# Crescent School Model United Nations 2025

A Background Guide for:

## World Health Organization

Written by: **Noah George**

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# Land Acknowledgement

Crescent School and the staff of CSMUN III acknowledge that we are gathered upon and would like to honour the traditional territory of many nations, including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee, and the Wendat peoples, and it is now home to many diverse First Nations, Inuit, and Métis peoples. We thank them for their stewardship of the land, and we are in solidarity with our Indigenous Brothers and Sisters as we move forward in reconciliation.

Acknowledging the traditional territories of Indigenous peoples is not only a gesture of respect but also a recognition of the historical and ongoing injustices they face. It is a reminder that the impacts of colonization, displacement, and systemic discrimination continue to reverberate today. We would like to take the opportunity to honour the resilience of Indigenous communities and commit to amplifying their voices in our pursuit of justice and equity.

# Equity Disclaimers

In the event that you have concerns about equity, diversity, inclusion, or belonging or are uncomfortable due to the actions of another delegate, chair, co-chair, or staff member of CSMUN III, please reach out to the Equity Team to file your concern. Equity is outlined through the code of conduct listed above. You may reach out to the equity team through an anonymous form, by speaking with your chairs, or by emailing any member of the CSMUN II Secretariat if you feel comfortable doing so. The Equity team can be reached at csmunequity@crescentschool.org

**The Equity Form is here to submit any equity concerns (Equity Form). This can be found also in committee rooms.**

Equity concerns are taken very seriously at CSMUN III. The equity policy of CSMUN III is strict in accordance with the school's Diversity Statement and the Crescent School Constitution, which includes the Crescent School Declaration of Student Rights, and violations outside of reason will not be tolerated. The School's Constitution was prepared in accordance with, and in support of, the Safe Schools Act and corresponding principles in the Education Act, as well as the Human Rights Code. When an equity is filled, the CSMUN III Equity team will step in and take appropriate steps and actions to remedy the situation. CSMUN III is committed to ensuring that everyone is valued with respect, responsibility, honesty, and compassion. We are committed to pursuing disciplinary action as stated above if needed to facilitate a positive and safe environment.

# Tech Policy

Please note that a Smart Device is required to participate in CSMUN III. While we are a paper conference (with the exception of crisis committees), delegates will need to use their computers to write and work during the unmods. Communications with delegates, the dias or other staff can be done either via paper notes or email.

Delegates at CSMUN are expected to utilize technology responsibly and ethically throughout the conference. While the use of smart devices, computers, and digital tools is necessary for research, writing, and collaboration, delegates are prohibited from utilizing artificial intelligence (AI) systems or automated tools to gain an unfair advantage or manipulate conference proceedings. Pre-writing resolutions outside of unmods and using AI to write resolutions and working papers is also prohibited. Delegates must also refrain from engaging in any illegal activities, including but not limited to hacking, piracy, or the distribution of harmful content to anyone in or outside of the conference.

# Letter from the Secretary-General

*A Letter from the Secretaries General and Deputy Secretary General of CSMUN III*

Dear Delegates and Faculty Advisors,

Welcome to the third iteration of the Crescent School Model United Nations conference! Thanks to your support, our inaugural conference in April 2024 was a tremendous success, and CSMUN II built on that momentum with even greater participation and enthusiasm. We are now thrilled to invite you to CSMUN III, taking place on December 13–14, 2025, at Crescent School in Toronto.

Since our last conference, the Crescent MUN team has continued to grow in both size and passion. We've welcomed new members, explored fresh ideas, and remained committed to fostering a vibrant environment where students can engage with global affairs, diplomacy, and debate. We're excited to share this passion with you once again.

CSMUN III will feature a dynamic range of committee simulations, including but not limited to DISEC, WHO, the Canadian House of Commons, and an Ad Hoc, along with a special networking event. Delegates can look forward to rigorous debate, thought-provoking dialogue, and the opportunity to connect with peers from across the region and beyond. Registration for CSMUN III is now open! We encourage all interested delegates and faculty advisors to explore our website for full details and to secure your place at the conference. Please note that registration will close on December 10, 2025.

To stay updated on all things CSMUN, be sure to follow us on Instagram at @cs.modelun. If you have any questions or need assistance, don't hesitate to reach out to us at modelun@crescentschool.org. Our team is here to support you every step of the way.

Thank you for considering attending CSMUN III. We can't wait to welcome you to Crescent School for what promises to be our most exciting conference yet.

Sincerely,

Deren Terzioglu & Gregory Mavroudis | Secretaries-General of CSMUN III
Joel Green | Deputy Secretary-General of CSMUN III
Crescent School Model United Nations 2025

# A letter from Dais

## A Letter from the Chair

*Dear Delegates,*

"Medical science has proven time and again that when the resources are provided, great progress in the treatment, cure, and prevention of disease can occur." — Michael J. Fox.

My name is Noah George, and I am honoured to serve as your chair for the World Health Organization committee.

This is my third year in Model UN, and I have attended several conferences across North America. Additionally, I am serving as the USG of Logistics for CSMUN III. I can't wait to delve into the unique importance and role that the World Health Organization plays in the well-being of our communities. Exploring the importance of disease prevention through debate and diplomacy offers a unique perspective on the future of medicine. I have attended several conferences in North America, and I hope to make CSMUN your most memorable conference.

I look forward to a dynamic and engaging debate!

Sincerely,

Noah George| Chair of CSMUN III: WHO

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## A Letter from the Co-Chair

*Dear Delegates,*

"The people who are crazy enough to think they can change the world are the ones who do." – Steve Jobs.

Hello, my name is Sri Ganty, and I am thrilled to serve as your Chair for the WHO General Assembly at CSMUN III. As we gather here to discuss and debate some of the most pressing international health challenges, I would like to take a moment to introduce myself.

This marks the end of my first year in Model UN, and it's been an incredible journey learning about international affairs, diplomacy, debate, and global collaboration.

What excites me about this committee is the chance to explore bold, innovative ideas. I'm passionate about the intersection of technology and medicine and fascinated by how creative solutions, even ideas that seem "crazy" at first, can transform healthcare and improve lives worldwide.

As your Chair, my goal is to create a space where every delegate feels encouraged to think outside of the box, challenge conventional thinking, and propose imaginative, innovative, and impactful solutions. I want this session to be dynamic, energetic, and full of ideas that push boundaries while remaining practical.

I look forward to seeing your creativity in action and to a session where collaboration, curiosity, and bold thinking lead the way. Let's make this debate exciting, innovative, and truly memorable.

Signed,

Sri Ganty | Co-Chair of CSMUN III: WHO

Part 1

# About the Committee

The World Health Organization (WHO) is an agency within the United Nations. The WHO was established in 1948 in Geneva, Switzerland, and is currently composed entirely of sovereign states. The organization is responsible for achieving the highest possible level of global health, including physical, mental, and social well-being. The WHO's mandate includes advocating for universal healthcare, monitoring health risks, coordinating responses for health crises, and promoting human health and well-being.

Before the creation of the World Health Organization in 1948, international public health was fragmented and inconsistent. Early attempts to create global health organizations occurred, such as with the International Sanitary Conferences of the 19th and 20th centuries. The conference, along with other attempts, lacked enforcement power and was slowed down by politics and debates about national sovereignty. Without a central governing body, health responses varied widely across countries, resulting in ineffective crisis management and limited communication.

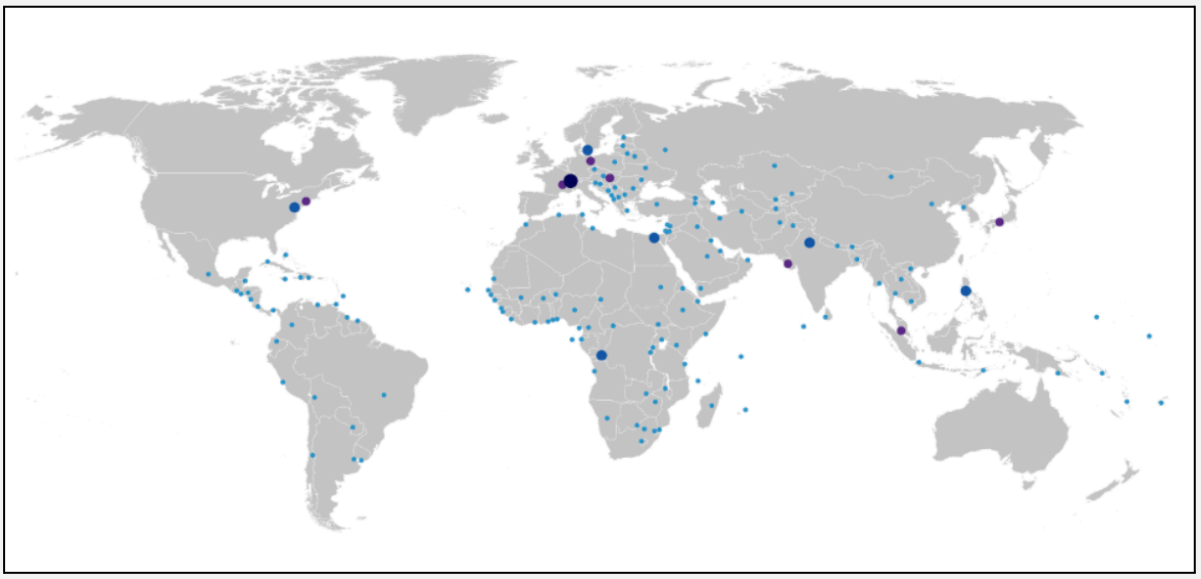
During the 1945 United Nations Conference on International Organization, a Chinese delegate, Szeming Sze, discussed with representatives from Norway and Brazil the creation of an international health organization under the auspices of the United Nations. After a failed resolution on the matter, Szeming Sze and others lobbied, which led to a declaration being passed. This declaration demanded the establishment of an international organization focused on public health. They emphasized using the word ' world' rather than 'international' to highlight the global nature of the organization's task.

Since its founding, the WHO has helped unify global health governance. Landmark successes include the eradication of smallpox in 1980, large-scale vaccination campaigns, and the near-eradication of polio. However, the organization still faces challenges, such as dependence on voluntary funding, political influence and corruption by member states, and limited enforcement power during crises such as COVID-19 and Ebola.

As of October 2025, the WHO is led by Director-General Dr. Tedros Adhanom Ghebreyesus. Dr. Ghebreyesus was first elected in May 2017 and subsequently re-elected in May 2022. Dr. Ghebreyesus graduated from the University of Asmara with a Bachelor of Science degree in Biology. Following, he completed a Master of Science degree in Immunology of Infectious Diseases at the University of London. After completing his Master of Science, he completed a Doctorate of Philosophy in Community Health from the University of Nottingham and an Honorary Fellowship from the London School of Hygiene and Tropical Medicine. After his studies, Dr. Ghebreyesus returned to Ethiopia, where he

served as the Minister of Health (2005-2012) and later as the Minister of Foreign Affairs in 2016. Under his leadership, the WHO has overseen many major initiatives, including pandemic preparedness, global vaccination programs, and discussions towards a new international pandemic treaty.

At this General Assembly, delegates will represent their member states and address global health issues through speeches, moderated and unmoderated caucuses, and the drafting of resolutions. The dais will facilitate debate and ensure that procedures are followed. Still, the responsibility lies with delegates to collaborate and develop innovative, realistic solutions that reflect both the opportunities and constraints faced by the real-world WHO.



Part 2

# Topic A: Global Response to Infectious Diseases

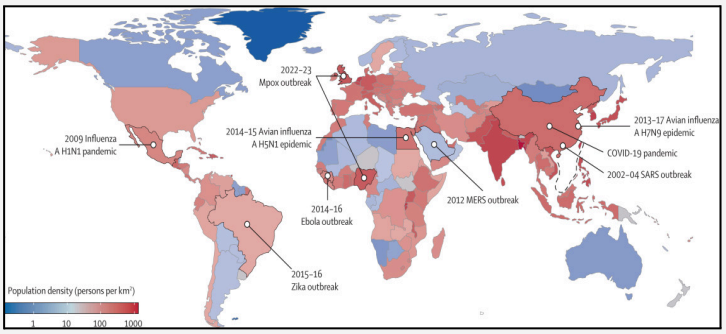
## Outline of Topic

Infectious diseases are among the most persistent and devastating threats to human life. From historic pandemics to modern outbreaks, global health systems have been repeatedly tested by emerging and re-emerging pathogens. As the world becomes increasingly interconnected through trade, travel, and migration, infectious diseases are spreading faster and reaching farther than ever before. The World Health Organization (WHO), along with national governments and partner organizations, plays a central role in coordinating global responses to these outbreaks. Yet, present-day gaps in preparedness, funding, and equity persist as major challenges.

### Historic Outbreaks

The 1918 Influenza Pandemic, known as the Spanish Flu, remains one of the deadliest disease outbreaks in history, infecting an estimated ⅓ of the global population and killing over 50 million people. At that time, global coordination was virtually nonexistent, and the absence of a formal international health body made continent-wide efforts across countries.

Later outbreaks, such as the Ebola epidemic (2014-2016) in West Africa, exposed the fragility of local health systems. With over 28,000 reported cases and 11,000 deaths, the crisis highlighted how weak infrastructure, delayed reporting and limited resources can turn a localized outbreak into a global emergency. The World Health Organization was criticized for its slow initial response, leading to significant reforms in emergency preparedness and surveillance.




More recently, the COVID-19 pandemic revealed limits to the most advanced public health systems. While vaccine development occurred at record speed, inequitable distribution and misinformation undermined progress. By the end of 2022, only about 18% of people in low-income countries had received a vaccine dose, compared to 63% globally. The pandemic has demonstrated that global solidarity, particularly in vaccine access, funding, and transparency of information, is essential for an effective crisis response.

## Global Health Governance and Current Regulations

Global health security operates within an established legal framework, which includes the International Health Regulations (IHR 2005). As a legally binding agreement, the IHR was signed by 196 states, providing legal protocols for the identification, communication, and management of global public health emergencies of the highest order. While the IHR attempts to balance national sovereignty with international cooperation, its enforcement provisions are also the weakest. The WHO's inability to sanction states for non-communication and for failing to take specific actions often results in delayed global action.

The discussions about a Pandemic Treaty have focused on lessons learned from the COVID-19 Pandemic. The purpose of which would be to strengthen the WHO's authority around rapid data sharing and providing equitable access to life-saving health technologies. While supporters believe the WHO should have the authority to coordinate a global response, critics warn that such over-centralization could infringe on national sovereignty.

## Funding and Health Infrastructure Inequality

The World Health Organization (WHO) 's financial weakness stems from the low proportion of its budget funded through assessed contributions. Only about 20% of the budget is financed from assessed contributions or mandatory payments from member states. The rest of the budget is funded through voluntary donations. Such a system strains the organization financially and curtails its ability to respond to crises.

The funding gaps most severely affect low-income countries, where the financial and material infrastructure for identifying and containing outbreaks is lacking, thereby hindering epidemic prevention. The regions affected by the Ebola outbreak had fewer than two physicians per 100,000 people. During the COVID-19 pandemic, the same structural inequalities resurfaced in the form of supply chain disruptions and vaccine hoarding by high-income countries.

## Coordination, Early Warning, and Rapid Response

The World Health Organization (WHO) plays a central role in coordinating global disease surveillance through systems such as the Global Outbreak Alert and Response Network (GOARN). This network connects over 250 technical institutions worldwide, enabling them to rapidly exchange laboratory results, epidemiological data, and field expertise when new threats to public health emerge. In practice, GOARN has been a vital early warning system, helping identify outbreaks before they spiral out of control. However, its success still hinges on whether member states are transparent and willing to report emerging threats. When politics interferes with reporting, response times slow, and the world pays the price.

In recent years, digital surveillance tools and artificial intelligence have started transforming how health agencies detect unusual patterns, sometimes spotting outbreaks before hospitals do. Still, challenges remain in this system. Privacy laws often limit data sharing. Misinformation spreads faster than containment updates, and poorer countries struggle to afford the technology needed to join these systems. For these reasons, closer collaboration among the WHO, national ministries of health, and non-governmental organizations (NGOs) is not only helpful but also essential. The next major outbreak will demand a response measured in hours, not weeks.

### Case Study I: COVID-19 (2019 - 2022)

The COVID-19 pandemic began in December 2019, when clusters of pneumonia cases were reported in Wuhan, China, linked to a local seafood market. The virus, later identified as SARS-CoV-2, spread rapidly, helped by asymptomatic transmission and international travel. On January 30, 2020, the WHO declared a Public Health Emergency of International Concern (PHEIC), and by March 11, 2020, SARS-CoV-2, now called COVID-19, was officially declared a pandemic. The disease quickly spread to over 200 countries, classified as a pandemic. The disease soon spread to over 200 countries. This disrupted daily life, global trade, and especially healthcare systems. Death rates varied by age and health status. Still, the social and economic consequences were profound, with lockdowns, school closures, strained healthcare infrastructure, and mental health challenges becoming everyday experiences around the world.

Throughout the pandemic, the WHO played a vital role in coordinating the global response to the disease. It issued daily situation reports that tracked cases and deaths, developed technical guidance for healthcare providers, and promoted infection control methods and the use of Personal Protective Equipment (PPE). The organization also supported research on treatments through the Solidarity Trial and led efforts to ensure equitable access to the COVID-19 vaccine through the COVAX initiative. The WHO's guidance emphasized non-pharmaceutical interventions, such as social distancing, mask use, and travel restrictions, while also promoting risk communication to counter misinformation.

## Guiding Questions:

1. Should the WHO be granted greater legal authority to enforce emergency measures under the International Health Regulations?

2. How can the global community ensure equitable vaccine manufacturing and distribution across low-income regions?

3. What strategies should be prioritized to combat misinformation while preserving freedom of expression?

4. How can governments and international institutions sustainably finance pandemic preparedness and health infrastructure?

Part 3

# Topic B: Vaccines and Resistance

## Overview

Vaccines have proven to be one of humanity's most powerful tools against infectious disease. From smallpox to measles to COVID-19, vaccines have saved millions of lives and prevented countless hospitalizations. Yet, as more emphasis continues to be placed on vaccination, resistance has emerged, driven by misinformation, distrust, politics, and inequities in supply. The WHO's role is more vital than ever: to support safe and equitable vaccination and to counter resistance in ways that respect autonomy while protecting public health.

## Current Global Landscape of Vaccines

Vaccination campaigns worldwide saw unprecedented efforts in 2022, with billions of doses administered through national programs and initiatives such as COVAX. These efforts, however, were met with uneven coverage. While high-income countries achieved vaccination rates of 60-70%, many low-income countries reached only 20-30%. This disparity is not a matter of vaccine supply; it involves infrastructure, trust, and logistical challenges.

The technology used to create vaccines has also advanced, utilizing mRNA, viral vectors, and protein subunits. While these technologies facilitate more rapid adaptation to new pathogen variants, they also pose challenges related to patent protection, scalability, and cost barriers. For example, mRNA COVID-19 vaccines. Their production involves a complicated web of intellectual property that limits who can manufacture these vaccines. A network analysis of mRNA vaccine patents reveals how interlocking claims can stifle generic production and, therefore, access to the vaccine.

### Resistance: The Roots of Anti-Vaccine Movements

Anti-vaccine organizations (for example, Children's Health Defence) and vaccine-skeptical grassroots movements are not new, but their reach and impact have expanded. Some primary motivations fueling this opposition include:

1. Misinformation and Conspiracy Theories

Social media platforms, forums, and targeted campaigns have amplified the spread of false claims about vaccines. Claims linking vaccines to autism, infertility, or even microchipping are shared widely and persist despite overwhelming scientific evidence to refute these claims. Fringe scientific claims, such as those published by J. Bart Classen, alleging links between vaccines and diabetes, lend a veneer of credibility to these false narratives, which reinforces skepticism. Misinformation is particularly prevalent in societies with limited

scientific literacy and is often intertwined with broader conspiracy theories about government control, corporate influence, or global agencies.

2. Distrust in Institutions

Institutional distrust is a large driver of vaccine hesitancy, particularly in regions where governance and public health systems are weak, fragmented, or marred by historical corruption. Populations may perceive health recommendations as politically motivated or externally imposed, rather than grounded in medical evidence. For example, communities that have experienced neglect, unequal access to healthcare, or unethical research practices may be skeptical of vaccine campaigns. In these contexts, the WHO's guidance may be seen as an extension of foreign influence, making local buy-in more difficult. Effective global health policy must consider more than the science of vaccines, but also the social and political dynamics that influence one's chances to accept a vaccine.

3. Risk Perception

Individuals often evaluate vaccines based on perceived disease risk. In regions where vaccine-preventable diseases are rare, even minor effects are magnified in public view, sometimes outweighing the benefits of vaccination. Cognitive biases, such as the availability heuristic, in which stories of vivid vaccine side effects are more memorable than statistical evidence, further increase hesitancy toward vaccines.

## Case Study II: COVID-19

On March 11, 2020, a bustling world came to a screeching halt. The World Health Organization declared SARS-CoV-2, now called COVID-19, a global pandemic, sending shockwaves through everyday life. One moment, we were all together, laughing over family dinner, and the next, we're all at home, terrified of what's to come. This was reality for millions globally during the COVID-19 pandemic. In this case study, we'll cover the development of vaccination, the emergence of vaccine resistance, and the roles of the WHO and local governments.

### Timeline of Vaccine Development

| Time Period | Events |
|---|---|
| **Pre-COVID-19** | **1987:** Dr Robert Malone mixes mRNA with lipid droplets and finds that human cells absorb the mRNA and produce proteins. He also discovers that frog embryos can absorb mRNA. These experiments are seen as early steps towards developing mRNA-based COVID-19 vaccines.<br>**1990s:** Scientists test mRNA treatments in rats and experiment with mRNA vaccines for influenza and cancer in mice. |

| | |
|---|---|
| | **2000s:** Research continues to explore mRNA vaccines. However, because mRNA is fragile and expensive to produce, many projects struggle to get funding and aren't researched further.<br><br>**2005:** Dr Katlin Kariko and Dr Drew Weissman discover that modifying synthetic mRNA prevents the immune system from attacking it, which is a breakthrough that advances mRNA vaccine research. |
| **2019** | A new virus, SARS-CoV-2, emerged in China, causing the COVID-19 pandemic. The WHO declared a pandemic in 2020. Both the WHO and CDC issue guidelines for prevention and treatment. |
| **2020** | Multiple COVID-19 vaccine clinical trials begin. Researchers use previous knowledge from SARS-CoV, MERS-CoV, and other viruses to develop vaccines. Studies also focus on COVID-19 symptoms, long-term effects, testing, treatment, and drugs. The FDA grants emergency use authorization to the Pfizer-BioNTech and Moderna mRNA COVID-19 vaccines. Because of an urgent need, the FDA authorizes these vaccines with less data than usual, typically requiring evidence of safety and efficacy (ensuring the vaccines work). Extensive safety monitoring continues. |
| **2021** | The FDA authorizes the Janssen/Johnson & Johnson vaccine and approves Pfizer-BioNTech for people 16 and older, later expanding authorization for children aged 5-15. Vaccine development and clinical trials continue for several candidates. |
| **2022** | The FDA approves Moderna (Spikevax) for adults 18 and older and expands Pfizer-BioNTech (Comirnaty) approval to ages 12 and up. Pfizer is authorized for children 6 months-11 years, and Moderna for ages 6 months-17. Novavax receives authorization for adults 18 and older, and later for ages 12 and up. |
| **2023** | Pfizer-BioNTech (Comirnaty) is approved for ages 12 and older, with emergency use authorization for ages 6 months -11 years. Moderna (Spikevax) is approved for ages 12 and older, with approval for children 6 months to 11 years. |

**Vaccine Resistance**

Science is often used to distort political, social, or economic agendas. This manipulation transforms the objective pursuit of knowledge into a powerful weapon, wielded by those seeking to validate their beliefs or advance their narratives. In an era where information travels at the speed of light, we find ourselves caught in a web of selectively curated data and cherry-picked studies that can sway public opinion and government policies. How often do we accept these findings without questioning the motives behind them? As we dive deeper into the complex play between science and society, we must ask ourselves: can we truly trust the facts, or have they become merely another tool in the game of political influence?

## Guiding Questions:

1. Should the WHO and UN advocate for national vaccine mandates during health crises? What safeguards should be put in place?

2. How can global institutions counter harmful misinformation without censoring legitimate dialogue?

3. Should patent protections be suspended during global health emergencies? If so, how can manufacturers be fairly compensated and production capacity ensured?

4. What strategies (monetary incentives, public campaigns, involvement of community leaders) effectively increase uptake in vaccine-resistant populations? How can institutions engage communities that distrust authorities?

Part 4

# Committee Structure

The World Health Organization (WHO) is a UN agency founded in 1948 to coordinate global health efforts, unify pandemic response, and promote physical, mental, and social well-being worldwide. It grew out of earlier fragmented attempts to unify public health, and it now operates as a body of sovereign states led by the Director-General. The WHO monitors global health risks, supports universal healthcare, and leads major initiatives such as vaccination campaigns and pandemic preparedness.

In committee, delegates act as their countries' representatives, debating issues through speeches, caucuses, and resolution drafting in their respective blocs. While the dais oversees procedure and keeps the debate structured, the solutions are left up to delegates. The dais encourages you to think creatively and boldly, and to create innovative solutions to today's problems.

Part 5

# Closing Remarks

Despite years of debate, the world is still nowhere near fully prepared for the next pandemic. Outbreak surveillance remains inconsistent, global health funding is even worse, vaccine access is entirely political, and public mistrust spreads faster than any virus ever could. None of these problems has a simple fix, and that's precisely why this committee matters.

Here, you, as a student, are stepping into a space where the usual barriers don't apply. You don't have to worry about bureaucracy, elections, or ministries dragging their feet. You get to think the way real delegates wish they could: Creatively, boldly, and without being boxed in by geopolitical debates. Whether you're tackling the failures exposed by the COVID-19 pandemic or the rising threat of vaccine resistance from populations, your job is to imagine what cooperation could look like if we removed all the excuses.

If you've made it all the way through this background guide and our dense writing, congratulations. Most delegates won't. But suppose you walk away from this committee with even one new insight on how fragile our global health systems really are, or one new friend you met while arguing about epidemiology (the study of disease) at 5 PM on Saturday. In that case, this experience will have done its job. Whatever you take away from CSMUN, I hope that it impacts your life for the better. Feel free to reach out to me if you have any questions or concerns at noahgeorge2028@crescentschool.org

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