NMMUN 2022

WHO - BACKGROUND GUIDE

World Health Organization

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Letter from the Chairs

Greetings Delegates!

We are delighted to serve as the World Health Organization (WHO) chairs and are proud to extend a warm welcome to you at NMMUN 2022. As your chairs, it is our pleasure to accompany you through this MUN and ensure that you all have a remarkable conference!

Being a delegate calls for unwavering dedication and diligence. Each delegation participates in each council diversely and offers a unique perspective to the session. Each of you will be pivotal to how the council proceeds. You must be effectual by being factually and logically prepared with your issues. As a delegate, you are liable for your country regarding the policies and legislation that the government of your assigned nation has adopted.

This background guide will aid you with the fundamental basis for your research with reference to WHO's council issues. It'll provide the core groundwork for each topic to be discussed, upon which each delegate must conduct meticulous and comprehensive research; however, you should not confine yourself to the material in this guide. The secret is to push your limits and think ingeniously.

We strongly encourage the delegates to be cognizant and well-informed of the key evidence and facts about your respective nations, latest changes to the legal framework of your country regarding the issue, the UN's engagement in your nation, the general status of all member states in the council and sustainable approaches to abolish the issue internationally.

As chairs, we hope to bring you, as delegates, one step closer to direct the emerging society in the best way possible. We are thrilled for the upcoming conference and hope to see each of you engage in fruitful and passionate debates and challenge each other and yourself every step of the way. For any queries or concerns, feel free to reach out to us, and let's make this an incredible conference!

Your Chairs,

Veda and Romeir

Issues:

- Prevent and treat non-communicable diseases and mental health conditions.
- Delivering health amid conflict

ABOUT THE COMMITTEE

The World Health Organization (WHO) is a specialized agency of the United Nations responsible for international public health. The WHO Constitution states its main objective as "the attainment by all peoples of the highest possible level of health" Headquartered in Geneva, Switzerland, it has six regional offices and 150 field offices worldwide.

History

WHO was established on 7 April 1948. The first meeting of the World Health Assembly (WHA), the agency's governing body, took place on 24 July of that year. The WHO incorporated the assets, personnel, and duties of the League of Nations Health Organization and the Office International d'Hygiène Publique, including the International Classification of Diseases (ICD). Its work began in earnest in 1951 after a significant infusion of financial and technical resources.

Mandate

It seeks and includes working worldwide to promote health, keeping the world safe, and serve the vulnerable. It advocates that a billion more people should have: universal health care coverage, engagement with the monitoring of public health risks, coordinating responses to health emergencies, and promoting health and well-being It provides technical assistance to countries, sets international health standards, and collects data on global health issues. A publication, the *World Health Report*, provides assessments of worldwide health topics. The WHO also serves as a forum for discussions of health issues.

Function

It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring, and assessing health trends

GLOSSARY

1) Mental Health- The state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.
2) Noncommunicable diseases- also known as chronic diseases, they tend to be of long duration and are the result of a combination of genetic, physiological, environmental, and behavioral factors.
3) Hyperglycemia- The state where the level of sugar in your blood is too high. It mainly affects people with diabetes and can be serious if not treated.
4) Hyperlipidemia- Hyperlipidemia means your blood has too many lipids (or fats), such as cholesterol and triglycerides.

ISSUE 1 - PREVENT AND TREAT NON-COMMUNICABLE DISEASES AND MENTAL HEALTH CONDITIONS

Introduction

Noncommunicable diseases (NCDs) – mainly cardiovascular diseases, diabetes, cancers, and chronic respiratory diseases – are the leading cause of death worldwide. They represent 7 of the 10 main causes of death equivalent to 74% of all deaths globally. This includes more than 15 million people who die prematurely every year from a major NCD between the ages of 30 and 69 years; 85% of these premature deaths occur in low- and middle-income countries.

Mental health conditions are one of the major groups of noncommunicable diseases (NCDs) with crucial relevance in efforts to control and prevent NCDs. Mental health also has links to cancer, diabetes, cardiovascular and respiratory diseases and other NCDs. By considering mental ill health and other NCDs together, we can improve the lives of people affected by NCDs worldwide, and guide advocacy at global, regional, and national level for strong commitments at the September 2018 UN High-Level Meeting on NCDs.

By definition, mental, neurological and substance use disorders are NCDs, and they often co-occur and share many features:

- Mental conditions are often determined by the environment and social circumstances in which people live, and their exposure to risk factors. Many of the modifiable factors that influence the likelihood of a person being affected by major physical NCDs (diabetes, cardiovascular disease, respiratory conditions, cancer) also impact on mental health, for example diet, exercise, and use of alcohol and drugs.
- Mental conditions can occur at any time of life and are often long-lasting (chronic) and require long-term management and support rather than one-off treatment. In many parts of the world, this care is not widely available.
- Mental conditions often occur in conjunction with other physical NCDs. People living with chronic physical conditions have higher rates of mental conditions, especially depression and anxiety. This may not be well recognized, but we know that physical health outcomes are worse if people have a mental condition, including a drastically reduced lifespan.1 Likewise, mental health outcomes tend to be worse for those living with comorbid chronic conditions like other NCDs

Mental health has long been overlooked when NCDs are discussed or seen as being separate. But the synergies across all NCDs including mental health mean it makes sense for governments to address the common risk factors and systems barriers to reduce premature and preventable

suffering and death. In alignment with target 3.4 of the Sustainable Development Goals (SDGs), “by 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being”, mental health must be integrated into the response to NCDs.

This resource details 6 key campaign priorities for ENOUGH and was developed by members of the World Federation for Mental Health, Mental Health Innovation Network and NCD Alliance to support advocacy by global health advocates seeking integration of Mental Health into policy, processes, and actions to prevent and control NCDs.

We summarize evidence on these overlaps to support the call for including mental health in strategies for reducing NCDs. We also provide evidence for explicitly considering childhood adversity as an environmental risk factor. We emphasize findings from the World Mental Health Surveys, a unique international dataset comprising more than 100 000 respondents in more than 20 countries

- NCDs and mental disorders often coexist, and their risk factors overlap
- The causal mechanisms underlying this comorbidity are increasingly understood and can therefore be targeted
- Evidence supports the effectiveness of collaborative care to integrate mental health treatment into general services
- The inclusion of mental health in the five-by-five framework for tackling NCDs is appropriate
- Adding childhood adversity as a subcategory of environmental risk factors would also be helpful

People At Risk

People of all age groups, regions and countries are affected by NCDs. These conditions are often associated with older age groups, but evidence shows that 17 million NCD deaths occur before the age of 70 years. Of these premature deaths, 86% are estimated to occur in low- and middle-income countries. Children, adults, and the elderly are all vulnerable to the risk factors contributing to NCDs, whether from unhealthy diets, physical inactivity, exposure to tobacco smoke or the harmful use of alcohol.

These diseases are driven by forces that include rapid unplanned urbanization, globalization of unhealthy lifestyles and population ageing. Unhealthy diets and a lack of physical activity may show up in people as raised blood pressure, increased blood glucose, elevated blood lipids and obesity. These are called metabolic risk factors and can lead to cardiovascular disease, the leading NCD in terms of premature deaths.

Modifiable behavioral risk factors such as tobacco use, physical inactivity, unhealthy diet, and the harmful use of alcohol, raised blood pressure, overweight/obesity, hyperglycemia, hyperlipidemia all increase the risk of NCDs.

In terms of attributable deaths, the leading metabolic risk factor globally is elevated blood pressure (to which 19% of global deaths are attributed), followed by raised blood glucose and overweight and obesity.

Socio Economic Impact

NCDs threaten progress towards the 2030 Agenda for Sustainable Development, which includes a target of reducing the probability of death from any of the four main NCDs between ages 30 and 70 years by one third by 2030.

Poverty is closely linked with NCDs. The rapid rise in NCDs is predicted to impede poverty reduction initiatives in low-income countries, particularly by increasing household costs associated with health care. Vulnerable and socially disadvantaged people get sicker and die sooner than people of higher social positions, especially because they are at greater risk of being exposed to harmful products, such as tobacco, or unhealthy dietary practices, and have limited access to health services

In low-resource settings, health-care costs for NCDs quickly drain household resources. The exorbitant costs of NCDs, including treatment, which is often lengthy and expensive, combined with loss of income, force millions of people into poverty annually and stifle development.

Prevention and Control

An important way to control NCDs is to focus on reducing the risk factors associated with these diseases. Low-cost solutions exist for governments and other stakeholders to reduce the common modifiable risk factors. Monitoring progress and trends of NCDs and their risk is important for guiding policy and priorities.

To lessen the impact of NCDs on individuals and society, a comprehensive approach is needed requiring all sectors, including health, finance, transport, education, agriculture, planning and others, to collaborate to reduce the risks associated with NCDs, and to promote interventions to prevent and control them.

Investing in better management of NCDs is critical. Management of NCDs includes detecting, screening, and treating these diseases, and providing access to palliative care for people in need. High impact essential NCD interventions can be delivered through a primary health care approach to strengthen early detection and timely treatment. Evidence shows such interventions are excellent economic investments because, if provided early to patients, they can reduce the need for more expensive treatment. Countries with inadequate health care coverage are unlikely to provide universal access to essential NCD interventions. NCD management interventions are essential for achieving the SDG target on NCDs.

WHO Response

The 2030 Agenda for Sustainable Development recognizes NCDs as a major challenge for sustainable development. As part of the agenda, heads of state and government committed to develop ambitious national responses, by 2030, to reduce by one third premature mortality from NCDs through prevention and treatment (SDG target 3.4). WHO plays a key leadership role in the coordination and promotion of the global fight against NCDs and the achievement of the Sustainable Development Goals target 3.4.

In 2019, the World Health Assembly extended the WHO Global action plan for the prevention and control of NCDs 2013–2020 to 2030 and called for the development of an Implementation Roadmap 2023 to 2030 to accelerate progress on preventing and controlling NCDs. The roadmap supports actions to achieve a set of nine global targets with the greatest impact towards prevention and management of NCDs.

Suggested Moderated Caucus Topics

1. How can the burden of noncommunicable diseases be eased?
2. How can the unopposed marketing of unhealthy food impact the prevention and control of noncommunicable diseases?
3. How is the importance of surveillance in preventing and controlling noncommunicable diseases explored?
4. How can we improve the role of primary health care in combating noncommunicable diseases?

Bibliography

Linking Mental Health and NCD Priorities

Integrating Mental Health with Other NCDs

Suggested Reading

WHO - NCDs and Mental Health

Non-communicable Diseases and Mental Health

Integrating Mental Health in Care for NCDs

Global Strategies to Reduce NCDs

Issue 2 - DELIVERING HEALTH AMID CONFLICT

Introduction

Armed conflict is a global health issue. Long-lasting and protracted conflicts have consequences not only for the war-wounded but also for the health of entire communities. Over the years, global health actors and humanitarian health actors have developed health policies, guidelines, frameworks, and structures to improve delivery of health services in emergencies or humanitarian crises. Despite these advancements, however, the international health response in conflict-affected settings still faces gaps and challenges.

Armed conflict between warring states and groups within states have been major causes of ill health and mortality for most of human history. Conflict obviously causes deaths and injuries on the battlefield, but also health consequences from the displacement of populations, the breakdown of health and social services, and the heightened risk of disease transmission. Despite the size of the health consequences, military conflict has not received the same attention from public health research and policy as many other causes of illness and death. In contrast, political scientists have long studied the causes of war but have primarily been interested in the decision of elite groups to go to war, not in human death and misery. Some policies and frameworks need to be rethought or redesigned, while others need to be better implemented.

Case Study

Armed conflicts are known to have detrimental impact on availability and accessibility of health services. However, little is known on potential impact on utilization of these services and health seeking behavior. The detrimental impact of armed conflict on health is not limited to deaths, injuries, and disability; conflict also bears indirect health effects through a variety of risk factors. Attacks on healthcare and other disruptions to health systems reduce access to curative and preventive services. Current wars tend to be protracted and increasingly take place in urban settings, which can amplify their health consequences. This study examines whether exposure to different types of war incidents affected utilization of key health services—outpatient consultations, antenatal care, deliveries, and C-sections, in conflict affected areas of northwest Syria between 1 October 2014 and 30 June 2017.

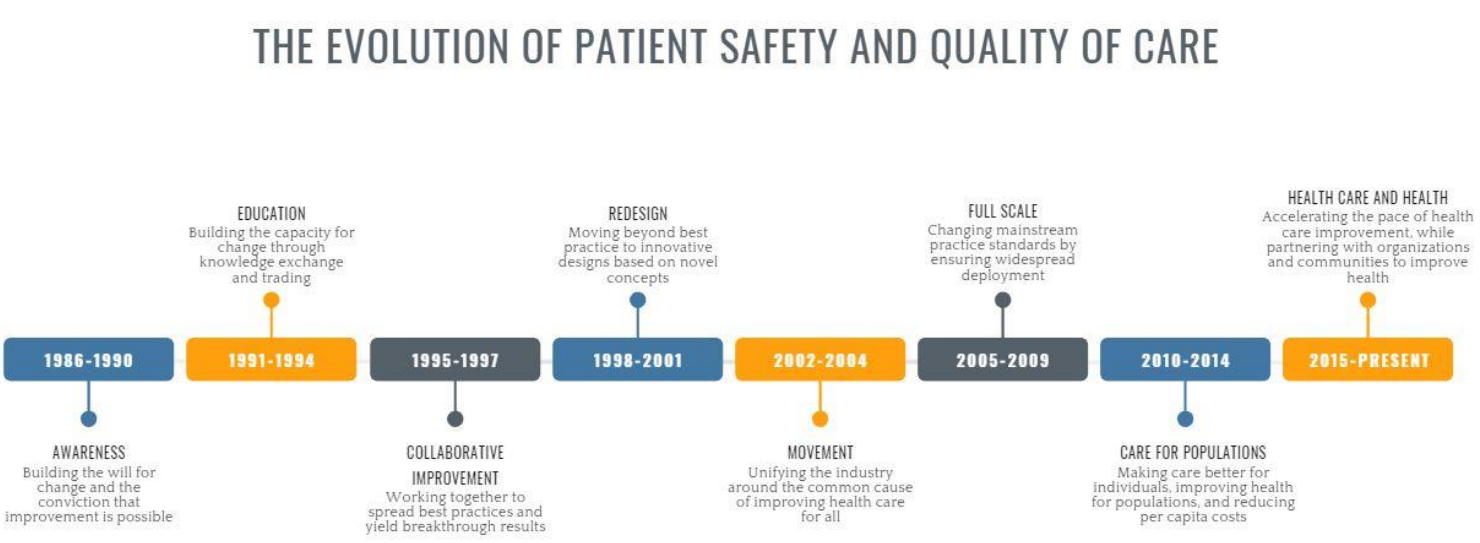
The study is an observational study using routinely collected data of 597,675 medical consultations and a database on conflict incidents that has 11,396 events. The study found strong evidence for a negative association between bombardments and both consultations and antenatal care visits.

Explosions were found to be positively associated with deliveries and C-sections. Each one unit increase in explosions in each month in each village was associated with about 20% increase in deliveries and C-sections

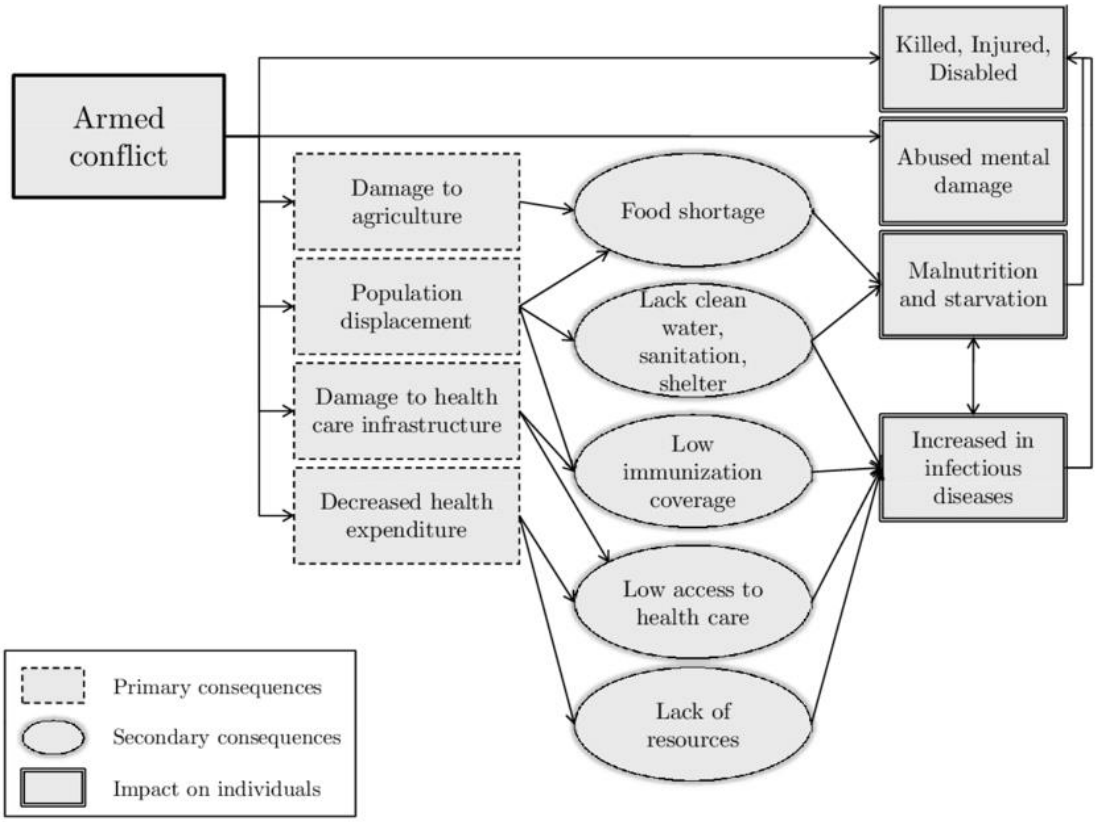
The study found that access to healthcare in affected areas in Syria during the study period has been limited. The study provides evidence that conflict incidents were associated negatively with the utilization of routine health services, such as outpatient consultations and antenatal care. Whereas conflict incidents were found to be positively associated with emergency type maternity services—deliveries, and C-sections.4

It is estimated that armed conflicts kill around 133,750 people every year, but this estimate does not account for indirectly attributable mortality. Warring parties may deliberately seek to damage and curtail access to civilian health services or may do so collaterally due to their military tactics. In either case the laws of war are contravened, but, aside from deaths and damage directly resulting from attacks on health services, the full effects of such actions are not easily quantifiable. Stronger evidence could better illuminate the scale of the problem, support memorialization of wars, inform civilian protection and potentially aid prosecution of war crimes.

Timeline of Quality of Healthcare



Impact of Conflict on Healthcare



Country Backgrounds

Syria

More than ten years of conflict in Syria has had a devastating impact on civilians, infrastructure, and services, with more than half a million deaths and half of the entire population displaced either internally or to neighboring countries. What started as peaceful demonstrations in March 2011 has turned into a proxy war with complex regional and international dimensions, dividing the country into different areas of control. The health system in northwest Syria was severely affected by the conflict. The withdrawal of the Damascus ministry of health starting from 2012 from all opposition-controlled areas, shortages in resources including health workforce, attacks on healthcare, and the lack of central health authority to coordinate health interventions are all some of the challenges faced by

this health system. Attacks on healthcare have been a pre-eminent war tactic that was often used in these areas.

Afghanistan

Over the years, conflicts negatively impacted Afghanistan's public and private sector services, including healthcare services. Healthcare workers were not left out as they have been at the center point of the crisis since the early days due to the insubstantial condition of the dooming country. Moreover, the number of healthcare workers is lower than the World Health Organization (WHO) recommended physician to population ratio, which stood at 0.278 per 1000 people in 2016.1 Hence, this added a considerable burden on healthcare workers.

The true number of infections in Afghanistan is thought to be much higher, given that millions of vulnerable people have no access to health care in a country wracked by conflict, even before the pandemic. Afghanistan had only 172 hospitals and four doctors per 10 000 people, according to a 2019 government report. Around a third of the 37 million population has no access to a functional health center within 2 h of their home, says the UN Office for the Coordination of Humanitarian Affairs (OCHA)

Ukraine

For more than two months now, Russian troops have been destroying cities in Ukraine. On February 24, 2022, Russia attacked Ukraine. The bloody conflict in Ukraine has seen several attacks on healthcare institutions, including hospitals and clinics. Mariupol's children's hospital was targeted, while Ukraine accused Russia of bombing a mental facility in Kharkiv. Since the inception of the war in Ukraine, the healthcare system in some regions has been devastated. As per records, a total of 103 assaults have been documented, including 89 attacks on healthcare institutions and about 13 attacks on healthcare transportation. Healthcare is a significant force, especially in the context of military conflict. Not only because it takes care of wounded combatants, but also because it allows the society to continue to function before, during, and after the war. The healthcare system in Ukraine is facing the terrible challenges of war and needs humanitarian aid and the support of the international community.

Yemen

Availability of functioning health infrastructure, such as hospitals and primary care centers, has dwindled under the weight of conflict, with a significant share of the population having challenges with access to health care. Currently, only 50% of health facilities are fully functional, and over 80% of the population faces significant challenges in reaching food, drinking water and access to health care services. Shortages of human resources, equipment, and supplies are severely hindering healthcare provision. Yemen’s health system is extremely reliant on external funding and the provision of health services is primarily done through implementing organizations, with a weak health system and an overreliance on development partners executing vertical health programs.

External financing for health has dropped drastically from previous years, leaving Yemen's health system exposed to looming threats such as COVID-19. This, augmented with the consequences of prolonged and ongoing armed conflict, economic decline, and institutional collapse has exacerbated health challenges in Yemen and resulted in weak governance.

Myanmar

Myanmar simultaneously faces multiple armed conflicts and crises, each with its own challenges. In Rakhine state, the government's persecution of the Rohingya people has led to massive displacement, as have decades of armed conflict in Kachin and northern Shan states. Combined with chronic underdevelopment, these humanitarian crises have left people without access to adequate healthcare, leading international humanitarian actors to step in. In crisis-affected areas, UN agencies and international and local NGOs play an important part in providing healthcare services. However, international action can be unbalanced both regionally and medically. In many areas, health actors have focused on responding to diseases like malaria, HIV/AIDS, and tuberculosis, leaving a critical gap in mental health services and clinical health responses to sexual and gender-based violence. Likewise, funding has been imbalanced, with Rakhine state receiving more funding than Kachin or northern Shan.

Suggested Moderated Caucus Topics

1. How do the consequences of conflict affect children's access to healthcare?
2. How can areas with extreme atrocities be prioritized?
3. Should healthcare workers' wages be altered? If so, how can universal access to healthcare be assured alongside a raise in their pre-existing meagre salaries?

Bibliography

Hard to Reach: Providing Healthcare in Armed Conflict

The impact of armed conflict on utilization of health services in north-west Syria

Further Reading

A human rights approach to health care in conflict

Protecting Healthcare in Conflict; Protecting Future Generations