



ALOK MODEL UNITED NATIONS
2019-2020

A Background Guide for the
World Health Organisation

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Alok Model United Nations

A LETTER FROM THE SECRETARY-GENERAL

Dear Delegates,

It is my distinct pleasure to welcome you to the first session of Alok Model United Nations. I hope that you are excited to embark on your preparations for the conference, and even more excited to begin working in one of the four challenging, creative, collaborative, solutions-oriented, and above all substantively enriching committees.

The United Nations as a body and Model UN an activity stress diplomacy, innovation, and cooperation. It is through becoming substantively engaged and deeply knowledgeable about these topics that you may proceed to develop your own solutions and work with your fellow delegates in discussion, promotion, and hopefully even resolution about the challenges facing your committee. We encourage you to take this background guide as a starting point for your research and use it as inspiration in your own preparation as well as in your everyday thinking. As a conference, in AMUN delegates will tackle issues spanning the centuries from 1740 to 2019, topics pertinent to every inhabited continent, and ideas that are capable of nothing short of changing the world. The opportunity to discuss and develop innovative approaches to the world's most pressing global questions with is an unparalleled one, and I hope you seize it to its full extent.

We look forward to meeting each and every one of you on this adventure together. For now, allow this background guide to be your starting point on your AMUN journey. We hope it will be a memorable one.

Sincerely,
Lavansh Sagtani
Secretary-General
Alok Model United Nations

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Alok Model United Nations

A LETTER FROM THE DIRECTOR

Dear Delegates,

It is my pleasure to welcome you to the First Session of Alok Model United Nations and to the World Health Organization. My name is Lavansh Sagatani, and I am first year student. I grew up in Nepal, where I first became involved in Model UN in high school. I am very involved in Model UN and I have attended various MUN conferences from around the world. Apart from MUN, I also enjoy travelling and going on adventures. In my free time, I thoroughly enjoy playing basketball competitively and playing the flute as well.

I am thrilled to be serving as your Director for the World Health Organization and discussing such challenging issues. Malnutrition leading to child mortality threatens our hopes for a brighter future by debilitating the next generation of global citizens, our children. I hope that with your critical thinking, collaboration, and creativity we will develop innovative solutions to these problems and come to a new understanding of how to best advance our progress in achieving the related Sustainable Developmental Goals and beyond.

I am fully confident that AMUN will provide you with not only an enriching and fulfilling substantive experience, but also a simply incredible and memorable life experience, and I will do my best to contribute. If you have any questions prior to conference, feel free to get in touch with me. I look forward to seeing you at the conference!

Sincerely,

Lavansh Sagatani
World Health Organization, Director
Alok Model United Nations

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Secretary-General

Amulya Chaudhary
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Introduction

The World Health Organization (WHO), a specialized agency within the United Nations General Assembly, possesses the main responsibilities of “providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.”¹ More generally, the WHO functions to ensure the highest possible quality of health for all citizens of the world. This committee will address a single topic that directly concerns the work of the WHO: malnutrition leading to child mortality.

Global Health and Epidemiological trends both indicate a transition from communicable diseases to non-communicable disease in terms of recent global health burden, making adequate nutrition and finding solutions to malnutrition increasingly important.² This is especially applicable to children, as studies suggest that the first two years of a child’s life following birth constitute the critical period for nutrition, often dictating the quality of long-term health. This rapidly evolving topic requires a critical examination of current global standards relating to child nutrition, and analysis of past and potential interventions. Therefore, it is of utmost importance for the World Health Organization to address this crucial issue and provide guidance to the international community as to how to combat and reduce child malnutrition globally.

During our time together in Hyderabad, we will explore potential policy recommendations, tactical action plans, the implementation of new strategic framework, reallocation of resources, and building upon existing partnerships and infrastructure. Discussion and debate will range from economic analysis to health policy, social and cultural issues, and even ethics. Though the nature of these issues is indeed multi-faceted, the resources and potential of the WHO are abundant and versatile, and the ultimate goal of our

committee is to draft comprehensive resolutions addressing the problems at hand, going above and beyond our existing solutions to these issues to incite meaningful change for the future.

History of the Committee

Established on 7 April 1948 in Geneva, Switzerland, the World Health Organization has evolved over the years in its approach to international public health.³ As it transcends the barriers of time and place, health has always been a concern of the public, from the plague pandemic of the Middle Ages to disease outbreaks of the 19th century such as the cholera epidemic in Europe. These issues prompted the holding of international sanitary conferences during the late 1800s, which consisted of basic meetings of small governmental delegations, with countries represented by usually only one physician and a diplomat.⁴ The establishment of the International Sanitary Bureau (1902) (later known as the Pan American Health Organization) and the Office International d’Hygiene Publique (1907) in Rome served as two of the earliest formal international public health agencies.⁵ The League of Nations’ Health Organization followed suit in 1921, built upon these agencies and served as a precursor to the WHO.⁶

Upon the conclusion of World War II, international governments met in San Francisco to draft the UN Charter and establish the United Nations.⁷ The general consensus was that there was a clear need for a unified global health organization that addressed the public health needs of an increasingly complex and globalizing world.⁸ On 22 July 1946, all 69 member states of the United Nations signed the constitution of the World Health Organization, which came into order on 7 April 1948 (known as World Health Day) and held its first meeting on 24 July 1948.⁹ At this meeting, the resources of pre-existing international health organizations were consolidated under the WHO, which emphasized its unified and truly

	Vitamin	Functions	Deficiency Disease
A	Retinol, β -carotene	Visual pigments in the retina; regulation of gene expression and cell differentiation; β -carotene is an antioxidant	Night blindness, xerophthalmia; keratinization of skin
D	Calciferol	Maintenance of calcium balance; enhances intestinal absorption of Ca^{2+} and mobilizes bone mineral	Rickets = poor mineralization of bone; osteomalacia = bone demineralization
E	Tocopherols, tocotrienols	Antioxidant, especially in cell membranes	Extremely rare—serious neurologic dysfunction
K	Phylloquinone, menaquinones	Coenzyme in formation of γ -carboxyglutamate in enzymes of blood clotting and bone matrix	Impaired blood clotting, hemorrhagic disease
B ₁	Thiamin	Coenzyme in pyruvate and α -ketoglutarate, dehydrogenases, and transketolase; poorly defined function in nerve conduction	Peripheral nerve damage (beriberi) or central nervous system lesions (Wernicke-Korsakoff syndrome)
B ₂	Riboflavin	Coenzyme in oxidation and reduction reactions; prosthetic group of flavoproteins	Lesions of corner of mouth, lips, and tongue; seborrheic dermatitis
Niacin	Nicotinic acid, nicotinamide	Coenzyme in oxidation and reduction reactions, functional part of NAD and NADP	Pellagra—photosensitive dermatitis, depressive psychosis
B ₆	Pyridoxine, pyridoxal, pyridoxamine	Coenzyme in transamination and decarboxylation of amino acids and glycogen phosphorylase; role in steroid hormone action	Disorders of amino acid metabolism, convulsions
	Folic acid	Coenzyme in transfer of one-carbon fragments	Megaloblastic anemia
B ₁₂	Cobalamin	Coenzyme in transfer of one-carbon fragments and metabolism of folic acid	Pernicious anemia = megaloblastic anemia with degeneration of the spinal cord
	Pantothenic acid	Functional part of CoA and acyl carrier protein; fatty acid synthesis and metabolism	
H	Biotin	Coenzyme in carboxylation reactions in gluconeogenesis and fatty acid synthesis	Impaired fat and carbohydrate metabolism, dermatitis
C	Ascorbic acid	Coenzyme in hydroxylation of proline and lysine in collagen synthesis; antioxidant; enhances absorption of iron	Scurvy—impaired wound healing, loss of dental cement, subcutaneous hemorrhage

global nature, with the primary objective of “the attainment by all peoples of the highest possible level of health.”¹⁰

In the following years, 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. Perhaps the most significant success of WHO was the eradication of smallpox through the Smallpox Eradication Programme (SEP) from 1966 to 1980.¹¹ 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.¹² 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.¹³ 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 with non-governmental organizations, and has collaborated in some form with nearly 300 more.¹⁴ Some key partnerships include Oxfam International, and the Bill and Melinda Gates Foundation.¹⁵ 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 the post-2015 strategic framework with regard to the 2015 UN Millennium Developmental Goals.

History and Discussion of the Problem

Malnutrition, defined by the World Health Organization as “the cellular imbalance between the supply of nutrients and energy and the body’s demand for them to ensure growth, maintenance, and specific functions,” has been considered the greatest single threat to public health worldwide.¹⁶ As an underlying cause of approximately 45% of deaths of children under the age of 5 (child mortality), and the leading cause of immunodeficiency diseases worldwide, malnutrition has a significant impact ranging from global health and social culture to economics and politics.¹⁷ Additionally, recent epidemiological trends indicate that non-communicable diseases related to malnutrition are overtaking communicable diseases in terms of global health burden, making it crucial to understand malnutrition and explore possible solutions.

Much of public health in the 20th century was dominated by the emerging study of nutrition, and its relation with other health fields such as infection and immunity.¹⁸ From the origins of examining nutrition and lack thereof, it was apparent that there existed a dichotomy of malnutrition: undernourishment in developing countries, and over-nourishment in developed countries.¹⁹ Both instances result in situations in

which the body is not receiving the proper amount of vitamins, minerals, protein, and nutrients, therefore constituting malnutrition.²⁰ Often times, severe deficiencies from undernourishment lead to harmful, visible diseases such as vitamin C deficiency causing scurvy, or vitamin D deficiency causing rickets in children and osteomalacia in adults.²¹ Other micronutrients, their functions, and deficiency diseases are shown in the following table.

In more recent years, the exploration and characterization of these diseases resulting from micronutrient deficiencies has led to the idea of hidden hunger. Afflicting billions of people worldwide, hidden hunger is the concept of having no major phenotypic signs of a disease, yet possessing serious potential health problems due to lack of essential vitamins and minerals.²² Hidden hunger has predominantly affected areas of poverty in developing regions, and is known to lead to blindness, illness, decreased productivity, and poor mental development.²³ Clearly, this problem transcends the realm of public health and affects all aspects of life, especially for children, as early nutrition has been shown to have long-term effects.

Types of Nutrition Interventions

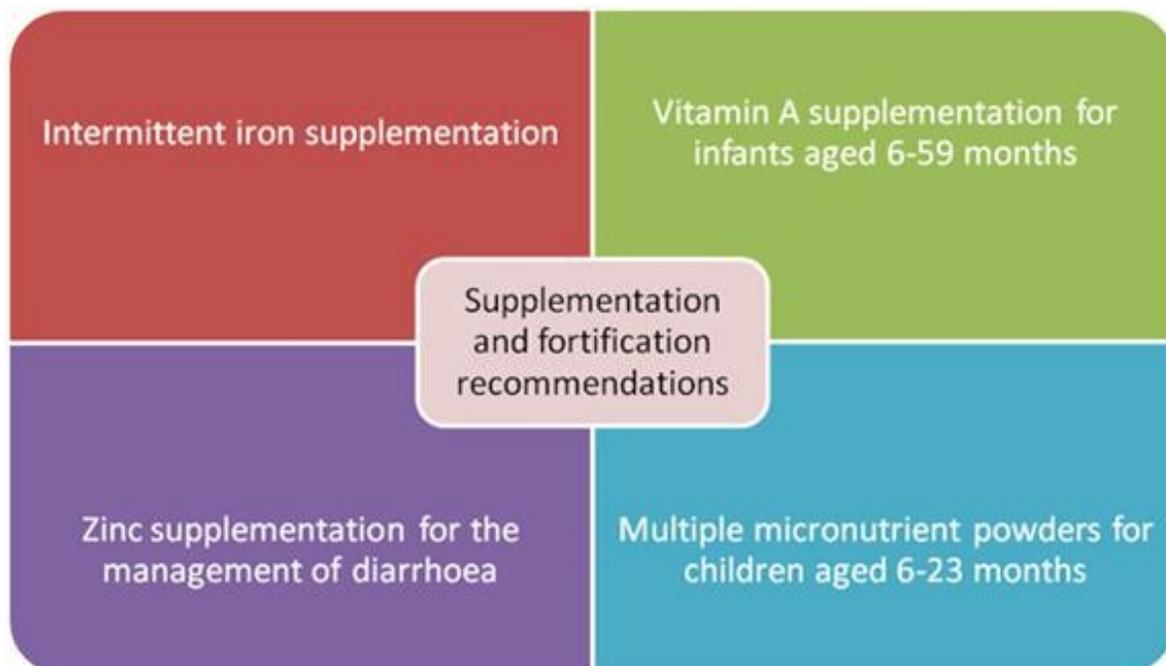
Given the prevalence of this issue, there have been many attempts to combat hidden hunger and malnutrition in general through different types of nutritional interventions. Historically, nutrition interventions have fallen into a few major categories: the promotion of breastfeeding, increasing dietary diversity, supplementation of essential vitamins and minerals (micronutrient supplementation), and food fortification.²⁴ The promotion of breastfeeding is based on the idea that the first two years of a child’s life represent the critical period for nutrition, and adequate nutrition can be achieved by exclusive breastfeeding during this time period followed by complimentary breastfeeding.²⁵ The literature supporting this plan of nutrition is extensive, and the World Health Organization along with

UNICEF has released guidelines describing the benefits of safe, proper breastfeeding.²⁶ However, there are certain complications that limit the effectiveness of breastfeeding, such as concern over HIV/AIDS transmission from afflicted mothers to children, and improper feeding practices.²⁷ Though the WHO has taken stances on these issues, many countries remain unsure and divided regarding the best option to take in these situations.

Micronutrient supplementation, as a nutrition intervention, holds many potential benefits but negatives as well. As seen above, global health recommendations for supplementation include zinc, iron, and vitamin A, which constitute the majority of deficiency occurrences among children worldwide, along with iodine.²⁸ Supplementation, or the act of administering essential vitamins and minerals in drug form, directly improves nutritional status and is a precise method to target specific populations and individuals.²⁹ Also, by accurately addressing micronutrient needs, supplementation preserves medical supplies and resources. However, there are many limiting factors to the effectiveness of micronutrient supplementation, one being compliancy issues.³⁰ As supplements must be taken

repeatedly, when people fail to do so for a number of reasons, it reduces the impact of the treatment. Additionally, micronutrient supplementation is often times expensive and impractical, given the many combined needs of children, especially in developing countries (see figure above).³¹

The practice of increasing dietary diversity is another nutrition intervention that has been utilized in the past. An intervention of this type consists of implementing the proper infrastructure to improve both access to and availability of micronutrient-rich foods for populations.³² Whereas people living in developing regions may have originally ate one specific food or food group mostly due to economic feasibility or practicality, after being provided a greater variety of food they are enabled to improve their nutritional status and incorporate more essential nutrients into their diets. The major problem that has been seen in this type of intervention is effective planning and execution of the programmes that will produce and disseminate new foods. Since this aspect of the intervention is often variable and cannot always be properly put in place, increasing dietary diversity usually serves as a recommendation rather than a concrete plan of action.



Food Fortification

Food fortification, a similar practice as enrichment, is the deliberate adding of nutrients to increase the nutritional value of foods with respect to essential vitamins and minerals.³³ With many types of fortification being endorsed by the World Health Organization, they have demonstrated great promise in both developing regions and developed nations, possessing potential public health benefits with minimal risk.³⁴ For example, given that iodine is found in relatively small values in normal diets, the World Health Organization has recommended universal salt iodization, the fortification of salt with iodine, to prevent and correct iodine deficiency.³⁵ This suggestion has been met with great success in the past decade, as return on investment of iodized salt with reference to the economics of increased public health status and worker productivity has been in the thousands percent range.³⁶ As a commercial process, some of the most commonly fortified foods include milk and cereal products.³⁷

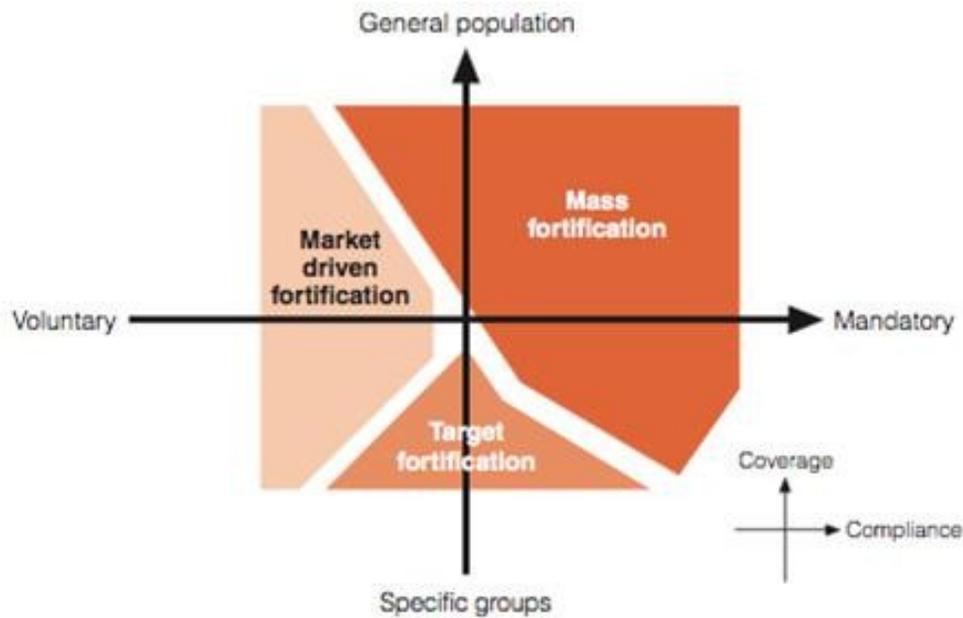
Though food fortification began mostly in industrialized countries, recent years have seen less industrialized countries adopting such measures. In the 1920s, both the United States and Switzerland began salt iodization, a practice that is now utilized by nearly all countries.³⁸ Fortification expanded to milk and cereal products in the 1940s, with mostly the B vitamins (i.e. thiamine, niacin, riboflavin).³⁹ One intervention that has persisted due to its success is the fortification of sugar with vitamin A in Central America. Historically, vitamin A deficiency has been a severe health concern in Central America, but since the sugar fortification technique was made mandatory in the 1970s, the problem has abated considerably.⁴⁰ Developing countries in sub-Saharan Africa have been identified as potential targets for similar fortification interventions.

The basic principles of food fortification are outlined in the Codex General Principles for the Addition of Essential Nutrients to Food. After years of development, food fortification has been divided into multiple forms based on the

parameters of levels of coverage and compliance (mass fortification, targeted fortification, and market-driven fortification), as depicted below.⁴¹ Mass fortification is the addition of micronutrients to foods that are commonly consumed by the public.⁴² Most often used by governments in situations when a large portion of the population is at a high public health risk of deficiency, mass fortification requires substantial evidence before implementation given its high levels of coverage and compliance.⁴³ Targeted fortification involves fortifying food for specific subgroups of the population, selected based on need, practicality, and a number of other factors.⁴⁴ One example of targeted fortification is the foods developed for elementary school feedings programs.⁴⁵ Finally, market-driven fortification refers to manufacturers using fortification as a business approach. With relation to mass fortification and targeted fortification, market-driven fortification demonstrates less compliance as it is voluntary, and has the potential for either more or less coverage based on market mechanisms.⁴⁶ Since fortification occurs at the manufacturer, this technique can be used to supply less common micronutrients such as riboflavin (Vitamin B2).

Biofortification of Staple Crops

Biofortification, the genetic modification and breeding of staple foods to increase their nutritional value (essential micronutrient content), is an emerging and controversial nutrition intervention that has the potential to revolutionize public health and food security, but also lacks information and possesses financial, environmental and health safety risks. The development of biofortification can be divided into its two primary methods: genetic engineering and conventional selective breeding.⁴⁷ Though both methods function to improve nutrient content in plants and crops for consumption, they have different concerns and details regarding their development and use.



Current Situation

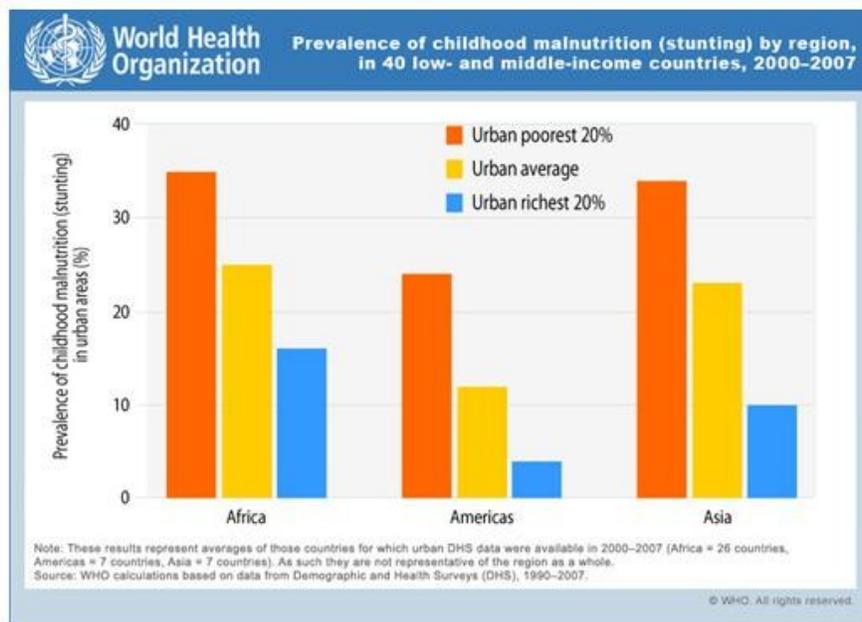
Malnutrition Prevalence

The prevalence of malnutrition worldwide is well documented. Though malnutrition also encompasses wasting (low weight-for-height ratio) and underweight (low weight-for-age ratio), the figure below illustrates the prevalence of childhood malnutrition on the basis of stunting (low height-for-age ratio), which is accepted to be an accurate indicator of chronic malnutrition and long-term developmental risks.⁴⁸ As depicted, there is a clear trend that negatively correlates income and socioeconomic status with increased risk of childhood malnutrition.⁴⁹ Additionally, though there are certain regions in which childhood malnutrition is more prevalent, namely sub-Saharan Africa and Southeast Asia, this issue affects nearly every population and must be addressed.⁵⁰

Though the previous data is taken from urban populations as it is more difficult to measure malnutrition prevalence in rural areas, it is estimated that the problem remains consistently bad or even worse in such areas.⁵¹ Although there

has been a decrease in childhood malnutrition in the Americas in the 2000s as compared to the 1990s, there has been relatively no change in Asia and an increase in Africa.⁵² The lack of progress in reducing childhood malnutrition has perplexed the WHO and governments worldwide, for though specific nutrition interventions have demonstrated some success and promise, the overall landscape of the issue has not seen much improvement. This is why such a large current proportion of under-five deaths (the major measure of child mortality) is associated with undernutrition.

The most recent statistics, coming from joint estimates of the WHO, UNICEF and the World Bank, indicate that 162 million children under the age of five were stunted in 2012, with 56% of these children living in Asia and 36% living in Africa.⁵³ These trends extended to both wasting and underweight, with the majority of children who are wasted and underweight living in Asia, followed by Africa.⁵⁴ Though estimates suggest that overall childhood malnutrition prevalence worldwide is decreasing, the rate of decrease is not enough to meet the standards set by the UN Millennium Developmental Goals for 2015.⁵⁵



Breastfeeding and HIV/AIDS

Currently, HIV (human immunodeficiency virus infection) and AIDS (acquired immunodeficiency syndrome) are directly impacting child health. Mothers with HIV/AIDS have compromised immune systems, and risk passing their disease to their offspring during childbirth or the postpartum period (breastfeeding).⁵⁶ Transmission tends to occur in poorer, developing areas, as chances of disease transmission sharply decrease with increased education and proper treatment, but such services are not provided in these regions.⁵⁷ As a result, there has been controversy as to whether or not disease-affected mothers should breastfeed their children, bearing the risks of transmission versus malnutrition in mind. The debate regarding breastfeeding while possessing the HIV infection continues, as global health experts argue whether or not it is feasible to improve education infrastructure in developing regions to a point at which the risk of disease transmission is low enough to be considered safe, and if child malnutrition is worse than HIV transmission.⁵⁸

Past International Actions

eLENA Brief

The first and foremost action of the WHO when dealing with issues of health and nutrition is to refer to its e-Library of Evidence for Nutrition Actions (eLENA).⁵⁹ eLENA is the official source and provider of the latest nutritional guidelines, recommendations, and general information regarding nutritional interventions.⁶⁰ Currently, eLENA is used as the WHO's forum to assist countries in the implementation of nutritional interventions and the development of policy guidelines.⁶¹

Collaborative Research Studies

In addition to reference of eLENA, the WHO has gathered information on optimal nutritional interventions via collaborative research studies. In 2007, it was involved in a number of studies published in the Food and Nutrition Bulletin by the International Nutrition Foundation for the United Nations University.⁶² This specific investigation, titled "From harvest to health: Challenges for developing biofortified staple foods and determining their impact on nutritional status" by C. Hotz and B. McClafferty, represents

the findings from a multi-agency partnership that ranged from the Center for Global Development to the United Nations Standing Committee on Nutrition.⁶³ The research brief itself discusses biofortification as a potential nutritional intervention, concluding that collaboration between health and agricultural sectors must occur, and that there are many challenges in achieving actual population-level impact.⁶⁴ Such research studies are prime examples of testing hypotheses regarding nutritional interventions.

Global Conferences on Child Nutrition

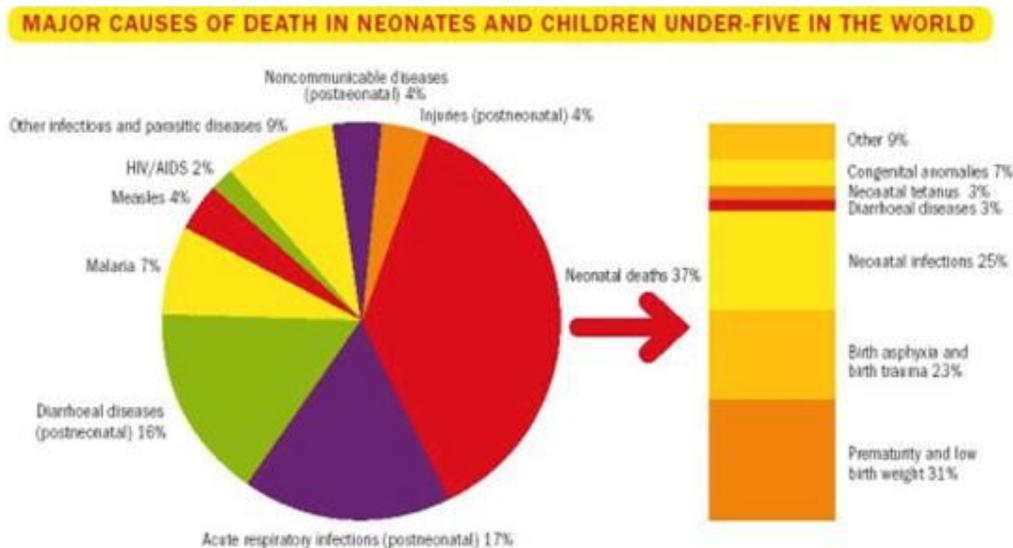
Key recent global conferences on the topic of child nutrition include the Global Child Nutrition Forum (2014) sponsored by the Global Child Nutrition Foundation, and the International Conferences on Nutrition headed by Feed the Children. These conferences, formed primarily as results of collaboration between the World Health Organization, the World Food Programme, the Food and Agriculture Organization, and UNICEF. A major takeaway from these conferences included the need for prioritization of this issue, which is provided as an explanation for the success of UNICEF's child survival revolution (GOBI) and the failure of past

WHO efforts. Many have concluded that such an approach must be applied to determining policy for combatting malnutrition.

Timeline of Significant Events

26 June 1945- United Nations Conference on International Organization held in San Francisco. The need for a new, autonomous international health organization to be established is recognized.

- 22 July 1946- Constitution of the World Health Organization approved at the International Health Conference in New York, signed by 61 member nations.
- 7 April 1948- WHO's Constitution officially comes into force, the day now celebrated as World Health Day.
- 5 November 1974- World Food Conference held, importance of combating malnutrition discussed by UN Food and Agriculture Organization (FAO).
- September 2000- United Nations Millennium Declaration adopted at UN Headquarters in New York City, with three of the eight Millennium Developmental Goals being



35% OF UNDER-FIVE DEATHS ARE ASSOCIATED WITH UNDERNUTRITION

Sources:
For estimates of causes of neonatal and under-five deaths: World Health Organization, The global burden of disease: 2004 update.
For estimates of undernutrition: Black R et al. Maternal and child undernutrition: global and regional exposures and health consequences. Lancet 2008; 371:243-60.
Sources: (1) WHO. The Global Burden of Disease: 2004 update (2008); (2) For undernutrition: Black et al. Lancet, 2008

health-related, and one directly related to malnutrition.

- Early-2000s- Scholarly articles introduce biofortification as a nutritional intervention.
- Early-2000s- UNICEF places an emphasis on striving to eradicate hunger and poverty and reduce child mortality.
- 2000s- Studies conducted to develop potential solutions to malnutrition
- May 2004- 57th World Health Assembly adopts Global Strategy on Diet, Physical Activity, and Health, which discusses the importance of overcoming hidden hunger.
- 1 April 2013- “Improving Child Nutrition: The achievable imperative for global progress” is published, as a comprehensive document detailing WHO/ UNICEF policies.
- 24 September 2014- WHO, UNICEF and the World Bank released an updated joint dataset on child malnutrition indicators, titled “Levels and Trends in Child Malnutrition”

Proposed Solutions

Thus far, there have been several proposed solutions from governments and organizations around world the on nutritional interventions and new policies to improve child nutrition. However, the United Nations has yet to provide a comprehensive plan or solution in order to accelerate the rate of progress. The following are a few possible avenues that can be explored as potential solutions to smaller aspects of the larger problem. Delegates may build upon these general solutions, and are encouraged to consider innovative and practical methods in order to achieve such proposed solutions.

Standard Nutritional Interventions

As it has done in the past, the WHO can continue to rely on established protocol and standard nutritional interventions such as basic food fortification and micronutrient supplementation in order to improve health outcomes for

children. Combined iron, zinc, and Vitamin A supplementation has resulted in positive outcomes in recent years, along with the implementation of iodized salt. These standards are outlined in official World Health Organization documents and can be utilized and built upon. A benefit of using well-established interventions is the minimization of risk while maximizing benefit.

Breastfeeding

Many global health experts and people surrounding the UN Millennium Developmental Goals have outlined the importance and benefits of breastfeeding. For one, it is a self-sustaining process that is supported by indisputable scientific evidence as the best form of nourishment for young children (infants) when done properly. Given this, UN member states may view such proper nutrition as more important than potential cases of HIV/AIDS transmission. Additionally, collaboration with UNICEF to distribute antiretroviral therapies for HIV/AIDS may support the process of breastfeeding in all cases.

Research and Development

The World Health Organization can gather the needed resources to conduct substantial research into new methods for nutritional intervention. By utilizing its partnerships with non-governmental organizations, UNICEF and UN Food and Agriculture Organization, the WHO can invest in specific research and development for biofortification, while focusing on other more well-established nutrition interventions to combat malnutrition such as micronutrient supplementation.

Create a Child Nutrition Task Force

As many experts on food and agriculture have identified the importance of nutrition for children, it may be useful to create a special sub-committee or task force for the purpose of dealing with this issue. Either under the jurisdiction of the World Health Organization, UNICEF or the UN

FAO, the task force could supplement current UN infrastructure, or focus on understanding the issue from an entirely different perspective. Another possibility is to consolidate existing programs and efforts into a single organ, to encourage collaboration and efficiency.

Bloc Positions

As is often the case in the General Assembly, the formation of blocs will likely be based on geographic/regional norms, with the additional factors of socioeconomic status and food/agricultural production (within the larger context of GDP- growth domestic product). Though there are indeed a number of factors that may play into bloc formation with the large range of social, political, and economic concerns for countries within the WHO, there are three main categories into which countries can be divided. The groups are: most developed nations, developing nations, and least developed nations. It should be noted, however, that within each group there are countries that have differing opinions, so mobility amongst blocs, within reason, is a plausible option.

Most Developed Countries

For the most developed countries, the major distinguishing factor is the amount of resources available for deployment/implementation that other countries do not necessarily have. Though the ideas of selective primary health care, cost-effectiveness, and neoliberalism developed in the United States, the US has recently moved towards primary health care and the approach that entails health systems strengthening. This approach was lauded by many prominent countries at the Alma Ata Conference in 1978. With this in mind, it is expected that the most developed countries will work to find a way to integrate cost-effective interventions such as UNICEF's GOBI + FFF with the commitment to "Health for All" and then ideals of the Alma Ata Conference.

Developing Countries

In many cases, developing countries have demonstrated success from interactions with non-governmental organizations such as Partners in Health. However, many view such partnerships as difficult to sustain, simply because there is a need for government involvement as well, and in a number of developing countries, government is not a significant presence in global health. Therefore, these countries will look to the WHO to provide assistance and health infrastructure for children, but also for guidance in improving their governments' ability to support such infrastructure.

Least Developed Countries

The least developed countries of the world naturally form their own bloc, as they are the beneficiaries of any legislation adopted by the WHO in this session. These nations possess the most severe problems when it comes to child malnutrition and lack of infrastructure to support positive change and growth. Many members of the African Union and Latin American countries fall into this category. It is likely that this bloc will support margining newer technologies with the cost-effective interventions that the WHO supported along with UNICEF during the child survival revolution. Essentially, the least developed countries will support whatever results in the biggest benefit to the children of these countries, as long as it is economically feasible and there are checks to ensure responsibility on behalf of benefactors.

Relevant Partners

Given the nature of the World Health Organization and its established collaborative approach to dealing with international health concerns, there are many relevant non-state/ non-committee actors that may be critical to the implementation of potential resolutions. Apart from UN organs and bodies such as UNICEF, a major organization inherently involved in the topic of child malnutrition is HarvestPlus. As a

part of the Consultative Group for International Agricultural Research, HarvestPlus has been a leader in the global initiative against hidden hunger.⁶⁵ After receiving substantial funding for biofortification research from the Bill and Melinda Gates Foundation (another relevant partner of the WHO), HarvestPlus partnered with multiple NGOs to implement its biofortified crops.⁶⁶ The WHO can work with organizations like HarvestPlus to gain further information on agricultural efforts, and to utilize them while coordinating efforts with other NGOs.

Some other key non-governmental organizations that have built partnerships with the World Health Organization in the past and may possibly provide support and expertise when dealing with this issue include the Council on Health Research for Development, the Global Alliance for Improved Nutrition, and the International Union of Nutritional Sciences.⁶⁷ These are just a few of the many official relations the WHO has with NGOs that enable it to act as the coordinating authority on international health work. It is encouraged and expected that these NGOs and similar organizations will be considered in potential action plans and legislation.

Questions a Resolution Must Answer

Any resolution considered for adoption by this committee must thoroughly consider the following questions:

- 1.) What are the policy changes needed to better provide health resources and proper nutrition to children worldwide?
- 2.) Keeping in mind the need to protect national sovereignty, how can governments be incentivized to adopt and abide by policies established by the WHO and the United Nations in general?
- 3.) What are the other aspects of child health apart from nutrition that should be considered and incorporated into potential legislation?

4.) Where will funding for any actions/initiatives come from for use by the WHO?

5.) Should the WHO revise its current standards/take on breastfeeding in cases of potential HIV/AIDS transmission? How should the WHO deal with this issue from all aspects?

6.) Finally, which direction should the WHO be heading toward: primary health care or selective primary health care? Are the actions proposed in potential legislation consistent with the answer to this question?

Suggestions for Further Research

In addition to this study guide, the first and foremost resource to be familiar with is the official United Nations website (www.un.org), and the website of the United Nations Children's Fund (www.who.int). Navigating these online resources will provide information regarding the structure and functions of the UN and the WHO, as well as specific material regarding the WHO's current handling of child malnutrition, and nutritional interventions in general. Reviewing WHO fact sheets and related documents published by the World Health Organization, UNICEF and the World Bank (available online) is highly recommended. One such document is "Improving Child Nutrition: The achievable imperative for global progress" (UNICEF, 2013).

Additionally, a comprehensive understanding of the delegate's country and government's position on cost-effective interventions and child health policy such as breastfeeding is needed. This can be gained through the use of country-specific policy documents found in online databases and/or resources in print. It is important that delegates understand how the issues at hand pertain to international trade, economics, and commerce. Therefore, a strong understanding of these areas as they relate to the delegate's country should be developed by reviewing the necessary documentation prior to conference. Finally,

reviewing past resolutions of the World Health Organization, especially those dealing with child health and nutrition, for content and structure is highly suggested.

Times New Roman, size 12-point font. Position paper will be due two weeks prior to the start date of the conference.

Position Papers

As you prepare for the conference, writing a position paper is crucially important. Although this task may not seem fun, I am confident that your experience at HMUN India 2015 will be made much more exciting and intriguing by composing a brief position paper. The paper should summarize your research on your country's policies in a concise manner, so that it reflects the position you will take on the issues in committee. Keep in mind that you will be a representative of your government, so you should be cognizant of your country's views on the issues, past actions, current commitments, and agenda for the future. These should all be included concisely in your position paper.

Your position paper should address the selected topic comprehensively. You are advised to include not only a brief discussion of your country's views on the basic aspects of the problem, but also the specific facets of the problem that most concern your country. Be sure to specify the current position of your country and the past actions your country has taken, as well as your proposed solutions to the problem. This is an appropriate area to consider the "Questions A Resolution Must Answer (QARMA)" section of the study guide. You are strongly encouraged to be creative, innovative, and practical when formulating your solutions. The issues at hand are complex and though there have been numerous discussions about them, the problems remain. Remember, though, the importance of reflecting your country's position and policies, as we strive to stay true to the business of the actual United Nations.

Your position paper should exceed one page single-spaced; brevity is encouraged. Please use

Closing Remarks

The current issues facing the World Health Organization are both crucial to ensuring the highest quality of life for children and advancing overall world progress. By coming to an agreement on policies to be implemented by the WHO to combat malnutrition and improve child health, this committee can indelibly impact individuals and populations worldwide and shape society moving forward, beyond 2015.

While this background guide does provide a relatively extensive summary of child malnutrition, there is still much more to be explored and learned about these topics. In addition to researching your given nation's policies and official stances on these matters, reviewing the current challenges pertaining to the issues and brainstorming innovative solutions that fall within the policies will allow you to participate constructively and effectively in debate. It will be quite useful to research and understand past actions your nation has taken regarding malnutrition and child health, so these concrete examples can serve as foundation for discussion and draft resolutions. Although these issues have been addressed in a variety of settings and manners in the past, they are constantly evolving and still raise significant questions. I strongly believe these questions can be resolved through your hard work and understanding of the problems.

As director of this committee, my main goal is to foster an incredible intellectual experience accompanied by a truly memorable life experience. To do this, I hope all delegates are prepared and ready collaborate toward meaningful solutions and forge lifetime friendships and connections. If you have any comments, questions, or concerns, please feel free to contact me at rpammal@college.harvard.edu. I am here to help, and cannot wait

to meet you all in Hyderabad this coming August. Congratulations, and welcome to Harvard Model United Nations India 2015!

Endnotes

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