Amity International Model United Nations 2025

World Health Organisation

BACKGROUND GUIDE

Letter from the Executive Board

Greetings Esteemed Delegates,

This study guide is not intended to mark the conclusion of your research, but rather to serve as a foundation upon which you may explore further dimensions of the agenda. We encourage you to identify new perspectives, nuanced aspects, and unexplored avenues, and bring these forwards for the enrichment of the committee's deliberations.

It is the combination of rigorous research, cogent argumentation, and the accurate presentation of facts that constitutes an outstanding contribution. In our sessions, the Executive Board will encourage frequent and substantive participation. Please remember that it is the depth of your content, rather than the flourish of your oratory, that will ultimately strengthen your case and earn the respect of your peers.

Approach this with sincerity and curiosity. Speak with clarity, grounded in evidence. If you do so, your interventions will invariably resonate with reason and purpose. We are confident in your abilities and equally certain that we will learn from your insights, just as we hope you will find this engagement intellectually rewarding.

Should you seek clarification or guidance, do not hesitate to reach out. We will endeavor to respond with promptness and in a manner that advances your preparation.

We look forward to presiding over discussions that are both stimulating and meaningful, a committee where the very nature of the issue at hand allows for rich debate and impactful proposals. It is our hope that the exchange here will benefit all, including the Executive Board, for such dialogue is inherently reciprocal.

We wish you the very best for a thoughtful, informed, and productive session.

With regards,

Executive Board

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What is the World Health Organisation?

Mandate

The World Health Organization (WHO) is a specialised agency under the United Nations with a mandate to administer and regulate international public health affairs. It came into existence on 7 April 1948, under its constitution that sets out the main objectives that it aims to achieve:

- To improve global health and well-being.
- To administer international health programs and provide advice on issues on global health.
- For setting standards and disease prevention, treatment, and health care system norms.
- To properly handle health threats and address emergencies, including pandemics and epidemics.
- To help countries build more robust health systems and attain universal health coverage.

All WHO member states commit to working together to implement its recommendations and policies in the interest of promoting global health outcomes. Although other health agencies may make recommendations to governments, the WHO is empowered to issue international health emergencies of public interest (PHEICs) and call for international action.

Functions

In the occurrence of a health hazard, the WHO first assesses the situation and then provides advice to the concerned countries. This includes:

- Establishment of technical guidelines for disease prevention and disease control.
- Sending of specialized teams to help investigate outbreaks.

- Gathering research to accelerate vaccine and treatment development.
- Raising funds and resources to assist affected regions.

In instances of mass health emergencies, like pandemics, the WHO can:

- Declare a Public Health Emergency of International Concern (PHEIC) to trigger an international coordinated response.
- Develop global partnerships for the delivery of medical equipment and vaccines.
- Track travel and trade restrictions in order to limit disruption in managing disease transmission.

Apart from direct responses, the WHO formulates long-term health strategies like:

- Disease eradication programs (e.g., polio, malaria).
- Health policy formulation (e.g., nutrition policy, tobacco control policy).
- Enhancing healthcare systems in developing countries.

A primary objective is to guarantee that health interventions effectively reach at-risk populations while simultaneously reducing economic and social disturbances.

Structure

The World Health Organization's first assembly took place in 1948 in Geneva, Switzerland, and it continues to have its headquarters there. It functions through:

- Regional offices (Africa, Americas, Europe, Eastern Mediterranean, South-East Asia, Western Pacific).
- Country offices offering direct assistance to member states.

WHO is also tasked with the annual World Health Assembly (WHA), during which every member state is represented and policies determined, and budgets approved, as well as having a network of partners and experts to help it respond to health emergencies around the world quickly.

Link: https://www.who.int/about

Acceptable Proof of Evidence

1. Government Ministries and Their Reports - Places from where the official business of any governmental authority is transacted and allocated, including those of subordinate tiers of government.

   Examples: Ministry of External Affairs, Government of India; United States Department of State. Centers for Disease Control and Prevention (USA); Public Health Agency of Canada; Office for National Statistics (UK).

2. State Operated News Agencies - Those media platforms which are owned, controlled or managed by the government on an official basis and perform the task of public relations management for the government or its institutions on record.

Examples: Islamic Republic News Agency (ran), Xinhua News Agency (People's Republic of China), TASS (Russia), Anadolu Agency (Turkey).

3. United Nations Reports - all reports of the United Nations such as those of its institutions and subordinate bodies which are funded and administratively controlled by UN staff and personnel.

   Examples: Special Representative Reports, WHO Fact Sheets, Security Council Reports, UN General Assembly Resolutions. This does not include any acts done or statements made by any United Nations staff member in his/her personal capacity.

4. Selective International News Agencies - This is done on a case-to-case basis and primarily includes globally reputed organizations whose editorial standards and credibility have been established over time.

   Examples: Reuters (United Kingdom), Associated Press (United States), Agence France-Presse (France). While these agencies often serve as reliable sources, their content is still subject to scrutiny and challenge within the committee.

5. Peer-Reviewed Academic Journals - Publications that follow recognized academic peer review processes ensuring factual accuracy and expert validation.

   Examples: The Lancet, New England Journal of Medicine, British Medical Journal.

6. Recognized International Organizations - Official documents, statistics, or policy briefs from prominent multilateral or specialized agencies.

   Examples: WHO, World Bank, IMF, UNESCO, UNICEF, OECD, International Labour Organization.

   Important Note:

   Even though the above sources are accepted as credible pieces of information, nothing is beyond the scope of refutation and dispute, as the diplomats (delegates) have the authority to not accept the credibility of the above sources. Subjectivity and interpretation also figure significantly as far as state actions are concerned.

How to Research for an MUN Conference?

- **Know the basics about your country**
  - Where it is located, who its neighbors are, population, economy, government type.
  - Understand whether it is a major power, a developing nation, or dependent on alliances.
- **Understand foreign policy style**
  - Does the country usually support global powers or prefer to stay neutral?
  - Is it part of strong regional groups or international blocs?
  - This helps you know who you can collaborate with in committee.

- **Break down the agenda into simple parts**
    - What exactly is the problem?
    - Who is affected the most?
    - Why is it urgent?
    - How is it connected to your committee's responsibilities?
- **Find your country's stand**
    - Look for past actions, decisions, and statements related to the issue.
    - Check what policies or laws the country has made at home about it.
    - Understand the main interest: security, economy, human rights, development
- **Identify possible allies and opponents**
    - Which countries usually share similar positions?
    - Which ones are likely to go against your stance?
    - Which groups or organizations influence your country's views?
- **Collect real examples and data**
    - Past actions taken on the issue,use conventions and law.
    - Participation in agreements, initiatives, or programs.
    - Any progress, failures, or ongoing challenges.
- **Prepare practical solutions with reference to CASE STUDIES**
    - Suggest actions your country would realistically support.
    - Link them with what has already been done or proposed before.
    - Keep in mind where your country can compromise and where it cannot.
- **Stay updated**
    - Check the latest developments related to your agenda.

    - Be ready to adjust your stance if something significant happens before the conference.
- **Adopt the role of a diplomat**
    - Remember you are speaking as your assigned country, not yourself.
    - Defend your country's position even if you personally disagree.
    - Stay respectful, persuasive, and solution-oriented.

Research Guide – Tackling the Rise of Antibiotic Resistance: A Global Public Health Emergency

Antibiotics have been one of the greatest medical discoveries, saving millions of lives. But their effectiveness is now under serious threat. Around the world, bacteria are becoming resistant to drugs that were once reliable cures. This challenge of **antimicrobial resistance (AMR)** is no longer a distant warning. It is already here, spreading fast, and creating what global health experts call a **silent pandemic**.

Why is Resistance Rising?

Resistance occurs naturally as bacteria adapt, but human behaviour has accelerated the process dramatically. In healthcare, antibiotics are often prescribed when they are not needed for viral infections, for minor illnesses, or in broad doses instead of targeted treatment. Reports show that in some regions, over half of antibiotic use happens without medical supervision.

Over-the-counter sales, self-medication, and incomplete courses of treatment have made the situation worse.

Agriculture is another major driver. Farmers use antibiotics. This constant and widespread use creates ‘selection pressure’ among bacteria and those that survive develop resistance to antibiotics. These resistant bacteria multiply, and eventually find their way into humans through food chains, soil, and water.

Environmental factors also add fuel to the fire. Hospitals with poor infection control, communities with inadequate sanitation, and regions lacking access to clean water all become breeding grounds for resistant microbes.

The Innovation Gap

The problem is magnified in new antibiotic development. Pharmaceutical research has shifted toward medicines that are more profitable, leaving antibiotics underfunded. Very few new classes of antibiotics have been introduced in recent decades, hence resistant bacteria are quickly outpacing scientific innovation.

Policy Frameworks and Global Responses

Recognising the urgency of the problem, the World Health Assembly adopted the WHO Global Action Plan on AMR in 2015. This plan identifies five key objectives: improving awareness and understanding, strengthening surveillance and research, reducing the incidence of infection,

optimising the use of antimicrobial medicines, and developing sustainable investment in new medicines, diagnostics, and vaccines.

- The UN General Assembly reinforced these goals in 2016 through its Political Declaration on AMR, which called for national action plans aligned with WHO's recommendations. However, implementation has been uneven. According to WHO's most recent AMR Progress Report, only about one-fifth of countries have fully funded and operational plans in place.
- The 'One Health' approach — a collaboration between WHO, the Food and Agriculture Organization (FAO), and the World Organisation for Animal Health (WOAH, formerly OIE) — recognises that AMR is a cross-sectoral challenge involving human, animal, and environmental health. This framework promotes coordinated actions across all three domains to slow the spread of resistance.

Global Impact

The impact of AMR extends far beyond the realm of infectious diseases. The World Health Organization warns that without effective antibiotics, common medical procedures such as joint replacements and chemotherapy will become significantly riskier. Post procedural infections could rise sharply, and routine treatments could once again carry life-threatening risks.

The *Global Burden of Disease Study* estimated that in 2019, AMR was directly responsible for over 1.27 million deaths. The *Review on Antimicrobial Resistance* projects that if left unchecked, AMR could cause up to 10 million deaths annually by 2050, surpassing the death toll of cancer.

Economically, the crisis threatens to cost the world up to $100 trillion by mid-century due to lost productivity, increased healthcare expenses, and the strain on medical systems.

This burden falls unevenly across the globe. Low- and middle-income countries bear a disproportionate share of AMR's impact, in part because of weaker healthcare infrastructure, limited access to diagnostic tools, and a higher prevalence of infectious diseases. These same countries often lack strong regulatory frameworks for antibiotic use, making them especially vulnerable to rapid resistance spread. Farmers in these regions often rely heavily on antibiotics to protect livestock, because alternatives are scarce and expensive. This creates a situation where public health goals clash with food security and economic survival.

Key Challenges

Despite these frameworks, numerous challenges hinder progress. Enforcement of existing regulations is inconsistent, especially in countries where antibiotics can be purchased without a prescription. In agricultural sectors, economic dependence on antibiotics for productivity has led to resistance against regulatory restrictions.

Surveillance capacity remains a critical weakness. Many countries lack the laboratory infrastructure to detect and monitor resistant strains effectively, resulting in incomplete data that hampers coordinated action. Disparities in access to healthcare further complicate the issue; in some regions, the lack of affordable medical care pushes people toward informal drug markets, where counterfeit or substandard antibiotics are common.

The debate over intellectual property rights also affects the fight against AMR. While relaxing patent protections could improve access to life-saving drugs in poorer countries, it could also discourage private investment in antibiotic research. This tension between public health needs and market incentives remains unresolved.

Finally, the COVID-19 pandemic revealed how easily healthcare systems can be overwhelmed, leading to increased inappropriate antibiotic use during a viral outbreak. This experience underscores how AMR can worsen during global health crises, amplifying its threat.

Case Studies

Case 1: MRSA Epidemic in the UK and US (1980s–2000s)

MRSA (Methicillin-Resistant Staphylococcus aureus) was a hospital-born 'superbug' that thrived through the excessive use of antibiotics and lack of cleanliness, claiming tens of thousands before stringent containment policies were put in place. It was first detected in 1961 in the UK, only a year after the arrival of the drug. By the 1980s, MRSA had been declared endemic in US and UK hospitals, particularly in ICUs and surgical wards. The gravest consequence, as reported by the US CDC, was a 32% increase in MRSA infections between 1992–2003, with ~94,000 invasive MRSA cases and ~19,000 deaths in 2005 alone.

How was resistance developed?

- Selective Pressure was created because the overuse of methicillin, vancomycin, and cephalosporins in hospitals wiped out susceptible S. aureus, leaving behind only the resistant strains.

- MRSA underwent genetic mutation and acquired the SCCmec gene cassette, allowing it to resist beta-lactams. Later, some strains even developed vancomycin resistance (VRSA).
- Poor hand hygiene, dirty surfaces, and asymptomatic carriers (30% of healthcare professionals) provided transfer routes for MRSA.

Impact

Amongst the worst-affected regions were the United States, the UK, and Japan.

- For instance, in the US, Chicago's Cook County Hospital registered a 176% increase in MRSA infections (1998–2003), in the UK, London's St. Thomas' Hospital reported that 40% of S. aureus isolates were MRSA by 2000, and Japan experienced vancomycin-resistant MRSA (VRSA) outbreaks in 1997.
- At the economic end, the cost per MRSA case came to be $35,000–$40,000 because of longer hospital stays, isolation, etc, burdening the people.
- The Mortality Rate, which was initially merely 20% for bloodstream infections, increased to 50%, more so among older patients.

Resolutions

It was finally managed with smart policy, swift diagnostics, and international collaboration. The UK's 'Clean Your Hands' Campaign (2004) reduced MRSA by 57% within 4 years, while the US VA Hospital MRSA Prevention (2007), with universal screening, reduced infections by 62%.

References: https://www.cdc.gov/mrsa/about/index.html, https://pmc.ncbi.nlm.nih.gov/articles/PMC2871281/

Case 2: MDR-TB Crisis in India & Russia (1990s–Present)

The MDR-TB (isoniazid + rifampin-resistant) crisis in India & Russia was a human-made plague, created by cut-short treatments and counterfeit drugs. It is now spreading uncontrollably in prisons and slums from Mumbai to Moscow. It was first documented in New York City in 1991, but exploded in India, Russia, and South Africa by the 2000s. Among the worst hit places were Mumbai, India (2012), when 12 of 15 TB patients in one hospital had drug-resistant TB (TDR-TB) untreatable with known drugs, and Russian Prisons in the 1990s, where at least 10% of inmates would develop MDR-TB due to cramped conditions and interrupted treatment.

How was resistance developed?

- Cut-short Treatments, e.g., Indian TB programs with only 60–70% treatment completion rates (the 1990s), enabled survivors to grow resistant.
- The consumption of Fake/Counterfeit Drugs promoted resistance. For instance, Up to 10% of TB medication in India during the 2000s was substandard
- Overuse of Fluoroquinolones for minor infections inadvertently led to resistant TB strains.

Impact

- In India (2015), we see 130,000 MDR-TB cases per year with 25,000 deaths.

- Around the same time, Russia (2019) reports that 40% of the new TB cases were MDR-TB. Presently, this figure is the highest in the world.
- This disproportionately affects the poor as the treatment cost for normal TB was $3,500 as compared to $250,000 for XDR-TB, which is an even more advanced form of antibiotic resistance.

Current Situation

- Diagnostic Delays, like the GeneXpert tests which were introduced in 2010, are helping tackle the resistance better, but rural areas still rely on slow microscopy for diagnosis.
- There are Second-Line Drug Shortages, such as Mumbai still only managing to treat 5% of the MDR-TB patients.
- India's New TB Program (2017), with free diagnostics and $500 million capital, has contributed to lowering MDR-TB by 12% from 2017 to 2021.
- The finding of Bedaquiline in 2012, a new TB drug in 40 years, better addressed resistant strains, but resistance to the same has already begun to emerge according to new reports.

References: https://journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0174373, https://www.who.int/teams/global-programme-on-tuberculosis-and-lung-health/tb-reports/global-tuberculosis-report-2023/tb-disease-burden/1-3-drug-resistant-tb

Questions to Consider

1. What measures will the committee use to verify countries' claims of following international guidelines when their data on antibiotic use and resistance are incomplete,

unclear or even false? If this data is found to be false, what can the committee do to ensure compliance with the particular country's international obligations?

2. When countries refuse to share antibiotic usage data citing privacy or commercial secrets, how should the committee balance these concerns with the need for global health security?
3. How can the committee encourage better cooperation and coordination between human health, agriculture, and environmental sectors to effectively tackle antibiotic resistance?
4. How can the committee ensure that the countries who are claiming a lack of adequate funding are able to access and use the resources available at the disposal of WHO to fight antibiotic resistance?
5. What authority does the committee have to step in and coordinate responses to antibiotic resistance outbreaks that cross borders, especially if a country resists external help for political reasons?
6. What is the role of the pharmaceutical industry in the spread of antibiotic resistance, and how can the committee work with industry to promote responsible use, fair pricing, and better access?