



ZABMUN X

RESOLVING DISPUTES | REACHING MILESTONES



WORLD HEALTH ORGANIZATION (WHO)

**TOPIC : STRENGTHENING GLOBAL
COOPERATION FOR HEALTH ASSISTANCE IN
GRADE 3 EMERGENCY ZONES**

LETTER FROM THE PRESIDENT



Honourable participants,

ZABMUN has been the crown jewel of SZABIST since the past ten years, and being the President of ZABMUN X, the honor of meeting the standards falls upon me.

ZABMUN has always been a conference par excellence and within this year's theme: Resolving Disputes | Reaching Milestones, we intend to go further than we ever have.

Our aim is to promote the art of diplomacy and creating dialogue about the important world issues.

This year, ZABMUN not only promises to provide you an exhilarating conference but it even promises you to provide extensive training sessions which would provide you the best quality debate.

It would be an immense pleasure to host your brilliant minds at the 10th conference.

Kind regards,

Syed Ahmer Hussain Qadri,
President
ZABMUN

LETTER FROM THE SECRETARY GENERAL



Greetings everyone!

My name is Syeda Romaiza Ibad and I am currently in my Junior Year, pursuing BSc in International Relations and Political Science. Being an advocate of debate, diplomacy and discourse, I am honoured to welcome the leaders of tomorrow to the 10th Edition of Szabist Model United Nations. ZABMUN is a conference built on proud traditions and a legacy of MUNs at SZABIST. This conference is a timely reminder of the succeeding generations that have dedicated their hard work, blood and sweat in making this conference exceptional.

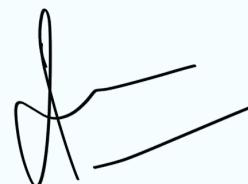
This year, we will be celebrating a Decade of Diplomacy with committees serving as 10 pillars, created with a blend of ambition, comprehensive concepts and internationally diverse topics, affirming high hopes of all. ZABMUN is modelled on open minds and fresh ideas where delegates are challenged and asked to represent national agendas or stands that they may personally disagree with. They will do so fairly and forcefully. This open-mindedness is the essence of successful diplomacy -- the ability to understand and analyse all positions, including those that they oppose.

As the Secretary-General of the conference, I recognize the value of having accomplished Committee Directors on board and how it contributes to making the conference a success and so, I have handpicked for you a mixture of ZABMUN Alumni and renowned Chairpersons from within the debating coterie, who have a profound knowledge and knack for Parliamentary discussions and debates.

I want this acceptance of differing viewpoints to clearly distinguish this conference from the rest. I believe it will prove crucial as delegates assume leadership roles in the twenty-first century. This year, the theme is quite simple: Resolving Disputes & Reaching Milestones. We want to harbour diversity and inculcate in our delegates the art of conflict resolution. I can assure all the delegates that by participating in this simulation and using this platform, these students can surely become better speakers. ZABMUN encourages each individual to trigger their analytical thinking skills, by stepping into the world of daily crisis and policy changes and enable their minds to interpret situations and suggest solutions.

Good luck to all those participating! Can't wait to see you all in December!

Kind regards,



Syeda Romaiza Ibad,
Secretary General
ZABMUN

TOPIC: STRENGTHENING GLOBAL COOPERATION FOR HEALTH ASSISTANCE IN GRADE 3 EMERGENCY ZONES

INTRODUCTION TO THE COMMITTEE:

The World Health Organization (WHO) was not the first international effort to address global health problems and challenges. The predecessor organization was named the Health Committee and Health Section and was established in 1922 as part of the League of Nations.¹ After the demise of the League of Nations, the organization was replaced by The World Health Organization (WHO), which was founded on the 7 April in 1948 by the UN General Assembly.² Today the World Health Organization has 194 Member States and more than 7000 people working in 150 countries.³ The WHO's headquarters are situated in Geneva.

The WHO's goal is to build a better, healthier future for people all over the world and help people reach the highest attainable standard of health possible.⁴ To achieve this goal the WHO is taking a wide range of actions:

- Promoting universal health coverage and the right to health - monitoring the health situation and assessing health trends.
- Battling non-communicable diseases (e.g. cancer, heart disease, stroke).
- Increase and sustain access to prevention, treatment and care of communicable diseases (e.g. HIV, tuberculosis, malaria).
- Helps countries to strengthen their national core capacities for emergency risk management to prevent, prepare for, respond to, and recover from emergencies.
- Providing leadership on matters critical to health
- Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge
- Setting norms and standards and promoting and monitoring their implementation - articulating ethical and evidence-based policy options
- Providing technical support

The World Health Organization is composed of three bodies: The World Health Assembly, the Executive Board and the Secretariat. The World Health Assembly is the decision-making body and is holding annually sessions, that are attended by delegates from all member states.⁵ The Executive Board consists of 34 members and decides on implementation of proposed policies and sets the agenda.⁶ One of the main tasks of the WHO secretariat is to translate the most up-to-date knowledge and evidence into advice, norms and guidelines.⁷ The current Secretary-General of the WHO Dr. Margaret Chan was elected for a second five-year term in 2012 and will serve until the 30th June of 2017.

INTRODUCTION TO THE TOPIC:

For decades, the international community has witnessed outbreaks and life-threatening health emergencies. A Grade 3 emergency zone, according to the World Health Organization is defined as "a single or multiple country event with substantial public health consequences that requires a substantial WHO response and/or substantial international WHO response".

WHO has specified that health crises and outbreaks occur often each year, in which all Member States have an identical potential to be exposed. Yet, when estimating the different capabilities states have in responding to health crises, it is apparent that individuals who exist in within less industrialized states tend to be the most affected when outbreaks emerge, due to their restricted health resources and services

Moreover, these life-threatening situations have been predominant in vulnerable areas throughout the world, including in West Africa, where development has occurred at a fairly fast pace, leading to an escalation in disease transmission due to overall population density.

Since its creation as a United Nations (UN) agency in 1945, WHO has promoted the importance of global health, and emphasized the importance of vigilance when it comes to health-related emergencies. In 2016 alone, it has been assessed that 1.1 million individuals, a 20% increase since the amount that was estimated in 2015, has had an urgent need for health-related assistance. This rising number is due in part to inadequately managed health facilities, poor hygiene, and poor sanitation; all of which are also connected to persisting diseases such as cholera and measles. Some examples of mutual epidemics which have been faced by Member States include the emergence of Ebola in West Africa, the pervasiveness of the Zika virus in South America, and the cholera epidemic in South Sudan. Although these specific examples are only a select few diseases among many outbreaks which have occurred in recent years, it is important to consider that proper coordination and response mechanisms are a crucial step towards alleviating these issues.

The past decades have also observed an exponential growth in the occurrence of natural disasters. In 2010 alone, there were more than 700 large-scale disasters, resulting in the death of approximately 100,000 people and causing economic losses in excess of US\$ 100 billion. While all countries are susceptible to natural hazards, developing countries are much more brutally impacted, especially in terms of the loss of lives and the proportion of economic losses in relation to their Gross National Product. 90 per cent of disaster victims live in developing countries. The cause of the extensive loss of life and damage, resulting from natural disasters, is linked to the increasing number of people and assets which are vulnerable to disasters. This is due to a number of factors, including the increased concentration of populations in areas of accelerated urbanization, and poverty, which often forces people to live in physically unstable locations and in inadequate shelters. The cyclical nature of some disasters has left large populations chronically vulnerable. In other instances, other factors, such as inapt land use planning, poorly designed buildings and infrastructure, lack of applicable institutional arrangements to deal with risk reduction, and an progressively degraded environment, symbolized by widespread deforestation, are all linked to the current trend towards increased vulnerability.

Key to the success of humanitarian action is the synchronized efforts of all players, backed by the political will and support of Member States. Member States have continued to be substantial in their response to both natural disasters and complex emergencies, not only in monetary terms but also in the establishment of personnel and technical support. Yet there are important needs that remain unmet. At the same time, opportunities to develop more efficient and effective responses exist, along with ways to support the most-affected countries in preparing for and responding strongly to the crises that afflict them.

Over the last ten years, the United Nations has become more efficient in its responses. The Security Council has become more closely involved with humanitarian schedules, such as the safety of civilians in conflict, the humanitarian aspect of sanctions, the protection of children in armed conflict, the prevalence of HIV/AIDS in conflict and the need to integrate gender standpoints in peace support operations.. The UN system as a whole has continued to develop different mechanisms for achieving its altruistic aims and has explored ways to link the different aspects of its humanitarian mandate into broader development and peace building backgrounds.

In light of the changed and changing humanitarian atmosphere, it is useful to examine whether the tools created ago by General Assembly Resolution 46/182 to improve coordination and response in humanitarian crises have adapted accordingly. During the last decades, there has been a greater pledge to management. More effort is put into deciding coordination arrangements and many have been regularized.The Inter-Agency Standing Committee and the Consolidated Appeals Process are key examples. But the response to each crisis identifies new lessons to be learned and there are still many challenges to the organization of humanitarian assistance to be met.

Emergency preparedness has traditionally focused on stockpiling relief goods and providing urgent services to meet the public's basic needs. In most countries political commitment and financial and human resources are concentrated overwhelmingly on these short-term emergency contingencies. While building up capacities for humanitarian response continues to be a priority for all countries, it is now widely believed (perhaps influenced by the severity and frequency of disasters and conflicts in the past decade) that more should be done to reduce the social, economic and human consequences of these emergencies. This translates into a need for placing much greater attention on the implementation of proactive strategies and a call for a more comprehensive approach to building national capacities in emergency preparedness and response as well as in risk reduction, focusing on those communities most at risk.

CHALLENGES ENCOUNTERED IN HEALTH ASSISTANCE

Natural Disasters

Natural disasters frequently strike many of the same regions and countries in an almost foreseeable manner. Widespread drought in the Horn of Africa endangered 12.3 million people in many parts of the region, including Eritrea, Ethiopia, Somalia, Kenya, Djibouti, Tanzania and Uganda. Severe drought in the first half of the 2000s also afflicted much of Central and Southern Asia, particularly Afghanistan, India, Iran, Pakistan, Tajikistan, Uzbekistan and the Caucasian countries of Armenia, Azerbaijan and Georgia. This resulted in significant losses of livestock and crops and rapid weakening of health and sanitary conditions. In addition, Afghanistan's Herat province was hit by a cold wave in January 2001. 5,000 displaced families, already weakened from a combination of drought and conflict, struggled in difficult and crowded conditions, exacerbated by a severe shortfall in emergency shelter. Many people died, particularly women, children and the elderly.

Adverse weather conditions also overcame many areas of Asia. Massive floods, triggered by last year's southwest monsoon rains, swept through several countries in south and south-east Asia, including India, Nepal, Bhutan, Bangladesh, Lao, Thailand, Cambodia and Vietnam. Thousands died and tens of millions of people were affected, notably in Cambodia where more than 2.2 million people (20% of the population) suffered from the worst monsoon floods to strike the country in forty years. In the Democratic People's Republic of Korea, longer-term economic problems and continuing poor harvests have been further aggravated by an uncompleted series of natural disasters: floods, drought and tropical storm damage. One third of the populace of 22 million people is now targeted for assistance with food, healthcare, water and sanitation.

Within a period of one month, two powerful shakings hit El Salvador in early 2001, affecting about 25 percent of the total population. 11,159 people died and thousands more were injured. As the intercontinental community was engaged in lecturing the consequences of the first earthquake in El Salvador, on 26 January 2001, a massive earthquake struck the western state of Gujarat in India, surprising the world with its scale. Over 20,000 people were killed and almost 16 million more were affected. The province, which held some promise in terms of economic development, is now weakened by an estimated USD 4.6 billion worth of damage.

Complex Emergencies

Text placComplex predicaments, resulting from conflict and often compounded by natural disasters, have strengthened in many regions of the world. In the past year, an already serious altruistic situation in the West African sub-region of Guinea, Liberia, Sierra Leone and Cote d'Ivoire, deteriorated because of growing hostilities between government forces and dissident groups.eholder

Border outbreaks by armed groups in Guinea's "Parrots Beak" area, which had been the momentary home for some 200,000 Liberian and Sierra Leonean refugees, resulted in massive displacement away from conflict areas. Following the large-scale mayhem and gross human rights violations committed against the resident and refugee populaces during the attacks, thousands of people fled back to Sierra Leone, while others were forced to move deeper into Guinea, to escape the fighting. The increasing role of armed non-State actors, the transnational nature of their criminal activities, the proliferation of small arms, the ineffective demobilization and reintegration of combatants, the continued staffing of child soldiers and the use of the populace as a "human shield" by the parties to the conflict is seriously jeopardizing regional peace and stability.

Although the trend in complex emergencies continues to be bleak, there are some cases where humanitarian needs have declined. In Republic of Congo, the last of the country's 800,000 displaced persons have been able to return over the last year and begin rebuilding their lives. The signing of the Cessation of Hostilities Agreement between Eritrea and Ethiopia in June 2000 (later followed by the 12 December Peace Treaty), allowed the majority of the refugees in Sudan to voluntarily repatriate, along with over 60,000 old caseload refugees. Some 600,000 persons displaced in Eritrea have also returned to their places of origin, although over 200,000 people remain in camps and some 100,000 continue to reside in host communities. The displaced within Ethiopia have also begun returning to their homes, with return rates of more than 70% in selected areas in Tigray being reported by the end of 2000.

Access

In numerous countries around the world, humanitarian actors are present but unable to reach large portions of affected populations needing their assistance. Access is one of the key challenges facing humanitarian operations, particularly in complex emergencies. Frequently access is limited by the prevailing security situation but sometimes the obstacle is also a question of policy on the part of the authorities controlling a given region or country. For example, from time to time, the Israeli Government has imposed external and internal closures on the occupied Palestinian territory, obstructing free movement of humanitarian goods and personnel. In the Democratic People's Republic of Korea, access to the population has become considerably easier since 1995 although some tight controls on the work of humanitarian agencies still remain, particularly with regard to freedom of movement, monitoring and evaluation.

Member States have a vital role in supporting the efforts of those negotiating access, to provide additional leverage or undertake complementary diplomatic and political action. It is clear that if access is successfully negotiated or is allowed by improvements in the security situation, the opportunity must be seized. But this also has important funding implications as gaining access may substantially increase the size of the beneficiary populations. In Angola, there are reportedly some 525,000 displaced persons in areas to which the humanitarian community does not currently have access. In the Democratic Republic of Congo, if improvements continue, the humanitarian community must rise to the challenge of providing support to more than two million internally displaced, less than half of whom were previously receiving humanitarian assistance due to lack of access. For many programmes, current beneficiary figures and related requests for funding are based on the people that can be reached now. Long-struggled for access to new beneficiaries must be accompanied by immediate assistance, which will be totally dependent on speedy and flexible funding arrangements.

Safety and Security of Staff

The Secretary-General's report on the "Safety and Security of United Nations Personnel" (A/55/494) highlighted the range of threats against UN personnel, the inadequacy of the existing security management structure and proposals to enhance the safety and security of UN personnel. Meanwhile, attacks on humanitarian workers have continued. The latest incidents since that report include the March 2001 murder of a UNHCR worker in the Democratic Republic of Congo, the kidnapping of eight aid workers by an armed faction in Somalia and the armed attack on a WFP food convoy in Burundi that left five relief workers injured, all occurring within a month.. This was followed by the kidnapping of four aid workers in Sudan and in April 2001, six ICRC workers were brutally murdered in a targeted ambush in eastern Democratic Republic of Congo. More recently, an ICRC co-pilot was killed when his aircraft was shot at whilst flying over south Sudan.

Security of humanitarian workers must clearly remain a high priority of the Secretary-General, Member States and humanitarian organizations.

Recognizing that the UN and its non-UN humanitarian partners operate in the same complex crises environments, the Inter-Agency Standing Committee has endorsed the recommendations of a task force on staff security which are aimed at increasing the security collaboration at the field level between the UN and non-governmental organizations. The recommendations deal with cooperation in the areas of training, use of common communications, joint security planning, information sharing and context analysis.

Security is indispensable but it requires the financial support of governments. In many cases, staff security is clearly limited by the amount of resources for security. UN Country Teams need to be given the resources to do their jobs more safely. Discussions are ongoing with Member States to ensure that the funds needed to cover the minimum requirements to strengthen staff security are provided. Staff security requirements have to be placed on a solid and stable financial basis and Member States are encouraged to make that commitment. This will clearly highlight the priority that both the Secretary-General and the Member States place on the safety of UN humanitarian staff.

Sanctions

Sanctions regimes continue to pose an increasingly difficult dilemma for the United Nations' dual mandate of preserving peace and protecting human needs. As the Secretary-General noted:

"Humanitarian and human rights policy goals cannot easily be reconciled with those of sanctions regimes" Economic sanctions are "too often a blunt instrument" and may impose hardships on a civilian population that are disproportionate to likely political gains. A general consciousness has evolved within the Security Council that, "further collective actions in the Security Council within the context of any further sanctions regime should be directed to minimize unintended adverse side effects of sanctions on the most vulnerable segments of targeted countries".

WHO's Actions in Grade 3 Emergencies

IRAQ

Since June 2014, the humanitarian crisis in Iraq has affected more than one third of its population and displaced almost four million people. About 7.8 million people are in need of health assistance. In four of the most severely affected areas in the country - Al Anbar, Ninewa, Salah Aldin and Diyala - 14 hospitals and more than 170 health facilities have been damaged or destroyed. Health services, protection, shelter, supplies of food and drinking water, and sanitation are priority needs, as violence and displacement continue to exacerbate the dire humanitarian situation across the country. As at September 2016, WHO had provided 500 inter-agency emergency health kits, 118 interagency diarrhoeal disease kits, 68 trauma kits and 11 surgical kits, and organized 902 000 consultations. WHO and its Health Cluster partners maintained their support to the Ministry of Health and its health directorates for primary health care services by procuring and delivering mobile clinics and caravans, and establishing and equipping clinics in displacement camps and newly accessible areas. They also supported referral services, including procurement of ambulances and mobile secondary health care units, linking services with reception sites, training, and spatial analysis of available referral services. WHO has supported improved control of infectious diseases, including detection and response to outbreaks, emergency vaccination, a robust disease early warning and response network system with 121 active reporting sites, and a strengthened Expanded Programme on Immunization. WHO is implementing a system to report on the protection of health workers through implementation of the Monitoring Events against Safe Use and Running of Health Services system that tracks attacks on health care workers and facilities.

NIGERIA

Since 2009, Nigeria has experienced instability and insecurity in the north-eastern part of the country, leading to the internal displacement of 2.2 million people. The crisis has resulted in damage to most health facilities and infrastructure, and many health workers have been killed or abducted, while others have fled. As a result, an estimated 3.7 million people in north-eastern Nigeria have limited or no access to basic primary health services. Once military operations improved access to previously unreachable areas, rapid assessments revealed mortality rates and levels of malnutrition that exceed emergency thresholds. The Nigerian Government declared a state of emergency in three States: Borno, Yobe and Adamawa. On 18 August 2016, WHO declared the crisis a Grade 3 emergency.

Following the declaration of the Grade 3 emergency, an Incident Management System was established in Maiduguri, Borno State. An Emergency Operations Centre was staffed with an initial team of 20 international and 10 national staff members. The WHO country office in Abuja was strengthened and US\$ 2.1 million was released from the WHO Contingency Fund for Emergencies, while efforts were undertaken to mobilize resources. Close collaboration with the polio eradication team has allowed for mass emergency vaccination campaigns. However, because of security constraints and limited access, the full extent of the needs is unknown and figures will likely rise significantly when more areas become accessible. Coordination of health sector partners is chaired by the Ministry of Health and co-chaired by WHO, supporting 17 health partners.

WHO's immediate goal is to reduce the high rates of preventable deaths and disease. WHO is working closely with the Government, focusing efforts on Borno State where 800 000 people in newly-liberated areas are in vital need of aid. Activities include rapid assessments of existing health facilities, delivery of essential health services and training community health workers. WHO supports outreach activities in difficult-to-access areas; teams provide integrated health services including routine vaccination, deworming, detection and treatment of diseases, and screening for severe acute malnutrition. 20. Three Inter-agency Emergency Health Kits were procured and prepositioned at the Borno State Ministry of Health and later distributed to various communities. Ten additional kits were ordered in September 2016. Plans are under way to vaccinate 1.6 million children against measles in a mass campaign.

South Sudan

In South Sudan, needs have increased rapidly as a result of multiple threats, including armed conflict and intercommunal violence, economic decline, disease, and climatic shocks. The resurgence of violence in July 2016 resulted in an influx of civilians into protection of civilian sites, particularly in Juba and Wau. Since December 2013, about 2.3 million people have been forced to flee their homes, 197 000 are sheltering in protection of civilian sites, and 8 out of the 10 former states are experiencing insecurity and access constraints. Health services are also needed for more than 300 000 refugees who have fled into South Sudan as a result of conflicts in neighboring countries.

Widespread insecurity in the states formerly not affected by conflict has also generated a need for an emergency response. Northern and Western Bahr el Ghazal are in the emergency food insecurity phase (Integrated Food Security Phase Classification Phase 4) and face an increased risk of acute malnutrition and elevated mortality rates.

From January to October 2016, there were multiple outbreaks of epidemic-prone diseases including cholera, malaria, measles and visceral leishmaniasis, as well as suspected cases of viral hemorrhagic fever. Outbreaks are occurring at the same time as the presence and capacity of Health Cluster partners to respond are at an all-time low: as at 29 September there were only 29 partners, compared with 67 in 2015, the difference resulting from evacuations due to increased insecurity earlier in the year.

WHO's emergency technical units have provided support to the Ministry of Health at national and subnational levels for strengthening health services' ability to deliver effective, safe and quality interventions. This collaboration has included capacity-building by Health Cluster partners and government counterparts on integrated disease surveillance and response, sustained support to the early warning and response system and policy guidance on emergency preparedness and response. From January to October 2016, WHO and its partners delivered life-saving medicines and supplies to more than one million people, including surgical supplies and equipment in 10 trauma response facilities and 73 000 oral cholera vaccine doses to vulnerable groups. As at September 2016, progress on the 12 indicators for the inter-agency Humanitarian Response Plan averaged 68% coverage per indicator; emergency measles vaccination coverage of children aged 6–59 months reached 78%, against a target of 80%.

The health sector component of the Humanitarian Response Plan was revised mid-year from US\$ 110 million to US\$ 144 million. WHO received US\$ 4 476 131 (17%) of US\$ 17.6 million requested. The Health Cluster received US\$ 43.3 million (33%) out of US\$ 144 million requested. Improved funding for the core humanitarian pipeline is urgently required.

Yemen

In Yemen, the conflict that erupted in March 2015 has had a significant impact on most of the population: more than 21 million people are in need of humanitarian assistance and 10.6 million are targeted for health interventions, including 3.1 million internally displaced people. After the peace talks in August 2016 failed to end the conflict, the number of casualties per month rose dramatically, EB140/7 8 almost doubling in August alone. Infrastructure has suffered widespread damage and destruction. Restrictions on commercial imports have caused severe shortages in fuel, food and medicines.

More than half the health facilities located in security-compromised governorates have either ceased to function or are only partially functioning. Nearly 600 of 3507 health facilities in 16 governorates are non-functioning. Most qualified health professionals have left the country owing to the conflict, creating a gap in delivery of primary health care, trauma, surgical and obstetric care services. In August 2016, the Ministry of Public Health and Population informed WHO that it can pay the salaries of health workers in only the main hospitals and health facilities, further disrupting health services.

As at September 2016, WHO has supported the Ministry of Public Health and Population in procuring and delivering more than 475 tons of medicines, medical supplies and vaccines; training and deploying 22 mobile teams (11 with the Ministry and 11 with partners); and supporting 29 health facilities in 16 governorates. WHO has also provided around 1 million litres of fuel to support 88 hospitals. WHO and its health partners have supported treatment for more than 2 million patients, including thousands requiring trauma care and surgery.

Moreover, WHO has provided around 19 million liters of clean water for health facilities and internally displaced people, and distributed hygiene supplies to the latter in all affected governorates. A total of 4.8 million of the targeted 5.1 million children under 5 years of age (92%) have been vaccinated against poliomyelitis, and 92% of the target population was vaccinated against measles and rubella in high-risk areas. Since January 2016, the surveillance system generated and investigated 12 500 disease alerts and supported the Ministry of Public Health and Population in preparedness and response, including a cholera control plan and a dengue fever response plan.

In 2016, the Health Cluster appealed for US\$ 184 million, including US\$ 124 million for WHO, to respond to the health needs of 10.6 million beneficiaries, including 3.1 million internally displaced persons. WHO's funding gap as at 31 August 2016 was 65%. The current financial crisis is posing a serious threat to the functionality of health facilities.

QARMA (QUESTIONS A RESOLUTION MUST ANSWER):

- Which zones are most likely to be affected and classified as "Grade 3 Emergency Zones" and are more vulnerable in general?
- What possible risk factors might exist in determining these zones and how could they be identified in a timely and efficient manner in order to take necessary steps?
- Which preventive/corrective measures can be taken at a local, federal and global level to ensure maximum damage control in the event of an emergency?
- How can the existing frameworks of WHO be amended/repaired to guarantee sensitivity and what proactive measures can be undertaken to make sure that the lost issues are not faced in the future?
- How can governments adapt to structural changes that might be required to achieve a fundamental monitoring system in an emergency and what steps can be taken to ensure its implementation?

Further reading

- https://www.who.int/hac/techguidance/preparedness/emergency_preparedness_eng.pdf
- http://www.who.int/hac/about/Global_survey_inside.pdf
- <https://www.paho.org/disasters/dmdocuments/pedhumen.pdf?ua=1>
- <http://www.ifrc.org/Global/Publications/disasters/disaster-response-en.pdf>
- https://www.unocha.org/sites/dms/Documents/UNDAC%20Handbook_interactive.pdf

