WORLD HEALTH ORGANIZATION

Topic A: The Plight of Mental Health
Topic B: Health Care During Times of Conflict-Emphasis on Iraq and Syria

Director General: Kali Croke
Deputy Director General: Scott Okuno
Assistant Director General: Jeremy Joseph
Email: gbsmun.who@gmail.com
Twitter: GBSMUN_WHO
Dear Delegates,

The dais of the World Health Organization (WHO) is pleased to welcome you to the first annual Glenbrook South Model United Nations Conference (GBSMUN). My name is Kali Croke, I am a senior here at Glenbrook South, and as your chair I will serve as Director General of the committee for the duration of the conference. I will be working alongside Deputy Director General Scott Okuno and Assistant Director General Jeremy Joseph as the entirety of our dais. Collectively we have been doing Model UN for over eight years, and we are very excited to be on the other side of the desk watching you of all different skill levels and experiences embark on the GBSMUN journey.

As your dais we have chosen two topics we believe are most relevant to the current state of the health world and most interesting to you as delegates: "The Plight of Mental Health" and "Health Care During Times of Conflict." Each topic requires thorough preparation in knowledge of your country's position and an advanced level of creativity for practical and successful solutions. We only ask that you come to committee ready to engage in constructive diplomatic debate and fully aware at the weight and girth of these issues at hand. As experienced delegates we acknowledge how much effort goes unseen during committee, but can promise that your level of preparedness and willingness to participate will directly influence the enjoyment you get out of the process.

We look forward to reading all of your position papers and relishing in the vast amounts of creativity and passion they will all have. Please email your position papers to gbsmun.who@gmail.com or turn in a hard copy prior to the opening of debate. It is encouraged that you submit your papers as early as possible so the dais can give you useful feedback and suggestions and answer any questions you may have. Also feel free to email us with any questions or if you just want to say hi, that's okay too! We look forward to meeting all of you and having a substantive - and fun!- session as the World Health Organization.

Sincerely,

Kali Croke, Director General
Topic A: The Plight of Mental Health

History of the Problem

Mental health has been a misunderstood field since the ancient Greeks and Romans. In fact, a clear definition and proper protocol of mental health did not exist until 20th Century. However, civilizations since the beginning of time deemed mental illness as a religious punishment or demonic possession. Because of this, mentally ill members of society were ridiculed and judged for their unexplained abnormalities. They were even forced to partake in undesired cleansing rituals to abide by ancient law. This style of thinking soon faded once the Classical Greek period emerged.

Hippocrates of Cos, the most prominent physician at the time, pioneered the first advancements in treating the mentally ill. Rather than carry on with the religiously based techniques, Hippocrates developed his own medical protocol. For instance, he encouraged his patients to change their environment, occupation, and medical treatments to examine their psychological effects. Despite his wonderful contribution to medicine, Hippocrates and his methods were forgotten for the next 700 years.

Since Hippocrates’ advancements, physicians and activist have drastically changed treatment for the mentally ill. Serious altercations in the system occurred during the years of Dorothea Dix. Her experience after teaching Sunday school at the East Cambridge Jail sparked her devotion to better the mental health system. She actively worked with the United States government to establish thirty-two psychiatric hospitals through her 40-year period and began to revolutionize the field. Her contributions made the public aware of the institutions’ poor living conditions, lack of funding, and
violations of human rights. As a result, governments throughout the world felt the need to deinstitutionalize care since the “asylum based” mental health system lost public appeal.

In that past decade, mental health has also made monumental improvements. In fact, the field has been divided into particular disorders that pertain to anxiety, behavior, eating, substance use, mood, and psychosis. Specialization has provided patients with precise care and medication, reducing the chance of misdiagnosis and mistreatments. Moreover, according to the Washington Post, the United States of America spends about 113 billion dollars on mental health each year. Billions are being spent internationally as well. This funding was initiated by the World Health Organization’s global program Nations for Mental Health. This organized high-profile awareness events, provided assistance to developing countries, and created a publication series to educate the general public. As a result of this program’s success, the WHO held another conference to improve the current system. This conference in 2004 specifically encouraged countries such as Belize, Egypt, Mongolia, Romania, Sri Lanka, and Yemen to develop more mental health facilities with the support of the UN. Recently, the WHO has been involved in countless studies, examining the presence of mental illness in today’s society. As a result of their finding, the WHO launched the Mental Health Action Plan 2013-2020, which aims to fulfill four major goals: develop effective leadership and governance for mental health, improve social services, implement strategies for promotion and
prevention, and strengthen information’s systems\(^2\). Though this program is designed to manage the mental health system for the next decade, it still has weak areas that can be improved.

**Current Status of the Problem**

The mental illness image has proliferated poor handling of many psychological diseases around the world. Where many nations are filled with people suffering from marginalization and refusal of basic rights, their image is often associated with violence, incompetence, and burden. Additionally, the majority of workers within the field do not know how to properly handle treatment of mentally ill patients. If a patient is not alienated and held at such high a stigma within the community, many health care workers continue to follow the common misconception that the best care lies in extensive hospitalization. Even among highly developed countries not only does this stigma exist, but mental health care still operates on a lower level of efficiency than physical health care.

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1.6.1. Suicide mortality rates, 2011 (or nearest year)

[Graph showing suicide mortality rates per 100,000 population]

A major issue for patients when it comes to treatment is not only lack of availability for care, but also that many times the only care available or widely accepted is institutionalization, which not only serves as a proponent of the mental illness stigma, but also inevitably leads to further human rights violations such as inhumane treatment practices and unacceptable living conditions. For those who do not have access to these institutions are consequently shunned from society and many times cannot acquire basic commodities like food and shelter, experience employment difficulties and discrimination, and sometimes are not allowed to vote, marry, or have children. Because of these conditions, people with mental disabilities are forced into poverty and desolation, making it even more difficult to gain the necessary care and assimilate into society.

Not only do mental health issues exhibit themselves biologically, but mental health stability is especially hard to maintain for what the WHO classifies as "any population exposed to extreme stressors," such as people experiencing internal conflict, natural disaster, or refugee status. The WHO Department of Mental Health and Substance Abuse prioritizes low-resource nations with high exposure to war or disaster in order to combat the effects of such tragedies on the collective mental health of a country's population. The Department aims to serve as a resource of advice, a spearhead of leadership, and a producer of evidence for policy and field-base work by governments, NGOs, and intergovernmental bodies.¹

According to a report issued by the WHO, it costs an average of two dollars to provide mental health treatment to patients in developing countries, which could account for up to 75% of global mental and neurological problems. The place where this standard is most difficult to attain is within African nations which particularly falter when it comes to psychiatrists and care. Countries like Ethiopia and Nigeria severely lack properly trained psychiatrists and basic infrastructure to carry out
treatment. Additionally, it is increasingly common in these nations to revert to non-traditional healing practices that are more likely to be subject to abusive treatment and still do nothing in ways of stigma. Especially in Nigeria is the mental illness image an issue, causing many families and individuals to ignore any problems rather than actively seek help for them.\(^2\)

Asia is especially guilty when it comes to stigmatization of mental health disorders. As previously stated, people with mental illness are considered aggressive and distant. This in combination with traditional and ancient beliefs and practices serves a tentative approach toward care. There is also a very strong dichotomy between urban and rural care in Asia. Personal finances prevent many patients from receiving care, making treatment available only to those who can afford it and promoting a further stigmatizing attitude and divide.\(^3\)

In fact, a survey conducted by the World Mental Health Surveys found that responses from 16 nations of different worldwide regions showed 22.1% participants from developing nations experience embarrassment, shame, and discrimination due to mental illness, while the percentage dropped to 11.7% in developed nations. However, it is expected these results widely underestimate true figures because they only looked at anxiety and mood disorders.\(^4\)

Perhaps the most important international development in regards to aiding the mental health care cause is the 2008 UN
Convention on the Rights of Persons with Disabilities (CRPD). The convention serves to delineate the civil, social, and political rights that are often not afforded to persons with mental disabilities, including the right to live in the community, to receive an education and health care, as well as to be employed. It also aims to promote inclusion within individual communities by providing access to deinstitutionalized health care services and programs oriented around social habilitation and service. Just as important as social rights is equal protection under the law as well. The CRPD also emphasizes rights such as those to own property, engage in contracting, managing personal finances, and maintaining their "legal capacity" to have and exercise.5

But aside from the CRPD, there are many international and regional agreements that exist in regards to the rights of persons with disabilities. On an international level, the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), and the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) are prime examples of the international community's effort to lower stigma surrounding mental health issues and maintain individual's rights. The Inter-American Convention on all Forms of Discrimination Against Persons with Disabilities, the Inter-American Convention to Prevent and Punish Torture, and the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment are additional examples of regionally based attempts at providing rights to disabled peoples.6

According to the WHO, currently worldwide "suicides account for 50% of all violent deaths in men and 71% in women."7 Additionally, only 28 countries have national suicide prevention initiatives, and there are still some nations who criminalize suicide, which makes it harder to seek help. Many nations, however, have taken successful steps toward mental health integration and
awareness in society. For example, the nation of Belize has recently shifted its focus in regards to treatment from institutionalization to a more community-oriented effort "to reduce the current treatment gap by improving mental health services' accessibility and acceptability." The country's Ministry of Health has begun to serve outreach programs where primary care in outpatient clinics are high-functioning in every district in the nation. The Ministry is also continuing its plans for further improvement by updating legislation, strengthening existing infrastructure, and allocating a larger budget to the cause.  

The Portuguese Republic has also committed measures to improving its mental health care system by devoting a new branch of its Ministry of Health to national mental health coordination and, most importantly, fostering collaboration between national health services, nongovernmental organizations, and disaffected persons and families. Like Belize, the road for Portugal continues as the country plans on issuing stronger guidelines for treatment, training professionals, and instigating anti-stigma and prevention programs.  

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6 http://www.who.int/mental_health/policy/legislation/un_and_regional_human_rights_instruments.pdf?ua=1  
7 http://www.who.int/mental_health/suicide-prevention/exe_summary_english.pdf?ua=1  
8 http://www.who.int/mental_health/services/belize_country_summary_2013.pdf?ua=1  
9 http://www.who.int/mental_health/policy/country/Portugal_CountrySummaryFINAL_MOH.pdf?ua=1
Possible Solutions

Firstly, doctors and administrators must come to understand exactly what mental illnesses are before they can begin to attempt solutions. Mental illnesses are actually very little understood, and proper treatments for mental illness are even less understood and agreed upon. Setting up educational policies to further research mental illness should be considered a prerequisite to forming practical solutions on this topic. In addition to further research in the medical field, improving general education on the topic will help to develop a broader understanding of the mentally ill that will allow for better treatment. By this it is meant educating the public on the roots of mental illness and how to effectively deal with mental patients can help to eliminate much of the problem at its source.

Secondly, reforming the insurance structures for many companies and nations globally should be a paramount concern. Many are unwilling to provide support to the mentally ill due to cost concerns, which leaves the mentally ill with little to no way of effective dealing with their condition. Perhaps highlighting the human rights concerns of this topic will promote an awareness that forces or convinces the insurance companies to include care for the mentally ill in their plans. Additionally, recent consequences of not caring for the mentally ill such as the Sandy Hook shootings could provide a basis for reform proposals in terms of how to best manage mental illness and the overall approach taken towards solving the problem.
In making solutions, it is important to realize and address the global aspect of the issue, as the WHO is a global body. Instead of focusing on solutions that may alter individual nation’s mental health care structures, find ways to work together as a committee to develop solutions that will benefit the world as a whole. Examples would be global efforts to eliminate stigmas against mental illnesses. Although the world has progressed in many ways, several areas of the world still treat mental health patients much like they do a criminal, which highlights the need to reform the view and stance of governments on mental health conditions globally. Delegates could work together to pass solution that agrees on a uniform and informed approach and acknowledgement of mental health conditions as medical conditions that need proper treatment. Standardizing responses and treatments to certain well-known mental illnesses may also be a viable option. For example, the WHO has recently established programs to raise awareness for schizophrenia and suicide specifically. Establishing similar programs or taking current programs beyond their status quo applications, such as creating a consensus on the proper response to specific conditions, could also be viable solutions.

Similar to the first topic, mental health care is a topic very much open to delegate creativity and innovation. Again, keep in mind there are already an excess of solutions for individual nations, however; the point of the WHO is to create solutions in a unique setting of international cooperation. Think global.

**Bloc Positions**

Western developed nations are much more likely to have stronger infrastructure in place toward mental health care. However, this does not mean that a stigma does not exist within these nations. It is the duty of developed countries to use their individual experience and successes to create solutions that encompass all nations and continue to combat the worldwide stigma.
Traditionally, countries with universal health care (such as Canada, Japan, Germany, France, the Netherlands or Switzerland) have some of the best mental health services because of the nationwide access and general wealth of the country. However, just because a nation may have universal coverage, this does not mean that its people are impervious to mental illness. In fact, Denmark, ranked in 2013 as the happiest nation on the planet by the World Happiness Report, has documented that 38% of women and 32% of men will receive treatment for some mental issue in their lifetime.¹⁰

Most developing nations, in particular those of Africa and Asia like Ethiopia, Nigeria, and Pakistan, are faced with very high instances of stigma and human rights abuses and are much less likely to have well-established mental health care systems in comparison to developed nations. These are the nations that will benefit the most from resolutions passed in this committee, but they must be willing to overlook many of their existing faults. Pakistan in particular has struggled with the privatization of its health care because this has been extremely disadvantageous for the poor, who are often the ones who need it the most. The correlation between poverty and mental illness acquisition has proven relatively strong for people all over the world.

However, according to the WHO Country Profiles on developing mental health systems, not all poor nations are failing at providing proper treatments or mental illness initiatives. Like Belize in³ Central America, African nations such as Gambia, Ghana, Kiribati, Nauru, Sierra Leone, Uganda, and Vanuatu are classified as some of the nations who have needed the most help with their mental health system, but have also been making significant milestones in terms of systematic infrastructure.

¹⁰ http://www.theguardian.com/science/blog/2014/may/14/mental-illness-happiest-country-denmark
¹¹ http://www.who.int/mental_health/policy/country/countrysummary/en
as well as overall ideology. Their systems are by no means as developed or functioning as they should be, but a few significant steps in the right direction are steps nonetheless.

Questions to Consider

1. What is the role of the government to prevent stigma in the community?

2. Which is more important: prevention or treatment? Are they both equal, or should the international community emphasize one over the other?

3. How can mentally ill persons assimilate into society most efficiently? What can the international community as well as individual nations do to aid assimilation?

Helpful Resources

- For a descriptive summary of your country's mental health system, reference the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS):
  http://www.who.int/mental_health/who_aims_country_reports/en/#B

- A list of ideas composed by the WHO on "What can be done"

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Topic B: Health Care During Times of Conflict: Emphasis on Iraq and Syria

History of the Problem

Governments throughout the world have discovered strategic ways to disband and eliminate anti-governmental protestors. They use tear gas, firearms, and other weapons to physically harm belligerents, but they have come to realize that it is simply not enough to stop the civil unrest. These nations experiencing civil unrest have concluded that the most effective way to end the protests is to target medical professionals.

These medical professionals are providing medical assistance to anti-governmental protestors. Their involvement in the battle between society and state is crucial to the outcome the civil conflict. Therefore, corrupt governments and private pro-governmental organizations feel the need to eliminate these figures to unfaithfully win the political battle. Certain non-governmental organizations also feel the need to execute or abduct medical personnel because reducing the medical care results in an advantage in a conflict.
Dozens of Shi’a Muslims gathered in Pearl Square in Bahrain to protest for economic and political reform, but the Sunni populated government refused to grant them any concessions. In response to the Shi’a reluctance, the government used tear gas, guns, and other chemical weapons with the intent of stopping the protests. Thousands were severely injured and were treated at the local hospital, and they then returned to Pearl Square. The government recognized this, so they began to secretly abduct and blackmail medical staff to prevent protesters from ever returning to the protest.

This strategy was also used by the Iraqi government in the battle against the Sunni minority. The power struggle between the majority Shi’a and the minority Sunni led to Iraqi civil conflicts. In one case, the Sunni dominated Fallujah General Hospital was assailed by a group of unidentified men. The government claims to have no involvement in the attack, but evidence shows that the mortal shells, fire weapons, and barrel bombs used in the attack were Iraqi governmental property.

Along with the Bahrani and Iraqi governments, the President Bashar Al-Assad and the Syrian government adopted the same method of attack. After a group of school children vandalized walls in the city of Derra with anti-governmental statements, the Syrian government began to violently punish all anti-governmental protestors. Its use of chemical weapons and arms would lead to thousands of casualties and injuries. Again, protestors were aided by medical personnel and returned to fighting the government. President Bashar Al-Assad
recognized this dependence on medical care, so he ordered medical staffs to not provide care to injured protesters. This eventually forced over 1.4 million Syrians to flee to other bordering nations to receive proper medical care.

Since both the Syrian and Iraqi governments are using this method to eliminate anti-governmental protestors, the citizens are helpless and are not able to receive proper medical care. Currently, the WHO as well as multiple other bodies in the UN are formulating new methods to punish and deal with the corruption.

**Current Status of the Problem**

According to the International Code of Medical Ethics of the World Medical Assembly, "medical ethics in times of conflict is identical to medical ethics in times of peace." However, during times of armed conflict and internal instability, standard practices and functioning mental health systems rarely follow this equilibrium. Although it is the duty of governments or organizations in positions of power to maintain standard care to all peoples during times of conflict, this obligation to comply with the Geneva Conventions and protect workers and facilities is rarely met. 12

At the start of 2014, almost 600,000 Syrian refugees have made their way into Iraq's borders, with almost 200,000 in camps and 300,000 in host communities, according to the
WHO. This influx has continued to put severe pressure on public health institutions within Iraq and has issued a major burden for resources as this number has expectedly risen since. While the WHO has taken many successful measures in aiding refugee camps and outside networks, there is still a need for more support, expansion, and resources. However, it is estimated that it will only take a USD $3.75 million to meet most if not all the needs for the health sector in Iraq to provide enough health care to displaced peoples.13

Not only do times of conflict dismantle health service and ideological infrastructure, but they also pose a physical threat to hospitals and health care workers which further increases the mortality rate during these instances of violence. The civil war in Syria in particular has demonstrated the physical detriment that war has on hospitals and medical personnel. Many health facilities have been deliberately targeted as a strategic weakening point, denying access to care and treatment.14 There are, however, many reactive efforts to replace these facilities by establishing temporary health clinics for refugees. In fact, the Government of Iraq has collaborated with humanitarian counterparts to improve the situation for Syrian refugees during the civil war by running free clinics within the camps, and for those outside of the camps as well within Iraq’s hospitals.15 The refugee situation in both Iraq and Syria has provided another tricky measure in regards to maintaining health care during war; the multifaceted issue not only includes the issue of maintaining existing health infrastructure within nations experiencing conflict, but how refugees can be provided proper care at a comparable level. Health care for refugees is a serious issue for both nations, because even though efforts have

12http://www.wma.net/en/30publications/10policies/a20/
been made to assist, there is still call for a strengthening of these institutions as the refugee situation is expected to worsen, as overcrowding accelerates the spread of many illnesses and basic injuries are harder to attend to.

Because of the Syrian crisis, the nation has experienced a "severe deterioration" of conditions that have consequently dismantled the entirety of the health system and its personnel. Aside from civilian casualties, numerous health staff have been killed and/or injured on-duty, infrastructure has been completely destroyed and devoid of shelter and security, and access limited if not nonexistent. Major concerns have surrounded maternal and child care, chronic illness that cannot have the continuous treatment it requires, and communicable diseases within refugee camps. As fatal or near-fatal injuries flow into whatever infrastructure exists, many long-term care patients are thrown on the backburner and do not receive the extensive care they need for their curable diseases. Overcrowding has been especially detrimental to the availability of drugs, space, and other resources, significantly lowering not only the quantity of care but also the quality.

Although there needs to be further comprehensive evaluation of the status of care at this time, one assessment conducted by the WHO this past June looked at the functionality of the services currently available in affected areas. The survey, which examined 342 primary health care centers and 38 hospitals in provinces all over Syria found that 43% of facilities are considered to be "partially functioning," 2% "nonfunctioning," and 13% "inaccessible" because of distance, insecurity, and/or transportation. Additionally, only 50% of hospitals are considered to be functioning because of a need for staff and resources. Many have little if any access to sanitation, generators for electricity, and basic apparatuses. These scarcities are expected to have worsened from the recent crisis escalation.
There is now a very urgent need for a holistic examination of the health situation within Syria as well as Iraq's capacity to handle further intrusion. This thorough, multilateral assessment needs to incorporate logistical concerns as well as the atrophying socioeconomic situation and political instability. Collaboration with the Syrian government is worrisome but inevitable if there is expected to be any long-term progress and rehabilitation of the health sector. The Syrian International Coalition for Health is one body that is currently working to carry through this evaluation, but its effectiveness and efficiency is questionable, and it will be a very large task to rebuild a collapse of the entire health infrastructure.

Possible Solutions

As of now, protections for health care professionals and facilities are protected under International Humanitarian Law (IHL) during times of armed conflict. While this provides adequate protection during times of armed conflict, instances of attacks on health care systems during times of non-armed conflict are not protected, leaving a huge gap in the IHL benefits. Extending the benefits for the protection of the health care system under IHL to include protection in times of non-armed conflict could help fill this gap. In doing so, it is important to define what constitutes a non-armed conflict, so it is clear which scenarios justify the protection of health care systems.
Techniques of implementing this protection are equally as important. Currently, several NGOs geared specifically toward providing health care during times of conflict have been proliferating. One example is Safeguarding Health in Conflict, which through its system of lessening violence, improving accountability, increasing evidence of attacks, and developing strategies for protection, has helped to improve the quality of care during times of conflict in many areas. While achieving widespread success, these missions are only able to be carried out on a small scale due to the limitations of NGO’s. As a committee, the WHO should come together and establish a system to implement similar systems on a global scale to ensure the protection of healthcare systems globally.

Past WHO resolutions have come up with great proposals, but have been ineffective in actually implementing their resolutions. For this reason, specificity of resolutions will be key to identify the best mechanisms for carrying out the proposals of the committee. In terms of approach, this is best done by discussing both reactive and proactive solutions to the topic. A major issue to deal with in terms of reactive responses will be finding ways to identify the violators of health care systems and holding them accountable for their actions. Too often do groups and individuals get away with their neglect of health care systems and even attempts to use the health care system as a weapon. In terms of proactive solutions, the committee could identify ways to establish safeguards against conflicts affecting health care systems and resiliency of health care networks. This is a very broad topic that encompasses many other aspects of conflict and health care, so creative solutions will be helpful and are encouraged.
Bloc Positions

Developed nations tend to be the primary suppliers of aid to regions and thus hold a lot in stake in terms of collaboration with regions and organizations. Because they rarely if ever experience consequences to health systems because of conflict, their primary concern is using their resources and innovation to help nations who do need such care. Currently, the United States leads all nations in financially supporting the refugees in Iraq and Syria. Its $177 million contribution has greatly impacted the health care service and quality in the region by providing essential medical equipment and personnel. The United Kingdom has also shown involvement in the crisis. In early January of 2014, British officials reassured the international community that they would provide “mobile clinics, health care and emergency surgery for up to 120,000 Syrian refugees.” Moreover, various European nations have also raised fund to financially support the cause such as Germany, Switzerland, and France.

Most developing nations have less of a capacity to provide for nations in need, but there is still a necessity for these countries to collaborate and provide ideas toward the resolutions on the floor. Some developing nations have individually experienced the repercussions of conflict within their own borders, thus they offer a key viewpoint as to the needs and problems with rebuilding health infrastructure and possibly providing for refugees. Nations such as Jordan have not been able to
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provide a substantial amount of aid. However, their involvement has definitely been critical because of their geographical relationship with the crisis.

Though there is support from nearly all nations, the situation still requires much more involvement from Eastern nations, specifically those in Southeast Asia and Australia. Their participation would definitely provide aid to the long lasting health care crisis in the region.

Questions to Consider

1. What needs to emphasized more: reactive or proactive measures? Is addressing both feasible?
2. To what extent should the committee focus on health care in refugee camps? Is reestablishing infrastructure within affected nations just as important? More important?
3. What is the role of individual nations capable of helping the cause? The role of international organizations/bodies?

Helpful Resources

- Evaluating the ways in which the healthcare system in Syria has been affected by the conflict is critical, and this is a good place to start: https://www.google.com/webhp?sourceid=chrome-instant&ion=1&espv=2&ie=UTF-8&q=healthcare+in+syria
- Safeguarding Health in Conflict NGO website: http://www.safeguardinghealth.org/resources

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