EuroMUN 2017, Maastricht, The Netherlands

Study Guide for the World Health Organisation (WHO)

Tackling the global issue of child malnutrition through social reform, food production and distribution of Lunch

Establishing a strategic coordination mechanism between state and non-state actors in medical emergencies

Introduction to the Chairs

Raviya Mysorewala

Dear Delegates,

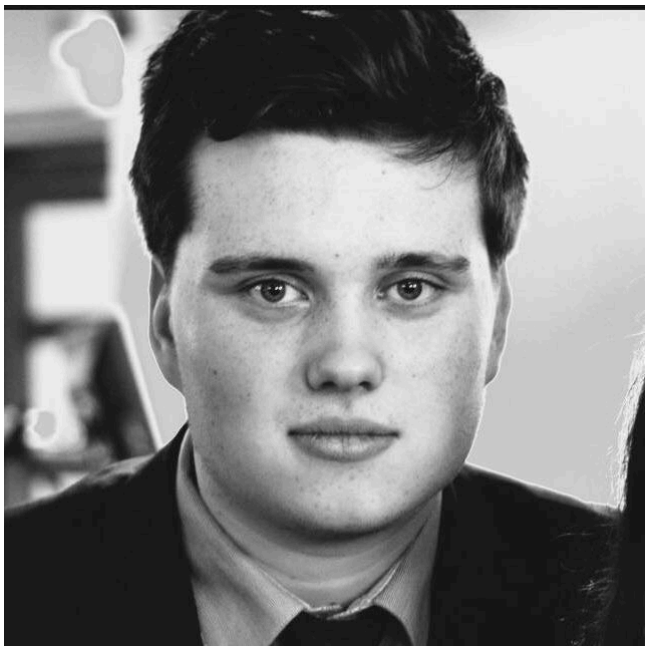
It is with utmost pleasure that I welcome you to the World Health Organization (WHO) at EuroMUN! My name is Raviya Mysorewala and I am really looking forward to be serving as your chair.

I'm currently a third year undergraduate student at the Institute of Business Administration, Karachi, Pakistan, studying Political Science. My MUN journey began in 2009 when I was in high school and I have participated in several national and international MUNs ever since. This will be my second time at EuroMUN and I am sure that the conference will be just as amazing as last year.

The World Health Organization and its topics are very crucial and relevant today. Therefore, I hope to see delegates indulging in substantive and high level debate, collaborating with others and making diplomatic efforts to bring forth comprehensive and practical solutions to the problems faced by WHO and the global community.

I am really excited to meet you all in April, and hope to provide you with an enriching and memorable experience. Please feel free to reach out to me with any questions!

James Clegg



Hello everyone. I am delighted to be chairing this committee and would like to welcome you all to the WHO. This will be my 4th time chairing a university-level MUN conference, and my 1st time chairing this conference.

My name is James Clegg and I am currently a Research Masters student in European Studies at the University of Maastricht, in the Netherlands. I am relatively well experienced as a delegate, as EuroMUN2017 will be my 13th career conference, and my 3rd EuroMUN (2014 & 2015). This means that I know what makes a great committee, or at least I hope I do, and try and keep it as entertaining as possible for all those who are involved, whether in the committees or the socials.

I believe that MUN is a good way for people to learn how to solve real life problems and tackle diplomacy in a fun environment and hope that the topics which we have picked enable you to do so. This is why I am very excited to chair at this year's EuroMUN and look forward to seeing all of you all in April.

Introduction to the Committee

The World Health Organization (WHO) was created on April 7th, 1948. As a specialized agency of the United Nations that is headquartered in Geneva, Switzerland, the WHO is responsible for maintaining international public health. A number of actions defined the role of the World Health Organization in global health and international affairs, and confirmed its validity as the premier international public health organization. . The illustrious history of the WHO includes the eradication of smallpox, reductions in child mortality, and horizontal primary healthcare initiatives. More recently, the WHO has held policy priorities of combatting communicable diseases including HIV/ AIDS, tuberculosis, and malaria. It is looked upon favorably for its encouragement of breastfeeding and immunizations for children in developing countries. By promoting community solutions and sustainable development approaches over hospital based healthcare, the WHO has impacted public health medicine and the delivery of medical services in both developing and developed nations.

Currently, the WHO is composed of 194 UN member states (excluding only the Cook Islands, Liechtenstein, and Niue) that appoint delegations to the World Health Assembly, the WHO's decision-making body that meets annually in Geneva, Switzerland. Many of the WHO's actions, suggestions, and policies can be enacted due to its extensive partnerships and collaborations, and the abundant resources they provide. The WHO has had 189 official partnerships. Some key partnerships include Oxfam International, and the Bill and Melinda Gates Foundation. Additionally, the WHO makes full use of the organs, programmes and agencies within the UN system that are related to health. In the coming years, it hopes to make progress in many realms, from reducing the global burden of non-communicable diseases, to implementing post-2015 strategic framework with regards to the 2015 UN Millennium Developmental Goals.

Topic A: Tackling the global issue of child malnutrition through social reform, food production and distribution of Lunch

What is Malnutrition?

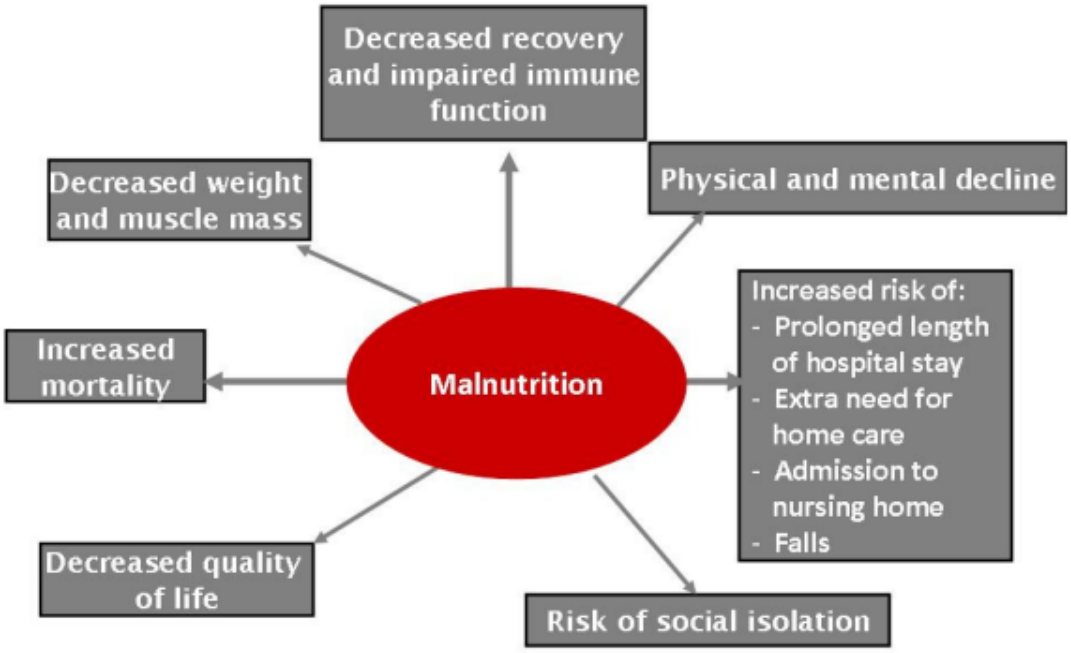
Malnutrition is "a broad term commonly used as an alternative to under nutrition but technically it also refers to overnutrition. People are malnourished if their diet does not provide adequate calories and protein for growth and maintenance or they are unable to fully utilize the food they eat due to illness (undernutrition). They are also malnourished if they consume too many calories (overnutrition)" (UNICEF). There are 170 million underweight children globally, 3 million of whom will die each year as a result of being underweight. Additionally, worldwide at least 20 million children under five years of age are overweight (WHO)

Discussion of the Problem

It is estimated that child malnutrition contributes to more than one-third of all the child deaths (WHO). For those who do survive, malnutrition can have lifelong irreversible effects on the cognitive and physical development of a child (Richards and Bellack, 2016). To further elaborate, there is evidence which shows that between the conception and a child's second birthday, it is important that he/she is provided the right nutrition since it can impact his/her structural and functional development. During this period, malnutrition can not only affect their cognitive development but can and can affect the ways children learn, their ability to interact and engage with the world (Save the children, 2013). It can also lead to stunted growth and decreased immunity resulting in greater vulnerability to diseases (Jonkers et al, 2011).

The need to tackle child malnutrition

As stated earlier, malnutrition is not only linked to the functional and structural development of a child but can have far reaching consequences as well. Evidence shows that malnourished children earn 20% less as adults than children who are well nourished (McGregor S, 2007). The impact of malnutrition on cognitive development and physical health can lock children into poverty. Malnutrition, in this case, can act as an obstacle to economic growth. According to the World Bank, improving nutrition enough to eliminate anaemia in working adults results in a 5–17% increase in adult productivity, increasing the national income growth by up to 2%. Nutrition has therefore been recognized as a basic pillar for social and economic development and the reduction of child malnutrition is integral to the achievement of the Millennium Development Goals (MDGs) — specifically those relating to the eradication of extreme poverty and hunger (MDG 1) and child survival (MDG 4).

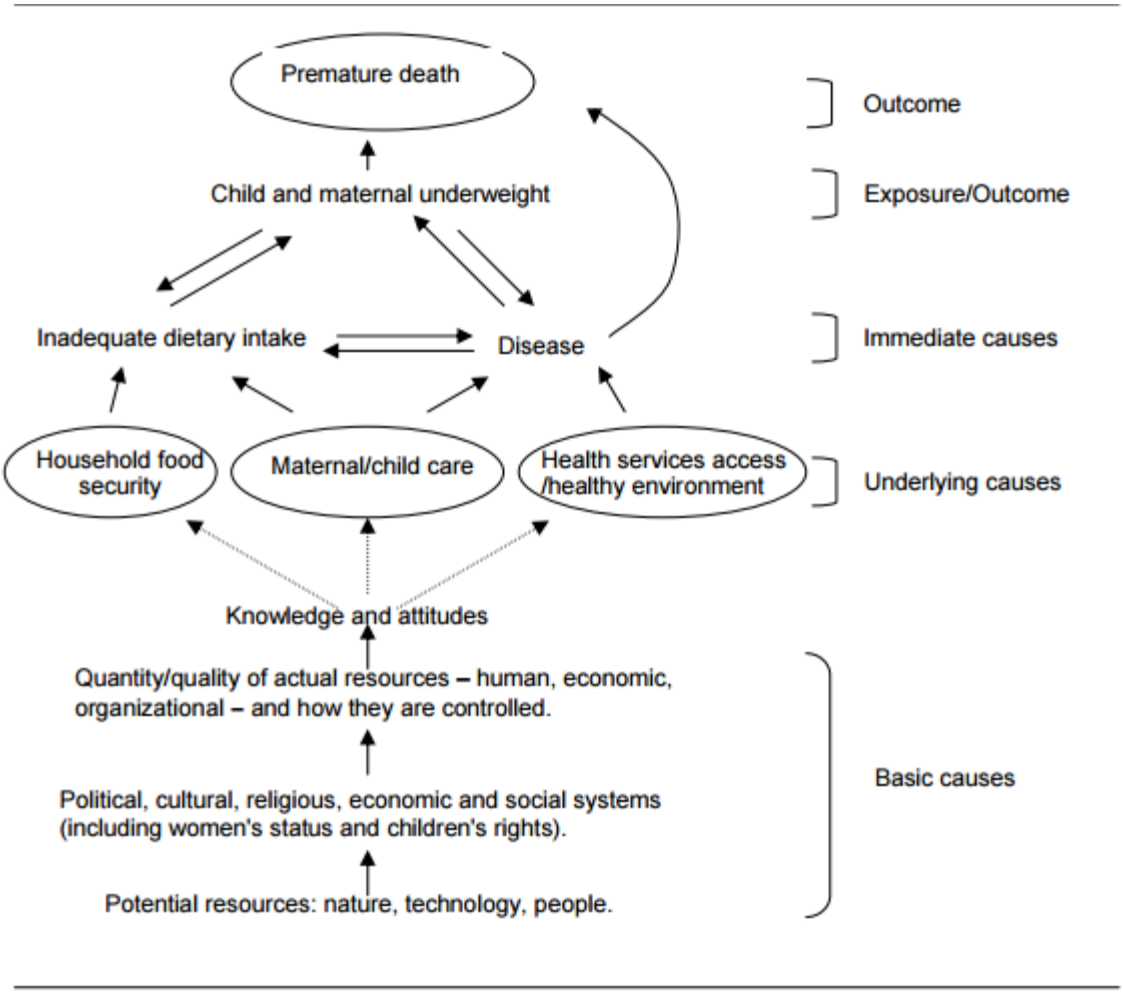


Causes of Malnutrition

There are certain social factors which result in malnutrition in the long term. These are associated with socioeconomic problems such as poverty, illiteracy, lack of awareness regarding the quality of food items, large family and poor sanitary environment (Van de Poel, 2008). According to a Survey held by International Institute of Population Science in Mumbai (2008), malnutrition is found to be 2.7 times higher among families with lower household wealth index. Population growth and political commitment have an indirect effect on malnutrition.

Moreover, although not the main cause but certain cultural practices also influence what people eat, how they prepare food and the type of nutrition they prefer. Some may cause malnutrition and some are particularly designed for better health, such as providing pregnant women with energy-dense food. Hence nutritionists need to be aware of a community's food practices (Lantham, 1997).

Causal Framework for Child Malnutrition



[a] Adapted from UNICEF (1990).

Undernutrition

The causes of undernutrition are inadequate dietary intake and infection. Infection can reduce appetite and increase nutrient requirements whereas insufficient intake of food of the right quality and quantity can make a body more vulnerable to diseases and infection. When lack of food and infection are combined a synergistic interaction can precipitate or worsen undernutrition.

There are however, three main underlying causes
1) inadequate access to food and or/poor use of available food

2) Inadequate child care practices

3) Poor water and sanitation and inadequate health services.

These causes often interact with each other and are underpinned by more basic causes which are rooted

deeply in the political, economic, cultural and religious systems and institutional structures that govern society. (OECD, 2009)

Another problem prevalent amongst children is the problem of protein-energy malnutrition (PEM). In populations where the staple food is a cereal such as rice, wheat, maize or millet, serious protein deficiencies seldom occur except where there is also an energy or overall food deficiency. The reason is that most cereals contain 8 to 12 percent protein and are often consumed with moderate quantities of legumes and vegetables. However, there can be protein deficiencies in children consuming these diets if they are suffering increased nitrogen losses because of frequent infections. However, among populations whose staple food is plantain, cassava or some other food with low protein content, protein intakes may be a problem for many children. Similarly, iron deficiency is another widespread nutritional disorder in the world which is also prevalent in industrialized countries. Two billion people – over 30% of the world's population –are anaemic (Anderson, 2006)

Also an important cause of malnutrition amongst children is malnourished pregnant mothers. Malnourished adolescent girls and women are more likely to give birth to low birth weight infants, who are malnourished in childhood and later life. In the case of girls particularly, there is a risk of them becoming malnourished mothers, thus contributing to the intergenerational cycle of malnutrition which then transfers undernutrition from one generation to the next.

Overnutrition

In the urban populations of many developing countries, there is an increase in the consumption of energy-dense nutrient poor foods (high in fats and sugars and not enough nutrients) and a decrease in physical activity. Social and economic progress has led to the greater consumption of meats, oils and sugars as cheap processed foods while the intake of fruits, vegetables and grains has decreased. This leads to diet related chronic diseases, such as heart disease, stroke, cancer and diabetes, later on when children reach the adult stage.

However, in addition to excess food intake, excess of of a single nutrient e.g. a single vitamin or mineral can also lead to problems of overnutrition. The health consequences of such excess depend on the nutrient and the severity of the excess consumption.

Many a times inadequate infant growth leads to under-nutrition in children in many developing countries, which if followed later in life by an increased intake of calories e.g. carbohydrates, fats, etc., could result in overweight or obesity (WHO)

Social Reform

Access to food, health care and education as a basic human right is included in the MDGs to which all member states of the United Nations (UN) committed themselves in 2000. They provide a strong mandate for action to support food and nutrition programming although the role of nutrition in achieving most of the goals is not well recognized. Both Article 28 of the Political Statement on HIV/AIDS Declaration of Commitment by the United Nations General Assembly Special Session (UNGASS) (UN, 2006 p.4) and a resolution passed by the Fifty-ninth World Health Assembly in 2006 encouraged countries to include nutrition as an integral part of their response to HIV

As establishes earlier, lack of education, lack of healthcare facilities, weak governmental policies and lack of household food security are some of the causes of malnutrition. Hence, when talking about social reform, there needs to be focus on measures which prevent as well as treat malnutrition taking into the

above causes.

Frameworks need to be designed and/or implemented with focus on the role of education, particularly nutritional education and different ways of spreading awareness regarding proper nutritional plans (that would address both the problems of undernutrition and over nutrition), hygienic practices and positive health behaviors. To avoid the exacerbation of the problem by diseases, delegates could also consider discussing ways that could improve the provision and access to better health and sanitation facilities and how can care be provided to those suffering from undernutrition and overnutrition. There also needs to be discussion on ways to increase the access to food by households along with food security granted to them. Global and regional partnerships and coordination in such implementation can also play a vital role.

An example is the Ending Child Hunger and Undernutrition Initiative which includes proposals falling under the following broad frameworks (WFP and UNICEF, 2006)

1) Increased awareness of hunger and undernutrition and understanding of potential solutions;

2) Strengthened national policies and programmes affecting hunger and nutrition;

3) Increased capacities for direct community action on child hunger and undernutrition;

4) Increased efficiency and accountability of global efforts to reduce child hunger and undernutrition, through monitoring and evaluation of the Initiative, programme interventions and impact for children.

Food Production and Food Security

The right to an adequate standard of living, including food, is recognized in the Universal Declaration of Human Rights. It is not only important that children of every household get access to food but it should be ensured that the food has balanced nutrients. For infants, while bottle-feeding can be a major cause of diarrhea and nutritional deficiency, breastfeeding during the first few months of life can ensure an adequate diet. Moreover, for adolescents to there needs to be good quality and safe food. In developing countries an important component of food policy is to improve and increase food production which is a domain for agriculture experts (Lantham, 1997). The decision-makers in this sector need to be aware of the nutritional needs of the children and to understand the nutritional implications of their actions.

Most food in the world comes from cereals and the second largest amount of food comes from root crops, followed by legumes or pulses. More of all these items are produced by developing countries as compared to developed countries. In contrast to this, industrialized countries produce more foods of animal origin like meat, milk and eggs, for example - than do the developing countries (Lantham, 1997).

There has been increased availability of new varieties of cereals such as rice, maize and wheat due to advancements in food production and agricultural research. These new varieties produce much higher yields per hectare than the old varieties but either requires increased fertilizer use or more irrigation, both of which may not be economically feasible for poor farmers. It is important to see that more resource-poor farmers have adequate access to such inputs.

Many countries, which were major food importers, such as India, are now self-sufficient. However, malnutrition still remains a prevalent problem. Countries like Indonesia have reduced malnutrition while making themselves self-sufficient in terms of rice production. However, some countries such as the Caribbean countries have low levels of malnutrition despite the fact that they aren't self-sufficient. They emphasize sugar production for export and choose to pay to import much of their food. However, it should be pointed out that in environments with risky markets, joint promotion of both food and cash crops can help achieve food security.

Furthermore, there is a need to take care of production of certain foods to address the problems of PEM

and iron deficiency. This can be done through an increase in cereal, legume, oil, vegetable and iron consumption by children, especially if combined with control of infectious diseases.

Hence, there is a need to expand agricultural efforts to increase food production and agricultural research can play a huge part in this. Moreover, there is a need a nutritionally adequate food supply at both the household and national level along with stability in food supply throughout the year.

Food security is also an important factor that can help tackle malnutrition along with increased food production. It is important to solve the problem of food storage limits and post-harvest losses due to unsuitable temperatures or insects.

Distribution of Lunch

Another important factor is the public distribution of lunch at school. Nutritional status of children can influence their ability to learn at school and their overall performance. Therefore, access to a nutritious mid-day meal or lunch or snack is important in determining the health status as well as the overall development and well being of school children. Students who have certain deficiency or suffer from protein energy malnutrition do not have the same learning potential as healthy children (WFP. 2006). Therefore, apart from contributing to a child's daily nutrient requirements, meals provided during school hours alleviate short term hunger, increase attention span and facilitate learning (Akanbi, 2010).

Content of lunch pack should supply a third to half of the daily nutrient requirements of school children (Bevans et al, 2011). To obtain the full range of nutrients, a child needs to consume a good variety of foods from different food groups, every day and in the right proportions. Packing adequate meals including fruits and vegetables is also a powerful way for parents to teach their children healthy eating habits and food preferences to support a lifetime of good health (Briley et al, 2012).

There are also government sponsored school lunch programs in many countries which are aimed at ensuring that every school child gets at least one adequate diet daily However, in many countries such as Nigeria, it is the sole responsibility of parents to provide food for their children while in school. On the other hand, more than 94% of schools (both public and private) in U.S.A. participate in the National School Lunch Program, which ensures that every child in school is served a nutritious and balanced meal in compliance with the United States Department of Agriculture dietary guidelines for Americans (Briley et al, 2012).

In many developing countries, mothers often face the challenge of deciding between what the child likes, what is available, affordable, easy to prepare and can remain in good condition after storage for hours in food flasks. Mothers may also be ignorant of how to combine the different variety of foods to meet the nutritional requirements of the school child. Thus, some mothers may resort to packing no lunch, poor quality food or only snacks (Briley et al, 2012). This can result in the over consumption of certain nutrients while under consumption of some, both of which can be harmful.

Some schools above primary level are boarding schools. These usually provide three meals a day, and the menu can be based on recommendations made to the school by someone with dietetics training. Occasionally schools plead lack of money as an excuse for an inadequate diet. School meals need not be luxurious, but they should be balanced and should provide all the nutrients necessary for growth and health such that problems of under nutrition, and over nutrition are avoided. (Lantham, 1997).

Moreover, in many areas, particularly urban areas, entrepreneurs set up stalls near schools so they can prepare and sell foods to school children. This "street food" often has the advantage of providing access to cooked foods at relatively low cost, but the disadvantages include poor hygiene, poor-quality food and high prices. Where the main source of a midday snack or meal for primary or secondary schoolchildren is a vendor, the food is available only to children who have money to purchase it. Often the wealthier

children participate and the children from the poorest families, or those whose parents will not provide money, do not (Lantham, 1997).

In many countries like the United States of America, there is also distribution of "engineered foods" The Secretary of Agriculture issues guidelines to the State educational agencies on the use of engineered foods in the school lunch and breakfast programs. Overall requirements are: "(a)that the food product be on the market or be intended for the commercial market in a form similar to traditional foods; (b) that there be adequate evidence that the new or modified foods contribute to improved nutrition; (c) that the new or modified foods be as acceptable and will cost the same or less than traditional alternatives." (Rorex, 1970). Engineered food are defined by its Department of Agriculture as "those foods which are so prepared and processed that they: improve nutrition, reduce cost, offer greater convenience in meal preparation, improve acceptability, and improve stability."

Past Examples of Tackling Child Malnutrition

India

In 2005, in response to reports of child deaths from undernutrition in a number of districts, India launched the Rajmata Jijau Mother-Child Health & Nutrition Mission. The State Nutrition Mission began by working to improve the effectiveness of service delivery through the Integrated Child Development Services and the National Rural Health Mission. Their focus was on filling vacancies in key personnel, particularly front-line workers and supervisors, and on improving their motivation and skills to deliver timely, high-quality services in communities.

Results the Comprehensive Nutrition Survey which assessed the progress of this programme in Maharashtra indicated that prevalence of stunting in children under 2 was 23 per cent in 2012 – a decrease of 16 percentage points over a seven-year period. Progress was associated with improvements in how children were fed, the care they and their mothers received, and the environments in which they lived. From 2005–2006 to 2012, the percentage of children 6 to 23 months old who were fed a required minimum number of times per day increased from 34 to 77 and the proportion of mothers who benefited from at least three antenatal visits during pregnancy increased from 75 to 90 per cent.

Four factors are seen as key to this project's success:

1) Remaining focused: Efforts are concentrated on delivering evidence-based interventions for infants, young children and their mothers to prevent stunting while simultaneously addressing adolescent girls' nutrition, education and empowerment to improve the start in life for the next generation.
2) Delivering at scale with equity: Efforts are made to combine services in facilities with outreach and community-based interventions to bring them closer to children under 2, adolescent girls and mothers. To ensure equity and impact, the focus is on the most vulnerable children, households, districts and divisions.
3) Improving children's birthweight: The approach calls for monitoring pregnancy weight gain at every antenatal care visit and counselling and supporting mothers to gain adequate weight during pregnancy. In addition, all children are weighed at birth, and children born weighing below 2,500 grams are monitored to ensure they catch up.
4) Coordinating and measuring for nutrition results across sectors: Planning and management are focused on nutrition results, and indicators of child nutrition are integrated across programmes and sectors. Another emphasis is on building strong monitoring and evaluation frameworks to measure programme performance. (UNICEF, 2013)

Peru

Between 1995 and 2005, stunting prevalence among children under 5 in Peru fluctuated but did not improve substantially. But in just a few years following the Child Malnutrition Initiative, which began in 2006, stunting fell by a third – from an estimated 30 per cent in 2004–2006 to 20 per cent in 2011.

The Initiative had the goal of placing nutrition high on the national agenda. They advocated with policymakers to raise their awareness of the magnitude of undernutrition, its impact on national social and economic development, and the lack of progress in tackling the problem, pointing to the achievements of small-scale programmes as evidence of the potential of low-cost interventions. Before the 2006 presidential election, the Initiative lobbied candidates to sign a '5 by 5 by 5' commitment to reduce stunting in children under 5 by 5 per cent in 5 years and to lessen the inequities between urban and rural areas. After the election of the new government, child malnutrition became one of the central agenda. The Child Malnutrition Initiative advocated for more resources and supportive policies for child nutrition, with a focus on the most deprived households and communities. Its success was due to the following reasons

1) Creation of a coalition of international agencies and non-governmental organizations: The coalition advocated for commitment to reducing malnutrition.
2) Capitalization on a political window of opportunity in the electoral cycle: Nutrition moved higher on the national agenda as a result.
3) Strong government commitment: The issue of nutrition was placed under the direct control of the Prime Minister's office.
4) Evidence from well-designed and evaluated programmes: Demonstrating the possibilities for success, these programmes fed into the design of a comprehensive, integrated national strategy, CRECER.
5) Commitment to equity: This led to targeting of vulnerable groups and development of the capacity to follow up.
6) Decentralization of administrative, financial and political responsibilities and adoption of a results-based budgeting mechanism: More effective financial management has improved operational efficiency. (UNICEF, 2013)

Kyrgyzstan

In 2007, a study found that just two months' use of micronutrient powder (MNP) reduced anaemia prevalence by 28 per cent among children 6 to 36 months old. In 2009, the Ministry of Health in Kyrgyzstan launched a pilot MNP home fortification programme to reach children aged 6 to 23 months in Talas Province. Single-serving MNP sachets, which could be mixed at home into solid or semi-solid complementary foods, were distributed to families by health-care providers at government clinics through a programme called Gulazyk, a Kyrgyz word referring to a dried meat product rich in nutrients and energy that was traditionally eaten by warriors or travellers to give them strength. A slogan was developed: 'Gulazyk – For the health and mind of your child'. Each child's caregiver was given 30 MNP sachets, enough to administer one to the child roughly every other day for two months. Caregivers were instructed to make sure that all 30 sachets were given within the two months and not to administer more than one sachet per day. Community counselling was available to address problems**.**

In 2008, before the MNP pilot programme was launched, a baseline survey of the nutritional status of children in Talas Province had been undertaken by UNICEF and the CDC. A follow-up survey in 2010, a year after initiation of the pilot, showed a decline in iron deficiency anaemia from 46 to 33 per cent,111 and that 99 per cent of caretakers had heard of Gulazyk

The factors that led to the success of the programme included:

1) A successful pilot programme, showing the potential of the intervention.
2) An effective distribution strategy, implemented by dedicated local health-care providers.
3) Communication and social mobilization at all levels, from communities to mass media, with clear arguments and messages supporting the intervention.
4) Provision of learning opportunities for early childhood development, appealing to mothers, which contributed to high adherence.
5) A comprehensive monitoring and evaluation system, which showed the effectiveness of MNPs and supported national scale-up.
6) The support of government and other high-level decision-makers and broad partnerships.
7) Involvement of a broad range of stakeholders in design, implementation and advocacy – from local nurses to professors, scientists and politicians. (UNICEF, 2013)

Points to Consider in a Resolution:

•What measures can be taken to improve food production and food security? What initiatives can World Health Organization and its member states take to maximize the availability of food?

•How can the problem of micronutrient deficiency and stunting be solved?

•What are the possible solutions to intergenerational cycle of malnutrition?

•What measures can be taken at school, particularly when it comes to the distribution of lunch/meals/snacks?

•What role can education play in tackling child malnutrition?

•What role can NGOs play in resolving the issue of child malnutrition and how can developing and developed countries assist each other in tackling this problem?

How can the global community assist in terms of research and finances?

Further readings:

https://www.unicef.org/about/execboard/files/Global_Framework_for_Action1.0--Dec2006.pdf

https://www.oecd.org/derec/denmark/43962804.pdf

http://www.who.int/pmnch/topics/child/acf_whitepaper.pdf

http://www.europarl.europa.eu/meetdocs/2009_2014/documents/acp/dv/background_/background_en.pdf

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Bevans KB, Sanchez B, Teneralli R, Forrest CB. 2011. Children's eating behavior: the importance of nutrition standards for foods in schools. J Sch Health. 81(7):424-9.

Briley ME, Ranjit N, Hoelscher DM, Sweitzer SJ, Almansour F, Roberts-Gray C. 2012. Unbundling outcomes of a multilevel intervention to increase fruit, vegetables, and whole grains parents pack for their preschool children in sack lunches. 43(3):135-142.

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World Health Organization. Child Growth Standards

World Food Programme and UNICEF. 2009. Global Framework for Action. Ending Child Hunger and Undernutrition Initiative.

UNICEF. 2013. Improving Child Nutrition; the achievable imperative for global progress.

Topic B: Establishing a strategic coordination mechanism between state and non-state actors in medical emergencies

From the great plague of the Middle Ages to the Spanish flu of 1917 and the more recent Ebola outbreak in West Africa, there have always been instances of medical emergencies in the history of the World. The changes we have developed over time are concerning the responses which have been implemented to deal with these cases. This study guide will aim to provide a deeper understanding of the issues you will need to consider for the discussion on developing a strategic coordination mechanism between state and non-state actors in medical emergencies. For the sake of this study guide, 'actors involved' will refer to NGOs, Governments (governmental health agencies and similar bodies), as well as the various relevant UN bodies.

Definitions

Coordination mechanism

To understand this topic, it is important to first define the term of 'coordination mechanism'. The WHO has already set out a definition in 2014 for this term, explaining that the function is

"to facilitate and enhance coordination of activities, multi-stakeholder engagement and action across sectors at the local, national, regional and global levels, in order to contribute to the implementation of [a specific aim] while avoiding duplication of efforts, using resources in an efficient and results-oriented way, and safeguarding WHO and public health from any undue influence by any form of real, perceived or potential conflicts of interest" (Director-General of the WHO, 2014).

This is a very complete definition which encompasses all aspects of actors, areas of action as well as means of actions.

Medical emergency

The WHO uses the definition of the Oxford Pocket Dictionary (1992) for the term emergency, which is defined as "a managerial term, demanding decision and follow-up in terms of extra-ordinary measures" (Oxford English Dictionary, 1992). As such, it can be extrapolated that the term medical emergency is a situation of a medical nature which requires immediate decisions and actions beyond those which would normally be required (extra-ordinary). A natural disaster is not always a medical emergency, but it can easily become one because the lack of facilities and clean drinking water can often lead to an outbreak of a medical emergency, with diseases such as cholera (example: Haiti earthquake, 2010, see Huffington Post (2017)).

Prior (recent) medical emergencies

To best determine a strategic coordination mechanism between state and non-state actors in medical emergencies, it is important to consider the previous medical emergencies which have occurred, as well

as the ways in which they were addressed, to determine pros and cons of certain actions. For the purpose of this study guide, 'recent' will be emergencies which occurred since the start of the 21st century.

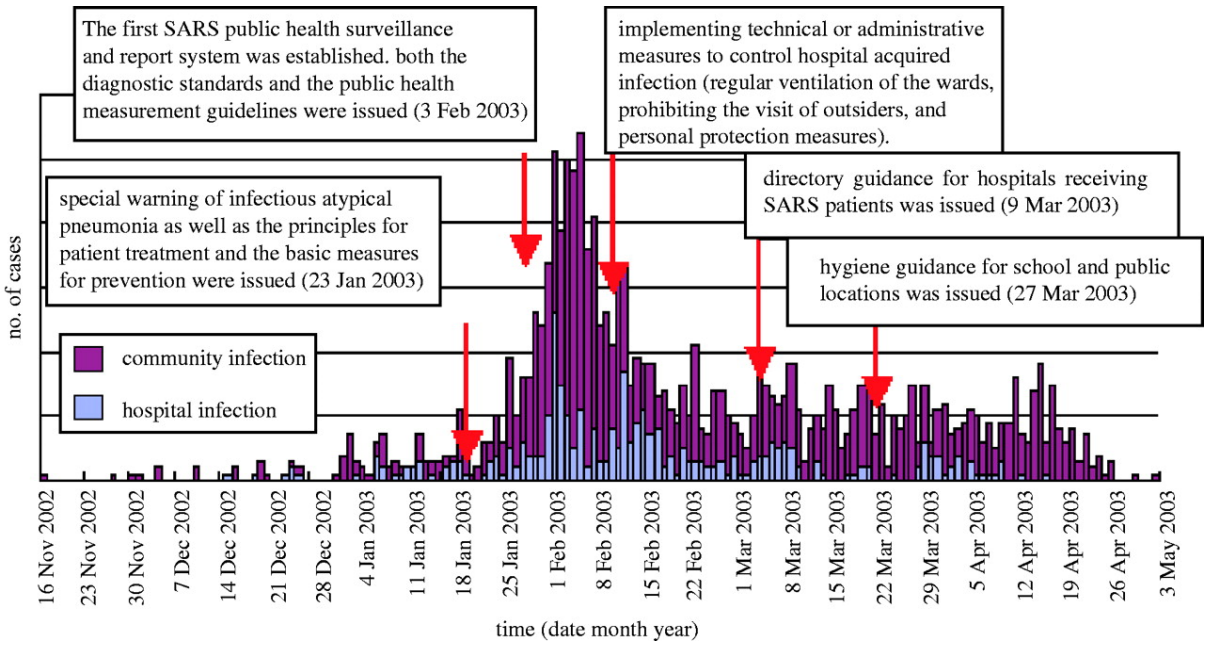
SARS outbreak (2002-2004)

The 2002-2004 Severe Acute Respiratory Syndrome (SARS) outbreak in Asia is the first case which this study guide will consider. It was a direct medical case and lasted for 2.5 years due to a lack of cooperation between the different actors involved.

In November 2002, the People's Republic of China (PRC) reported the outbreak to the WHO. This notification was made under the International Health Regulations (IHR). These regulations were established in 1969, as "a passive system for the reporting of three communicable diseases thought to be important because of their potential spread internationally—cholera, plague and yellow fever" (Heymann, 2004), and they were later changed to include such illnesses as Influenza. In 2002, Canadian and US health agencies picked up media reports from various Chinese provinces concerning influenza outbreaks and informed GOARN, "a network with a secretariat within WHO that links individual surveillance and response networks that have been established throughout the world" (Heymann, 2004). This lead to the WHO asking the PRC for a detailed report on the state of affairs.

The report was sent to the WHO by the PRC on 12th December. However, there is evidence that the report was incomplete. There have also been allegations that the PRC attempted to cover up the outbreak (Rosenthal and Altman, 2003). These allegations of a cover up, if they are true, would explain why the outbreak was so severe. In cases where the effect of a medical emergency is downplayed by officials, the spread is generally increased, either through the travel of infected citizens, or of foreign medical workers, as was the case here which lead to a spread of SARS throughout Asia and a few contained cases in North America and Europe.

However, the outbreak of "SARS has also demonstrated some of the positive features of a globalized society: the advantages that rapid electronic communications and new information technologies bring in responding to emergencies, and the willingness of the international community to form a united front against a shared threat" (Heymann, 2004). Heymann also argues that there was a certain element of luck involved in the containment of SARS, since it was unable to spread to developing countries which do not possess the same medical surveillance to detect such cases in a preventative manner.



Indian Ocean Tsunami and Earthquake (2004)

The case of the Indian Ocean Tsunami and Earthquake, while being a humanitarian emergency rather than a medical emergency, is the second example of the consequences of a lack of coordination between state and non-state actors when it comes to disaster relief.

On December 26th 2004, an underwater earthquake occurred in the Indian Ocean, which created a large Tsunami (Tidal Wave), devastating many South-East Asian Countries, India and Sri Lanka. An unprecedented number of donations were sent by people from all over the world, totaling around $6.25bn. However, as the author of the World Disasters Report (2005) explains, there was a lack of coordination between the various charities who were involved in the relief efforts and the report "highlights the difficulties faced following the tsunami as the relief effort was hampered by rivalries between agencies, delivery of inappropriate aid and difficulty in managing the huge sums of money donated" (The Guardian, 2005). While there has been no evidence that the mismanagement and lack of coordination by the different agencies led to any loss of life and that the "overabundance of supply also had positive effects. Basic needs had largely been covered by the end of January, even in remote locations" (The Guardian, 2005), this lack of information sharing can be viewed as having hindered the long-term effects of relief work in the region, with people being disaffected by the response. In this specific case, an overabundance of supplies helped to prevent a medical emergency, but this is not always the case (see Haiti 2010).

2014 West Africa Ebola Outbreak

In December 2013, a child died in the Guinea. In March 2014, the hospital where the child was being treated alerted the Ministry of Health followed by the medical charity Medecins Sans Frontieres (MSF), which was later confirmed to be Ebola (BBC, 2016). The disease killed a total of 11,315 people, and spread across six countries, namely Liberia, Guinea, Sierra Leone, Nigeria, Mali and the US. Liberia was declared Ebola-free on January 16th 2016, marking the end of the outbreak.

The outbreak started in the Gueckedou prefecture in Guinea, a major regional trading centre. The issue here is that despite a rapid response to the outbreak, the disease spread rapidly to neighbouring Liberia and Sierra Leone. This led MSF to declare it out of control in June 2014, and in August, the UN Health Agency declared an 'international public health emergency' (BBC, 2016). This outbreak spread so easily because of the "very weak health systems, lack of human and infrastructural resources, and have only recently emerged from long periods of conflict and instability" (WHO, 2016). Ebola also spread rapidly because of its transmission means: "human-to-human transmission via direct contact (through broken skin or mucous membranes) with the blood, secretions, organs or other bodily fluids of infected people, and with surfaces and materials (e.g. bedding, clothing) contaminated with these fluids" (WHO, 2016). This means that the people who are the most likely to become infected during an outbreak, as was the case here, are health-care workers, who are likely to come into contact with people who are infected, whilst treating them.

Current WHO Regulations in Place

The WHO does have guidelines to prevent and control spread of disease in the above described cases. In this instance, the WHO states that "Risk reduction messaging should focus on several factors:

Reducing the risk of wildlife-to-human transmission from contact with infected fruit bats or monkeys/apes and the consumption of their raw meat. Animals should be handled with gloves and other appropriate protective clothing. Animal products (blood and meat) should be thoroughly cooked before consumption.

Reducing the risk of human-to-human transmission from direct or close contact with people with Ebola symptoms, particularly with their bodily fluids. Gloves and appropriate personal protective equipment should be worn when taking care of ill patients at home. Regular hand washing is required after visiting patients in hospital, as well as after taking care of patients at home.

Reducing the risk of possible sexual transmission, based on further analysis of ongoing research and consideration by the WHO Advisory Group on the Ebola Virus Disease Response, WHO recommends that male survivors of Ebola virus disease practice safe sex and hygiene for 12 months from onset of symptoms or until their semen tests negative twice for Ebola virus. Contact with body fluids should be avoided and washing with soap and water is recommended. WHO does not recommend isolation of male or female convalescent patients whose blood has been tested negative for Ebola virus.

Outbreak containment measures, including prompt and safe burial of the dead, identifying people who may have been in contact with someone infected with Ebola and monitoring their health for 21 days, the importance of separating the healthy from the sick to prevent further spread, and the importance of good hygiene and maintaining a clean environment." (WHO, 2016).

Points to consider in a resolution

A resolution will need to specifically explain the means in which it will act, clearly defining the important topics of the issue. The examples which have been provided in the previous section are all cases in which there have either been issues which are yet to be addressed, or cases in which the solutions were already in place, but have not been as effective as they could have been in preventing the spread or the scope of the issue. Therefore, any resolution which the committee decides to put forward will need to address the specific issues of how to coordinate efforts between the various actors and the means by which the information is shared. The resolution will also need to address the ways in which the current mechanisms are flawed, and how they can be improved, without hindering the efforts of the various actors or infringing upon the national sovereignty of nation states. Furthermore, a resolution will need to address, if the guidelines exist, how they can be correctly implemented within the specific situation, to prevent the spread of the issue.

Further Readings

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