BACKGROUND GUIDE

BBPS-GLENGAZE-MUN

LETTER FROM THE EXECUTIVE BOARD:

GREETINGS DELEGATES!!!

When United Nations diplomats convened in 1945, an aspect on their agenda included the setup of a global health organization. Thus, as of April 7, 1948, the WHO Constitution came into effect—a date now recognized as World Health day. It was established that all countries that are Members of the UN are eligible to become a part of WHO by accepting its Constitution. The executive board is comprised of individuals designated in accordance to WHO region. In terms of its role in the United Nations in its entirety, WHO is responsible for directing and coordinating authority for health within the global system. WHO also provides leadership on global health matters, shapes the health research agenda, articulates evidence-based policy options, distributes technical support to countries, and assesses current health trends.

Best Regards.

JAYANT SHARMA: CHAIRPERSON

SHIVIKA KAKKAR:VICE-CHAIRPERSON.

What is WHO?

The World Health Organization (WHO) is a specialized agency of the United Nations responsible for international public health. The WHO Constitution, which establishes the agency's governing structure and principles, states its main objective as "the attainment by all peoples of the highest possible level of health." It is headquartered in Geneva, Switzerland, with six semi-autonomous regional offices and 150 field offices worldwide.

AGENDA BRIEFING:

1.Mandate:-

The WHO's broad mandate includes advocating for universal healthcare, monitoring public health risks, coordinating responses to health emergencies, and promoting human health and well being.[7] It provides technical assistance to countries, sets international health standards and guidelines, and collects data on global health issues through the World Health Survey. Its flagship publication, the World Health Report, provides expert assessments of global health topics and health statistics on all nations.[8] The WHO also serves as a forum for summits and discussions on health issues.[1]

The WHO has played a leading role in several public health achievements, most notably the eradication of smallpox, the near-eradication of polio, and the development of an Ebola vaccine. Its current priorities include communicable diseases, particularly HIV/AIDS, Ebola, malaria and tuberculosis; non-communicable diseases such as heart disease and cancer; healthy diet, nutrition, and food security; occupational health; and substance abuse.

The WHA, composed of representatives from all 194 member states, serves as the agency's supreme decision-making body. It also elects and advises an Executive Board made up of 34 health specialists. The WHA convenes annually and is responsible for

selecting the Director-General, setting goals and priorities, and approving the WHO's budget and activities. The current Director-General is Tedros Adhanom, former Health Minister and Foreign Minister of Ethiopia, who began his five-year term on 1 July 2017.[9]

2.SDG 3:-

Goal 3: Good health and well-being

We have made great progress against several leading causes of death and disease. Life expectancy has increased dramatically; infant and maternal mortality rates have declined, we've turned the tide on HIV and malaria deaths have halved.

Good health is essential to sustainable development and the 2030 Agenda reflects the complexity and interconnectedness of

the two. It takes into account widening economic and social inequalities, rapid urbanization, threats to the climate and the environment, the continuing burden of HIV and other infectious diseases, and emerging challenges such as noncommunicable diseases. Universal health coverage will be integral to achieving SDG 3, ending poverty and reducing inequalities. Emerging global health priorities not explicitly included in the SDGs, including antimicrobial resistance, also demand action.

But the world is off-track to achieve the health-related SDGs. Progress has been uneven, both between and within countries. There's a 31-year gap between the countries with the shortest and longest life expectancies. And while some countries have made impressive gains, national averages hide that many are being left behind. Multisectoral, rights-based and

gender-sensitive approaches are essential to address inequalities and to build good health for all.

Facts and figures

400 million

At least 400 million people have no basic healthcare, and 40 percent lack social protection.

1.6 billion

More than 1.6 billion people live in fragile settings where protracted crises, combined with weak national capacity to deliver basic health services, present a significant challenge to global health.

15 million

By the end of 2017, 21.7 million people living with HIV were receiving antiretroviral therapy. Yet more than 15 million people are still waiting for treatment.

2 seconds

Every 2 seconds someone aged 30 to 70 years dies prematurely from noncommunicable diseases - cardiovascular disease, chronic respiratory disease, diabetes or cancer.

7 million

7 million people die every year from exposure to fine particles in polluted air.

1 in 3

More than one of every three women have experienced either physical or sexual violence at some point in their life resulting in

both short- and long-term consequences for their physical, mental, and sexual and reproductive health.

Factors which leads to Unequal access to Healthcare:

The committee was tasked with identifying factors that influence a person's use of health-care services, including poverty and level of urbanization. This chapter will address those factors. The committee has organized the beginning of the chapter around individual and societal determinants of health-care utilization, including factors that

affect the need for care, the propensity to use services, and barriers to the use of services.

The availability of newer and improved health-care services, however, does not mean that they are equally available to all Americans. For example, white women are much more likely to have outpatient surgery than women of other races or ethnicities (Salasky et al., 2014) and Medicaid beneficiaries, who are poor and often disabled, are more likely to use emergency departments (EDs) than people who have other coverage, in part because they have less access to ambulatory care (MACPAC, 2016; NCHS, 2017a).

NEED FOR HEALTH-CARE SERVICES

Health status and the need for health-care services to improve or maintain health are major determinants of health-care utilization. The World Health Organization states that health is determined by a person's individual characteristics and behaviors, physical environment, and socioeconomic environment (WHO, 2017). People's individual characteristics include their biology and genetics, such as inherited diseases and conditions that require medical care. The prevalence of those conditions differs by sex, age, race and ethnicity, employment status, and other factors. Physical environments can affect health because of pollutants or other environmental health hazards. Individual behaviors, such as smoking or lack of exercise and overeating, also cause health conditions that require health care (ODPHP, 2017a). Recent attention to social determinants of health, such as education, economic stability, community safety, and availability of adequate housing and

healthful food, has shown that they correlate with healthier populations (ODPHP, 2017a). People who have unmet social needs are more likely to be frequent ED users, to have repeat "no-shows" for medical appointments, and to have poorer glycemic and cholesterol control than those who are able to meet their needs (Thomas-Henkel and Schulman, 2017).

How need affects differential health-care utilization by specific populations of interest is discussed below with reference to poverty and its correlates and geographic area of residence, race and ethnicity, sex, age, language spoken, and disability status. Ideally, need should be the major determinant of health-care utilization, but other factors clearly have an effect.

ACCESS TO HEALTH CARE

Access to health care is defined as having timely use of personal health services to achieve the best possible health outcome (IOM, 1993). Access requires gaining entry into the health-care system, getting access to sites of care where patients can receive needed services, and finding providers who meet the needs of patients and with whom patients can develop a relationship based on mutual communication and trust (AHRQ, 2010). Clinicians note that timely access to health care is important inasmuch as it might enable patients and physicians to prevent illness, control acute episodes, or manage chronic conditions, any of

which could avoid exacerbation or complication of health conditions (NCHS, 2017b).

There are many ways to think of access, and the term *access* is often used to describe factors or characteristics that influence one's initial contact with or use of services. Anderson and Newman (2005) present a framework of health-care utilization that includes predisposing factors, enabling factors, and magnitude of illness. More recently Levesque et al. (2013) defined access to health care by presenting five dimensions of accessibility: approachability, acceptability, availability and accommodation, affordability, and appropriateness. They saw access as the opportunity to identify health-care needs; to reach, obtain, or use health-care services; and to have the need for services fulfilled. Access can be seen as a continuum: even if care is available, many factors can affect ease of access to it, for example, the availability of providers who will accept a person's insurance (including Medicaid), ease in making an appointment with a given provider, the ability of a patient to pay for care (even if a patient is insured, due to cost-sharing copayments and deductibles), and the difficulty of arranging transportation to and from healthcare facilities (AHRQ, 2010, MACPAC, 2016). Some of those issues are discussed below.

Insurance and Ability to Pay for Services

Access to health care is tied to the affordability of health insurance. Financial barriers to care, particularly among low-income people and the uninsured, have been greater in the United States than in other high-income countries (Davis and Ballreich, 2014; Squires and Anderson, 2015). According to a 2013 Commonwealth Fund survey of adults in 11 high-income countries, the United States ranks last on measures of financial access to care (Schoen et al., 2013). The Kaiser

Commission on Medicaid and the Uninsured notes that people who lack insurance coverage have worse access than people who are insured, and 20 percent of uninsured adults in 2015 went without needed medical care because of cost (KFF, 2016). The lack of health insurance has been identified as an important driver of health-care disparities (IOM, 2002).

Race and Ethnicity

Racial and ethnic disparities are found in many sectors of American life. Black people, people of Hispanic origin, American Indians, Pacific Islanders, and some Asian Americans might be disproportionately represented in the lower socioeconomic ranks, in lower-quality schools, and in poorer-paying jobs (IOM, 2002). Racial residential segregation is a key mechanism through which racism produces and perpetuates social disadvantage. Black and Latino adults are more likely to live in disadvantaged neighborhoods and to have inadequately resourced schools, which yield lower educational attainment and quality (Braveman et al., 2014). Those factors can result in some racial and ethnic minorities experiencing higher rates of chronic and disabling illnesses, infectious diseases, and higher mortality than white Americans. Minority populations have more difficulty than the majority population in locating a "usual source" of medical care, and black and Hispanic adults report greater difficulty than whites in obtaining medical care at a consistent location (IOM, 2002; AHRQ, 2010).

Black adults have earlier onset of multiple illnesses, greater severity and more rapid progression of diseases, higher levels of comorbidity and impairment throughout the life course, and higher mortality than whites up to the age of 65 years. Similar patterns are evident in American

Indians, Pacific Islanders, Asian populations of low socioeconomic status, and US-born Latinos (Williams and Wyatt, 2015).

Sex

Women overall have higher health-care utilization than men. Although it had been thought that women receive health care primarily during child-bearing years for reproductive health, many health-care utilizations occur during and after menopause for such issues as cardiovascular disease and osteoporosis (Owens, 2008). Other studies have shown that women make more primary care visits and receive more diagnostic services, screening services, diet and nutrition counseling, and sexual health care than men even though men generally have higher rates of obesity and cardiovascular problems (Salganicoff et al., 2014).

Among people 18–64 years old, women have higher rates of disability and self-reported fair or poor health status. Among all people 18 years and older, women are more likely to delay or not receive care, or to not receive prescription drugs, because of cost. Women are more likely to have a health-care visit in a given year, to have 10 or more visits, and to have a hospitalization or ED visit (NCHS, 2017b). Those findings indicate that although women utilize health-care resources at greater rates, health-care needs go unmet.

Spoken Language

Many Americans in racial and ethnic minorities experience language barriers and have low or no proficiency in speaking, reading, or comprehending English. In a health-care setting, those barriers can present serious challenges to both patients and providers. A systematic review of studies of language barriers in health care for Latino

populations showed that access to care, quality of care, and health status all suffer as a result of language barriers. If a patient does not speak the language of his or her health-care provider, multiple adverse effects on the patient's health care might occur. For example, a patient's inability to understand a provider's diagnosis or treatment plan can lead to poor patient satisfaction, poor compliance, and underuse of services

Sociodemographic and Characteristics

Residents of rural areas differ from residents of urban areas in a number of important characteristics that correlate with health-care utilization. Rural residents have low incomes: 17 percent of rural workers earn less than the poverty level ($11,490 per year for an individual) compared with 14.6 percent of urban workers (Mueller et al., 2014). They are more likely to classify themselves as white. The greatest racial and ethnic diversity was found in central counties of large metropolitan areas. In 2010, the population of central counties nationwide was 27 percent Hispanic origin, 17 percent non-Hispanic black, 9 percent non-Hispanic Asian or Pacific Islander, 2 percent people identifying with multiple races, and less than 1 percent non-Hispanic or American Indian or Alaska Native (AI/AN) origin.