supply and demand barriers to vaccination, and to design suitable interventions based upon previous findings. These interventions firstly look at ways in which existing national vaccination programs are not effective. They then work to address this and look at the reasons why people choose not to be vaccinated. There is a spectrum of vaccine hesitancy ranging from reluctance through to outright denial of vaccination’s benefits.

**Case Study: 2017-2019 Measles Outbreak**

Measles is a highly infectious disease which is transmitted through close contact or through droplets from the mouth or nose entering the air. Before the introduction of a vaccine in 1963, as many as 2.6 million deaths occurred each year. After the vaccine’s introduction, the number of deaths dropped significantly

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299 Ibid.
301 Ibid.
302 Ibid.
303 Ibid.
304 WHO Regional Office for Africa, Nigeria Consolidates Efforts to Curtail Vaccine Hesitancy, 2019.
305 Ibid.
306 Ibid.
308 Ibid.
309 Ibid., pp. 17-18.
310 Ibid.
311 Ibid.
312 WHO, Immunization Coverage.
314 Ibid.
to approximately 110,000 deaths in 2017.\textsuperscript{315} The \textit{Global Measles and Rubella Strategic Plan 2012-2020} places the elimination of measles in at least five WHO regions by 2020 as one of its targets.\textsuperscript{316} One metric for monitoring progress against measles is the percentage of children who have received a first dose of the measles vaccine by their first birthday.\textsuperscript{317} Between 2000 and 2017, this number increased from 72\% to 85\%.\textsuperscript{318} Since 2017, the number has remained at 85\%, significantly below the 95\% needed to achieve herd immunity and to prevent outbreaks.\textsuperscript{319} Throughout the 2017-2019 period, many regions of the world have continued to see improvements in the metric, whereas others have begun to see declines due to vaccine hesitancy.\textsuperscript{320} These declines have led to certain regions no longer possessing populations with the necessary vaccination rates to provide herd immunity.\textsuperscript{321} At the end of 2017, 37 countries had eliminated measles, but by the end of 2018 this number had decreased to 35.\textsuperscript{322} The measles-free status is lost when measles is able to continuously spread through a country for a year, and at the moment, the United States is also at risk of losing it.\textsuperscript{323} These developments have left many regions vulnerable to outbreaks of measles.\textsuperscript{324}

Since 2017, there have been increasingly large outbreaks of measles in regions with historically high immunization rates, including parts of Europe and the United States.\textsuperscript{325} The first half of 2019 saw the highest number of measles cases worldwide since 2006.\textsuperscript{326} It was estimated that 2.5 million children in the United States and 600,000 children in France were not vaccinated due to concerns about the efficacy and safety of vaccines.\textsuperscript{327} This hesitancy was attributed to inaccurate information spreading online about the safety of the measles/mumps/rubella vaccines.\textsuperscript{328} This misinformation will often led parents to believe that vaccines cause dangerous side effects in children, that vaccines aren’t effective, or that it isn’t necessary to continue vaccination because the disease has been eliminated from the country.\textsuperscript{329} One of the most effective interventions, as mentioned above, can be done through healthcare workers who are well positioned to counter false beliefs about vaccinations.\textsuperscript{330} Some Member States, including Italy and certain regions of the United States, have also attempted to increase vaccination rates through making vaccination mandatory in order for children to attend public school, and fining parents who cannot prove that their children have received vaccinations for the most common infectious diseases.\textsuperscript{331}

\textit{Conclusion}

According to WHO, vaccinations are a very important and inexpensive solution to numerous infectious diseases and their implementation has saved millions of lives.\textsuperscript{332} As stated in scientific research, including the WHO’s own bulletin, the necessary amount of the population to attain herd immunity should be

\begin{itemize}
\item \textsuperscript{315} Ibid.
\item \textsuperscript{316} WHO, \textit{Global Measles and Rubella Strategic Plan 2012-2020}, 2012, p.16.
\item \textsuperscript{317} WHO, \textit{Measles: Key Facts}, 2019.
\item \textsuperscript{318} WHO, \textit{New Measles Surveillance Data From WHO}, 2019.
\item \textsuperscript{319} Ibid.
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\item \textsuperscript{322} UN DGC, UN Health Experts Warn ‘Dramatic Resurgence’ of Measles Continues to Threaten the European Region, 2019.
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\item \textsuperscript{327} UN DGC, Vaccinations Create ‘Umbrella of Immunity’ Against Global Measles Outbreaks, says UNICEF, 2019.
\item \textsuperscript{328} UN DGC, ‘A Global Measles Crisis’ is Well Underway, UN Agency Chiefs Warn, 2019; CDC, CDC Media Statement: Measles Cases in the U.S. are Highest Since Measles was Eliminated in 2000, 2019.
\item \textsuperscript{329} WHO, Six Common Misconceptions About Immunization, 2019.
\item \textsuperscript{330} European Centre for Disease Prevention and Control, Vaccine Hesitancy Among Healthcare Workers and Their Patients in Europe, 2015, p.1.
\item \textsuperscript{332} WHO, \textit{Vaccination Greatly Reduces Disease, Disability, Death and Inequity Worldwide}, 2008.
\end{itemize}
vaccinated in order to be fully effective and to protect those who are most vulnerable.\textsuperscript{333} Many once common childhood diseases including measles, mumps, and rubella, have been largely eliminated in many parts of the world.\textsuperscript{334} However, the increasing number of people in these regions have become vaccine hesitant because false information has caused them to think that is not safe or necessary to be vaccinated.\textsuperscript{335} To address this growing issue, WHO, UNICEF, civil society, and governments are working to counteract this information through media campaigns, engagement with communities, and health workers led interventions.\textsuperscript{336} These initiatives are having an impact but not enough to prevent outbreaks from increasing in size and severity each year.\textsuperscript{337} There needs to be more coordination between the different international actors and an increased global awareness of this growing issue.\textsuperscript{338}

\textbf{Further Research}

Vaccine hesitancy is a fast-developing topic which contains many aspects that delegates are encouraged to consider. What could WHO do to have a stronger online presence given that the internet is often the source of much vaccine-related misinformation? How can the international community expand their current efforts to reach the growing scale of vaccine hesitancy? How can health workers use their proximity to the issue to counteract hesitancy? How can the international community balance free speech with the promotion of reliable information? How can the international community respect individual freedoms while ensuring that enough people are vaccinated to receive herd immunity?

\textbf{Annotated Bibliography}


Vaccine hesitancy has been a growing trend throughout recent years, but it was the most recent outbreak of measles that has drawn the international community’s attention to the growing scale of the problem. This source shows the scale of the current outbreak of measles and takes a look at the role of vaccine hesitancy in making these outbreaks possible. It is also useful to provide context to the international community’s reaction to these growing outbreaks, and will equip delegates with the necessary background information to start developing their own ideas.


This resolution on vaccine hesitancy and drop in vaccination rates in Europe was adopted by the European Parliament on 19 April 2018. It brings together recommendations from the GVAP and other documents to highlight the severity of the current situation, and to begin to ascertain possible causes. It attributes the rise of vaccine hesitancy across the continent to “media controversies, media sensationalism and poor journalism.” It also looks at barriers caused by high price differences between EU Member States, and the necessity for a new European platform to counteract falsehoods related to vaccination.


\textsuperscript{333} WHO, \textit{Vaccination Greatly Reduces Disease, Disability, Death and Inequity Worldwide}, 2008.
\textsuperscript{334} Ibid.
\textsuperscript{335} France24, \textit{Fight Vaccine Hesitancy as ‘Contagious Disease’, UN Meeting Told}, 2019.
\textsuperscript{337} Ibid.
\textsuperscript{338} Ibid.
This survey of global attitudes to science and healthcare was undertaken in 2018. It obtained responses from approximately 140,000 people across the world. Chapter five deals exclusively with attitudes to vaccines. Given the lack of information on this subject, these findings are significant for understanding the scale and distribution of vaccine hesitancy across the world. The findings suggest that vaccine hesitancy is highest in higher income regions, particularly Europe, and that there is a clear link between trust in vaccines and in science more generally. This source is relevant for getting an overview of the scale of vaccine hesitancy, and also to gain an insight as to the potential cause of the issue.


This report was drafted by the SAGE Working Group on Vaccine Hesitancy in order to examine and clearly define the issue of vaccine hesitancy. The report furthermore categorizes the three determinants of vaccine hesitancy as: confidence, complacency and convenience. This report is an important foundational document for understanding the scope and approach taken by the international community to vaccine hesitancy. Taking the time to read through this report will provide delegates with a comprehensive understanding of the causes and potential solutions to vaccine hesitancy.


The Guide to Tailoring Immunization Programmes was created by the WHO Regional Office for Europe, and looks at how to reverse falling vaccination rates in the region. It sets out a strategy for collaborating with countries to identify deficiencies in their vaccination programs, and working to address them through restructuring. It also examines the behavioral reasons for people choosing not to be vaccinated, and attempts to construct strategies to address them through targeted interventions. Delegates will benefit from an increased understanding of how the WHO can work closely with governments to improve their vaccination programs.

Bibliography


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