

Dear Delegates,

Welcome to the Virtual FMUN 2020 and World Health Organization (WHO)! My name is Taylor Mackin, and I will be serving as your Director for WHO. I have been participating in Model United Nations (MUN) conferences for six years now, since my sophomore year of high school. At the collegiate level I have attended many national and international conferences, and this will be my fourth staffing experience, having most recently served as the 2020 Director General for the Tallahassee Southern Model United Nations Conference, and current Secretary General. I recently graduated from at Florida State University with my B.S. in international affairs with a concentration in public administration and began my Master's degree in Public Administration. Serving alongside me as your Assistant Director of WHO will be Kelly Huizzi. Kelly is an international student from Venezuela, currently studying Political Science at Santa Fe College, focusing on international relations and conflict resolution. She has attended Model UN conferences as a delegate since her junior year in high school in Venezuela, and credits Model UN as being an important bridge to her current academic and future career paths. Kelly and I are very excited to meet you all (virtually) this October, and work together in making this a memorable experience for all.

The topics under discussion in the World Health Organization will be:

- I. **Strengthening Medical Infrastructure and Regulations in Low and Middle Income Countries**
- II. **Sustaining Healthcare Accessibility in Conflict Zones**

This Background Guide should serve as an introduction to both this committee and the topics on the agenda. The issues explained here will not replace delegate's individual research on their Member States and on the topics. We encourage delegates to explore how these topics relate to their Member States' national and international policies, as well as utilize the research we have cited throughout this Background Guide. Delegates' work and conduct should promote the diplomacy, cooperation, and multilateral negotiations that are inclusive of all WHO Member States and the health rights of all people as stated in the *Universal Declaration of Human Rights*.

To be fully prepared for FMUN 2020 we recommend delegates not only utilize the research in this document, but also familiarize themselves with delegate preparation conference materials on www.FMUN.org including the Rules of Procedure, Position Papers and Resolution writing guide.

If delegates have any question or concerns about the topics, committee, or the FMUN conference in general, please feel free to contact us or your Executive Staff at any point during your preparation. Otherwise, we look forward to seeing you soon!

Sincerely,

Taylor Mackin
Director

Kelly Huizzi
Assistant Director

Chantel Hover
Secretary-General

Willett Hancock
Director-General

History of the World Health Organization

The World Health Organization (WHO) and its constitution was established on April 7, 1948, the date of which is now celebrated as World Health Day globally.¹ The organization's constitution was drafted in 1946 at the *International Health Conference* in New York City.² The constitution was enacted in 1948, providing a clear WHO mandate that in the next two decades led to the combating of the world's top global health concerns, including tuberculosis, malaria, yaws, syphilis, smallpox and leprosy.³ In 1947 WHO introduced the first ever global disease-tracking service, transmitting information via telex.⁴ Telex and other disease tracking services allow us to globally follow the growth and development of different viruses and compare the data across the world, allowing doctors to develop global solutions. WHO established the first International Health Regulations in 1969, leading to cross-border treatment.⁵ In 1977 the first WHO *Essential Medicines List* was published, outlining the core medicines needed for all basic health systems.⁶

At the Millennium Summit in 2000, world leaders adopted the UN Millennium Declaration which is commonly known as the Millennium Development Goals (MDGs) and has a deadline for 2015⁷. In 2003 the first global public health treaty, the *WHO Framework Convention on Tobacco Control*, was unanimously adopted, and WHO launched "3 by 5", an initiative aiming to bring HIV treatment to three million people by 2005 and reach 13 million infected people with antiretroviral treatment by 2013⁸. The UN Summit in 2015 signed off on the 2030 Sustainable Development Goals (SDGs) which includes SDG 3: Good Health and Wellbeing, which encompasses health education, food security and nutrition, and clean water priorities for all Member States⁹.

Today, over seven thousand people from more than 150 Member States work toward global health solutions at WHO's 150 offices, including the Global Service Centre in Malaysia and WHO headquarters in Geneva, Switzerland¹⁰. The values of the WHO workforce reflect the principles of human rights, universality and equity established in WHO's Constitution as well as the ethical standards of the Organization.¹¹ These values are inspired by the WHO vision of a world in which all peoples attain the highest possible level of health, the mission to promote health, keep the world safe, and serve the vulnerable, with measurable impact for people at a country level. WHO Member States are individually and collectively committed to put these values into practice.¹²

Structure

WHO's executive functions are managed by the Executive Board, composed of 34 health experts. Each member of the Board is appointed for a three-year term by a WHO Member State elected by World Health Assembly (WHA) depending on their population per region proportions¹³. The Executive Board's key policy development functions include the drafting of multiannual programs of work as well as submitting draft resolutions to WHO and along with

¹ About WHO, WHO We Are

² Global Guardian of Public Health

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

⁷ Ibid.

⁸ Ibid.

⁹ 2030 Agenda for Sustainable Development

¹⁰ Ibid.

¹¹ Ibid

¹² Ibid

¹³ 2020 executive board

the Budget Administration Committee, the executive board makes recommendations on WHO's planning, monitoring, and evolution of programs and WHO's administration and finance management¹⁴.

The Secretariat staff of WHO work side by side with Member States and other global partners to strive for the highest level of health for all people. WHO is made up of 11 sub-departments which report to the Deputy Director-General or the WHO Office at the UN, Office of Director General Envoy for Multilateral Affairs, the WHO Academy or the International Agency for Research in cancer; all of whom report to WHO's Director General and Cabinet¹⁵. WHO's Division of Science ensures new technologies and innovations are utilized effectively by producing cutting edge research, conducting quality assurance for norms and standards, and leveraging digital technologies to improve health outcomes¹⁶.

To ensure there is access to health care globally, a portion of WHO's funding is from Member State dues, which are decided based upon a calculation relative to their wealth and population. More than three-quarters of WHO's financing has been from voluntary contributions from Member States and foundations or civil society partners, however less than 1% of WHO's funding is private sector donation¹⁷.

Mandate

As a Specialized Agency in the UN, WHO reports to the Economic and Social Council. Membership in WHO is made up of 195 Member States, all of which are UN Member States except for Nieu and the Cook Islands¹⁸. Articles one and two of WHO's constitution names the organization as the "directing and coordinating authority on international health work" and instills their objective as "the attainment by all peoples of the highest possible level of health."¹⁹

¹⁴ Ibid

¹⁵ World Health Organization Headquarters (2020)

¹⁶ WHO Science Division 2020

¹⁷ Global Guardian of Public Health

¹⁸ WHO, Countries, 2018

¹⁹ Constitution Of The World Health Organization

I. Strengthening Medical Infrastructure and Regulations in Low and Middle Income Countries

Introduction

Over the past ten years, debates on global health have paid increasing attention to the importance of health care systems, which encompass the institutions, organizations, and resources (physical, financial, and human) assembled to deliver health care services that meet population needs.²⁰ It has become especially important to emphasize health care systems in low- and middle-income countries because of the substantial external funding provided for disease-specific programs, especially for drugs and medical supplies, and the relative underfunding of the broader health care infrastructures in these countries.²¹ A hospital's overall service delivery environment is heavily influenced by its basic infrastructure.²² This includes the physical structures (buildings) and supporting systems and services (such as power and electricity, water and sanitation, telecommunications) that constitute the fundamental operating platform needed to provide care.²³

Hospitals are complex infrastructures that include many types of resources that should be available and appropriate to the setting and to support the health care professionals serving the target population.²⁴ The safety and availability of specific health services is directly influenced by the availability and functionality of commodities needed to provide those services.²⁵ These include basic equipment and furniture such as beds as well as complex medical technologies/devices needed for effective diagnosis and treatment of specific conditions.²⁶ They also include other equipment and technologies needed for shared or cross cutting functions and services such as energy, ventilation, medical gases, refrigeration systems, information, communications and technologies (ICT systems).²⁷ Other infrastructure needs include kitchens, laundry services, storage areas, waiting rooms, and patient rooms.²⁸

Ensuring the resilience of this core infrastructure to external shocks, such as those arising as a result of natural disasters or other acute events, is of paramount importance for ensuring the continued and safe provision of essential health services.²⁹ The ability of health services to be delivered by critical infrastructure such as health facilities without interruption in these situations is a matter of life and death.³⁰ It is one of the targets of the Sendai Framework for Disaster Risk Reduction 2015-2030 “to substantially reduce disaster damage to critical infrastructure and disruption of basic services, among them health and educational facilities, including through developing their resilience by 2030.”³¹

²⁰ Mills, Anne, S. Hoehl, M. L. Holshue, N. Zhu, and London School of Hygiene and Tropical Medicine. “Health Care Systems in Low- and Middle-Income Countries: NEJM.” *New England Journal of Medicine*, February 18, 2020. <https://www.nejm.org/doi/full/10.1056/nejmra1110897>.

²¹ *Ibid*

²² “Infrastructure and Technologies.” World Health Organization. World Health Organization, October 4, 2018. <https://www.who.int/hospitals/infrastructure-and-technologies/en/>.

²³ *Ibid*

²⁴ *Ibid*

²⁵ *Ibid*

²⁶ *Ibid*

²⁷ *Ibid*

²⁸ *Ibid*

²⁹ *Ibid*

³⁰ “Making Hospitals Safe in Emergencies.” World Health Organization. World Health Organization. Accessed February 22, 2020. <https://www.who.int/activities/making-health-facilities-safe-in-emergencies>.

³¹ *Ibid*

History

Health systems continually improve based on new technologies, regulations, and research. Such improvements can be traced to information provided by global organizations that write guidelines and information for the Member States they represent. These improvements include the promotion of a new way of establishing relationships between the Member State and NGO's to develop infrastructure, fund salaries, and provide services. One example of this is in Cambodia where prior to 1999, the health system had flaws with maintaining the hospital and its staff; citizens could not afford treatment due to high out-of-pocket costs, drugs were scarce and mortality rates were considered high. However, after Cambodia adopted a system of "relational contracts" or less detailed agreements between parties that focus on how each party will benefit, thus establishing how it is in both parties' interests that the agreements are fulfilled. This form of agreement is different from a traditional commercial contract which focuses on which party will provide a service and which will receive it. Relational contracts are also easier to establish since it accounts for weaker legal systems and may be done with international aid organizations.

These improvements can be attributed to previous advancements in the guidelines available to hospitals such as the Hospital Safety Index, first published by WHO in 2008 and the Medical Device Regulations Global Overview and Guiding Principles, first published in 2003. The Hospital Safety Index tool was first created to establish universal standards by which hospitals can be measured. This step-by-step evaluating tool puts together information and recommendations from governments, ministries of health, and private and public hospitals from across six regions to prevent disasters and promote higher quality healthcare. This guide was established to implement the central theme present in the 2005 Hyogo Framework for Action of 2005 which works to "promote the goal of 'hospitals safe from disasters' by ensuring that all new hospitals are built to a level of safety that will allow them to function in disaster situations and implement mitigation measures to reinforce existing health facilities, particularly those providing primary health care."³²

Current Situation

The quality, quantity and accessibility of economic infrastructure in low-income developing countries (LIDCs) lag considerably behind those in advanced and emerging market economies along many dimensions, from electricity generation to access to sanitation and use of ICT services, with the gap particularly large in the power sector.³³ Firm-level data compiled by the World Bank as part of the Enterprise Surveys confirm the presence of large gaps in access to electricity, water, and transportation infrastructure, and indicate that such gaps are an actual constraint on real economic activity.³⁴ The percentage of firms in LIDCs that identify access to electricity and transportation as a major constraint to their business activity is, respectively, 43 and 24 percent.³⁵ By contrast, the same percentages are 32 and 18 per cent, respectively, in emerging markets (EMs).³⁶ Focusing on access to electricity, 74 percent of firms in LIDCs experience power outages—compared to 53 percent in EMs.³⁷ Furthermore, the average firm in LIDCs experiences 11 power outages per month, which averages to a cost of 7.1 percent of annual sales. In contrast, EM firms experience 4.3 power outages per month, which cost an average of 3.4 percent of annual sales.

³² Ibid.

³³ Gurara, Daniel, Klyuev, Vladimir, and Andrea F. "Trends and Challenges in Infrastructure Investment in Developing Co..." *International Development Policy | Revue internationale de politique de développement*. Institut de hautes études internationales et du développement, February 8, 2018. <https://journals.openedition.org/poldev/2802>.

³⁴ Ibid

³⁵ Ibid

³⁶ Ibid

³⁷ Ibid

A major problem in low- and middle-income countries is lack of financial support for those who need health care, deterring service use and burdening household budgets.³⁸ On average, almost 50 percent of health care financing in low-income countries comes from out-of-pocket payments, as compared with 30 percent in middle-income countries and 14 percent in high-income countries.³⁹ When payments from general government expenditures, social (public) health insurance, and prepaid private insurance are combined, only 38 percent of health care financing in low-income countries is combined in funding pools, which allow the risks of health care costs to be shared across population groups, as compared with approximately 60 percent in middle-income countries and 80 percent in high-income countries.⁴⁰ Thus, the key financing issue for low- and middle-income countries is how to provide increased financial protection for households. The part of the population in the formal sector of employment, in which payroll taxes can be levied, could be included in social insurance arrangements.

Meanwhile, National Regulatory Authorities (NRAs) play a vital role in the health care system by providing regulatory oversight of all medical products such as medicines, vaccines, blood products, traditional or herbal medicines and medical devices.⁴¹ The RSS team helps Member States strengthen regulatory systems through a variety of approaches including the assessment of regulatory functions using a standardized tool and the creation of an institutional development plan (IDP) designed to bring each NRA up to benchmarked international standards; direct technical assistance based on country IDPs; and support for information and work-sharing arrangements made possible through the implementation of harmonized standards and best practices and the creation of regional and global regulatory networks.⁴²

WHO has a mandate, as outlined in the World Health Assembly (WHA) Resolution 60.29 “to encourage member states to draw up national or regional guidelines for good manufacturing and regulatory practices, to establish surveillance systems and other measures to ensure the quality, safety and efficacy of medical devices and, where appropriate, to participate in international harmonization”.⁴³ In addition, The 67th WHA approved the resolution “Regulatory system strengthening for medical products.” It states the importance of regulations for medical devices as one of the medical products, for better public health outcomes and to increase access to safe, effective and quality medical products. The complete text of the Resolution, in the 6 WHO official languages are available.⁴⁴ A reinvigorated commitment was shown at the Global forum to improve developing country access to medical devices that was hosted in Bangkok, Thailand in late 2010.⁴⁵ The Forum hosted more than 350 leading health experts from over 100 countries to review new evidence and agree ways to improve developing country access to life-saving medical devices.⁴⁶

Actions Taken by the United Nations

WHO’s involvement in all aspects of health and health systems constitutes a real comparative advantage.⁴⁷ It is better placed than many other international agencies to identify competing demands across health priorities, and

³⁸ Mills, Anne, S. Hoehl, M. L. Holshue, N. Zhu, and London School of Hygiene and Tropical Medicine. “Health Care Systems in Low- and Middle-Income Countries: NEJM.” *New England Journal of Medicine*, February 18, 2020. <https://www.nejm.org/doi/full/10.1056/nejmra1110897>.

³⁹ Ibid

⁴⁰ Ibid

⁴¹ “Regulatory System Strengthening.” World Health Organization. World Health Organization, January 16, 2018. <https://www.who.int/medicines/regulation/rss/en/>.

⁴² Ibid

⁴³ “Regulations.” World Health Organization. World Health Organization, February 20, 2019. https://www.who.int/medical_devices/safety/en/.

⁴⁴ Ibid

⁴⁵ “Global Forum to Improve Developing Country Access to Medical Devices.” World Health Organization. World Health Organization, December 11, 2010. https://www.who.int/mediacentre/news/notes/2010/medical_devices_20100908/en/.

⁴⁶ Ibid

⁴⁷ “WHO Health Systems Strategy.” World Health Organization. World Health Organization, June 8, 2011. <https://www.who.int/healthsystems/strategy/en/>.

to understand how efforts to strengthen health systems affect services on the ground.⁴⁸ WHO's safe health facilities' program supports Member States in developing national policies and regulations on ensuring health facilities remain safe from the affects of natural and man-made disasters; protect the lives of the occupants of a health facility; protect the economic investment as well as the functionality of both new and existing health facilities and those identified as priorities (e.g., hub hospital) within the health services network; compile, organize and monitor the implementation of policies as well as national and international regulations on safe health facilities; and make health facilities safe, energy-efficient and resilient to future risks, including climate change.⁴⁹

The Pan American Health Organization, under the United Kingdom's Department for International Development (DFID) funded Smart Hospitals Initiative, developed a comprehensive Toolkit which provides guidance on achieving a balance between safety and an environmentally-friendly setting in health care facilities in the Caribbean, thus contributing to the goal of climate-smart and disaster-resilient hospitals – a balance that is achieved by targeting interventions that lessen the vulnerability of health facilities to natural hazards and the potential effects of climate change, while reducing their carbon footprint as well.⁵⁰ Health care facilities are most efficient when they link their structural and operational safety with green interventions, at a reasonable cost-to-benefit ratio. The Toolkit is composed of previously developed instruments such as the Hospital Safety Index, which many countries are using to help ensure that new or existing health facilities are disaster-resilient.⁵¹ The Green Checklist and other accompanying tools support the Safe Hospitals Initiative and will guide health officials and hospital administrators in achieving effective health care facilities.

The Hospital Safety Index developed by WHO is a tool used by health authorities and multidisciplinary partners to gauge the probability that a health facility will continue to be safe and operational in emergency situations.⁵² This tool includes evaluation forms, a guide for evaluators and a safety index calculator.

Conclusion

Strengthening medical infrastructure and regulations in low and middle income countries is vital for the United Nations to reach SDGs 3, 9 and 11. Formulating explicit prioritized strategies for research regulations and development at country and regional and inter-regional levels represent paramount importance for the World Health Organization. Supporting policies that will promote innovation based on traditional medicine within an evidence-based framework in accordance with national priorities and taking into account the relevant provisions of relevant international instruments as well as the establishment and consolidation of mechanisms for ethical review in the research and development process, including clinical trials, are crucial to address this issue

Committee Directive

In discussion of how Member States can strengthen medical infrastructure and regulations in low and middle income countries, Delegates should consider the following questions: How can Member States improve current policies for medical regulations and infrastructure agreements? How can low and middle income Member states advance their integration in the developing of infrastructure? How can Member States ensure effective medical regulations?

⁴⁸ Ibid

⁴⁹ "Making Hospitals Safe in Emergencies." World Health Organization. World Health Organization. Accessed February 22, 2020. <https://www.who.int/activities/making-health-facilities-safe-in-emergencies>.

⁵⁰ Munoz, Charo. "PAHO/WHO Health Emergencies - Smart Hospitals: PAHO/WHO." Pan American Health Organization / World Health Organization. Accessed February 22, 2020. https://www.paho.org/disasters/index.php?option=com_content&view=article&id=1742:smart-hospitals-toolkit&Itemid=1248&lang=en.

⁵¹ Ibid

⁵² Ibid

II. Sustaining Healthcare Accessibility in Conflict Zones

Introduction

As experienced by many people in Member States across the globe, their right to access health care under International Humanitarian Law is at risk due to the unpredictability and lack of a supply food chain within conflict zones. Over 2 billion people live in fragile conflict zones, where there is little to no access to food, water, sanitation, and healthcare⁵³. WHO defines attacks on health care as “any act of verbal or physical violence or obstruction or threat of violence that interferes with the availability, access or delivery of curative and/ or preventive emergency health services.”⁵⁴ Deeply rooted in the United Nations Sustainable Development Goal (SDGs) 3 and 16: is the issue of attacks on health systems and personnel in situations of conflict is crucial to the achievement of equal access to health care and inclusivity. The 16th SDG promotes just, peaceful and inclusive societies, and SDG 3 aims to ensure healthy lives and promote wellbeing for all.

The term medical neutrality refers to a globally accepted principle derived from International Human Rights Law and Medical Ethics (IHL) based on non-interference principles with any medical services in times of armed conflict and civil unrest and allows physicians and aid personnel freedom to care for the sick and wounded regardless of political affiliation – allowing humanitarian aid workers into conflict zones.⁵⁵ The targeting of medical and humanitarian workers during conflict has also been termed “irregular violence” by academics.⁵⁶ “Since 2014, over 1500 medical workers have been attacked, many more have been threatened, injured, or suffered kidnapping and torture.”⁵⁷

Areas of conflict not only disrupt the healthcare system through deliberate acts of violence or coordinated military attacks on hospitals and supply chains; but the threat of violence or kidnapping leads to an “exodus” of doctors and reduces the likelihood of patients seeking immediate medical care. In turn these problems make current medical facilities unsustainable and could lead to their total collapse even without direct attacks on their hospitals, -this is due to complexities of modern medicine and the necessity of emergency care facilities, consistent supply of medical equipment, medicines, and physicians to effectively care for patients.

Current Situation

According to WHO in 2019 over 1000 confirmed attacks on health care have been identified within emergency- conflict heavy countries. Such deprive people of urgently needed care, endanger health care providers, and undermine health systems.⁵⁸ The UN WHO Attacks on Health Care, developed in initiative aims to ensure that health workers everywhere are able to provide health care in a safe and protected environment without disruption from acts of violence. This initiative has three main pillars of work: systematic collection of evidence of attacks, advocacy for the end of such attacks, and the promotion of good practices for protecting health care from attacks.⁵⁹

⁵³ Ibid.

⁵⁴ “Stopping Attacks on Health Care.” World Health Organization

⁵⁵ Druce, Philippa

⁵⁶ Ibid

⁵⁷ UCDP, 2018

⁵⁸ “Stopping Attacks on Health Care.” World Health Organization

⁵⁹ Ibid

Action Taken By the United Nations

In 2012 the WHA adopted resolution 65.20 which requested WHO to provide global leadership in the collection of information on attacks on health care, called the Attacks on Health Care initiative⁶⁰. The initiative collects evidence in two main ways: Surveillance System for Attacks on Health Care (SSA), which provides WHO with real time data through the help of WHO country offices and partners on the ground in conflict zones⁶¹. The second way the initiatives reports attacks is by using secondary data in Members states where primary collection is not yet possible⁶². The WHO Surveillance System for Attacks on Health Care (SSA) separates attacks into six impact categories, which describe what the targets of these attacks are and how they affect citizens' access to healthcare. The SSA impact categories are: Facilities, Patients, Transport, Supplies, Personnel, and Warehouses all of which are extremely important pieces of every health care and emergency care systems.⁶³

While SSA does collect and confirm very informative information WHO does not collect nor verify information on perpetrators of attacks on healthcare as it is not within WHO's mandate nor their capacity to address the question of perpetrators of such attacks.⁶⁴ WHO's objective is not to instigate action in relation to attacks on healthcare, but to increase awareness of the issue through highlighting the extent and consequences of these issues, so as to prevent attacks from ever occurring in the first place.⁶⁵

The UN Security Council's Resolution 2286 was adopted in 2016 and it strongly condemned attacks against medical facilities and personnel in conflict situations, this was the start of formal international condemnation of such attacks not connected to the SDGs or International Human Rights law already in place. In June of 2019 the UN Security Council adopted resolution 2475, unanimously, which calls on both Member States and warring parties to ensure the protection and care of all persons with disabilities, allowing them access to justice, basic services, and unhindered humanitarian aid.⁶⁶

Case Study health in Syria

Following the adoption of UN Security Council resolutions 2139, 2165 and 2191, humanitarian actors operating inside Syria from Damascus and from neighboring countries launched the "Whole of Syria" (WOS) approach to develop a coherent response to prioritize humanitarian medical emergency needs through in-country and cross border operations.⁶⁷ A Cross-Border Task Force in Jordan operates under RC/HC's stewardship, and has been established as a senior strategic and decision-making body to oversee strategic coordination of cross border activities as part of the WOS approach. The Health Cluster Hub in Syria is composed by the partners who "actively contribute to the Health Response in South of Syria, following the Humanitarian Principles and Health response standards. It has monthly meetings and is led by the World Health organization WHO and International Rescue Committee IRC."⁶⁸

WHO is working globally through regional centers and by coordinating with local and national health organizations already in areas of conflict. It has led the humanitarian Health Cluster in Syria since civil war broke out

⁶⁰ Ibid

⁶¹ Ibid

⁶² Ibid.

⁶³ WHO. "Surveillance System For Attacks On Health Care (SSA)."

⁶⁴ Ibid.

⁶⁵ Ibid.

⁶⁶ <https://www.un.org/press/en/2019/sc13851.doc.htm>

⁶⁷ OCHA UN "Welcome To The Jordan Cross Border Health Cluster Hub Web"

⁶⁸ Ibid.

in 2011⁶⁹. WHO is supporting Health in Syria by detecting and responding to disease outbreaks, delivering medical supplies despite insecurity, damaged roads, bureaucratic obstacles, and import restrictions, reaching vulnerable populations, restoring local health care, training health workers, ensuring mental health services are accessible, supporting Syrians with disabilities, and through health coordination to increase efficiency⁷⁰. “Since the onset of the crisis the average life expectancy has fallen by 20 years.”⁷¹

Former WHO public health officer from Syria, reported that the majority of the health centers and major public hospitals in Syria were either destroyed and/or taken over by armed groups. He described the situation as an exodus of doctors early in the conflict due to threats, risk of kidnapping, or death.⁷² An estimated 15,000 doctors have fled Syria over three years, according to a report released Feb. 2, 2014 by Physicians For Human Rights [PHR], “representing half of the certified physicians in a country whose medical system was once the envy of the Arab world”.⁷³

Those who escaped left behind a horrifying medical crisis. According to WHO, more than half of Syrian hospitals have been destroyed or severely damaged and Syria’s largest city, Aleppo, once at around 6,000 doctors, only 250 remained as of July 2013, serving a population of 2,500,000.⁷⁴ In the Damascus suburbs, a pre-war population of 1,000 doctors had been cut down to 30 by December of 2013.⁷⁵

Conclusion

The Crisis in Syrian and in many parts of the world can not be solved immediately, but steps to provide all citizens caught in the crossfire, on all sides, with healthcare and human dignity can be put in place. Humanitarian and health care workers must be allowed access to equipment, water and all those in need of treatment or assistance.

Committee Directive Questions

How have the rules of war changed to allow for humanitarian and health related aid and how are they not working?
How can aid be provided in un-recognized or “cold” conflicts which are not named by member states as conflicts?

⁶⁹ 8 ways WHO supports health in Syria (2019)

⁷⁰ Ibid.

⁷¹ <https://www.who.int/health-cluster/countries/syria/en/>

⁷² Baker A. Syria’s health crisis spirals as doctors flee. Time. 2014.

⁷³ Ibid.

⁷⁴ WHO - Donor update The Syrian Arab Republic 9 April 2013

⁷⁵ Baker A. Syria’s health crisis spirals as doctors flee. Time. 2014.

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