KnightMUN XVII

World Health Orgonization

Background Guide

WELCOME LETTER

Delegates,

It is my pleasure to welcome you to KnightMUN XVII! My name is Kyleigh Savoie and I will be your director for this committee. Beginning with a little bit about myself, I am a senior here at the University of Central Florida and I am majoring in Sociology with plans to attend graduate school for Public Health Administration. I have been involved with Model United Nations since I was a freshman in high school. This year will mark my seventh year in Model United Nations, and my sixth KnightMUN. When I am not busy with school or MUN, I enjoy spending my free time watching an unhealthy amount of Netflix and traveling across the United States in attempts to visit all 50 states.

One of my passions as an undergraduate student and as a Sociology major has been the social determinants of smoking behaviors. I have completed my undergraduate research on the effects of socioeconomic status on smoking behaviors and have spent countless hours researching other determinants such as race/ethnicity, gender, and environment on a person's decision to begin smoking. I am more than excited to hear everyone debate this topic.

As the World Health Organization, I want to challenge each of you to explore the conditions of the environment, socioeconomic factors, and racial and ethnic factors that are impacting the rate of smoking within your Member State. Each Member State is unique in the composition of smokers within the country and I encourage you to explore these differences. Ideally, I would like to see comprehensive resolutions that cover a variety causes to smoking in addition to the production and sale of tobacco. While I do not cover this in my guide, I do encourage delegates to do light research on the expansion of the e-cigarette market, although it is not required that you do so.

Overall, I cannot wait for this weekend and I encourage you to reach out to me if you have any questions at all!

See you soon!

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COMMITTEE HISTORY

FORMATION

At the 1945 San Francisco Conference to establish the United Nations Charter, a proposition for an organization committed to global health was brought to the table. [1] Per article 57 in the United Nations Charter, the International Health Conference established the Constitution for the World Health Organization as a specialized agency of the United Nations. [2] The Constitution was signed on June 22nd, 1946 by the 61 representatives present at the International Health Conference in New York and ratified on April 7th, 1948.[3] The World Health Organization, since its formation, has been committed to their objective of the 'attainment of the highest level of health by all peoples,' defining health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' [4] In addition to the overall objective of the World Health Organization, the first priorities for the organization included improving maternal and child health, nutrition, combatting the spread of tuberculous, malaria, and sexually transmitted diseases, and nutrition.[5]

ESTABLISHMENT OF REGIONAL OFFICES

Chapter Eleven of the World Health Organization Constitution establishes the framework for regional organizations to work in accordance with the Organization and The Health Assembly.[6] The six regions of the World Health Organization are Africa Region (AFRO), Region of the Americas (AMRO), South-East Asia Region (SEARO), European Region (EURO), Eastern Mediterranean Region (EMRO), and Western Pacific Region (WPRO). Within the six regions, there are six regional organizations of the World Health Organization, tasked with the responsibility of coordinating regional efforts in the interest of the objective of the Organization. The goal of the regional organizations is to support the Member States with health information, decision making, and management and delivery of healthcare services.[7]

REFORM

In 2010, the World Health Organization recommitted itself to the objective of the organization by pursuing an organizational reform to better address the needs of the 21st century. The Organization established three goals for the organizational reform: improved health outcomes, greater coherence in global health, and an Organization that pursues excellence.[8] The reform lasted for a duration of five years, in which the Organization focused on creating new frameworks, addressing financial concerns, and creating independent bodies for additional oversight. Overall, the reform of the

[1] http://www.un.org/en/sections/history-united-nations-charter/1945-san-francisco-conference/index.html
[2] http://www.who.int/about/mission/en/
[3] http://www.who.int/about/history/en/
[4] http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1
[5] http://www.who.int/about/mission/en/
[6] http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1
[7] http://www.who.int/classifications/network/ro/en/
[8] http://www.who.int/about/who_reform/change_at_who/what_is_reform/en/

World Health Organization provided additional governance and guidelines to address the demands and health challenges of the global community.[9]

CURRENT AGENDA

The World Health Organization is committed to improving international health and continues to coordinate with regional organizations and Member States to achieve their objective. The Organization, with cooperation from the Member States, provides leadership regarding critical health matters, monitors health trends, shapes the research agenda, establishes norms and standards, and provides ethical policy options.[10] Every six years, the World Health Organization establishes health priorities that shape the direction and agenda of the organization. The current leadership health priorities are universal health coverage, International Health Regulations, increasing access to medical products, noncommunicable diseases, social, economic, and environmental determinants, and health-related sustainable development goals.[11] These six health priorities are reflective of the current reform and the direction that the World Health Organization wishes to pursue going forward.

TOPIC I: INTERNATIONAL TOBACCO CONTROL

INTRODUCTION

In 2015, over 1.1 billion people smoked tobacco. With over 7 million deaths each year, tobacco consumption is the largest preventable cause of death. Tobacco usage is most prevalent in low to middle-income countries, with smoking rates increasing in the Eastern Mediterranean and African regions.[12] The use and spread of tobacco results in serious consequences for public health and individual users. Death from tobacco use on the individual level often deprives families of necessary income, especially in low-income countries. On the public health front, tobacco usage and death from tobacco usage lead to deprivation of a healthy workforce, raise the cost of health care, and hinder economic development.[13] Tobacco control actions will prevent young people from starting to use tobacco, help current tobacco users to quit and protect non-smokers from exposure to second-hand smoke. International cooperation is necessary to devise and implement a comprehensive response to continually address the global tobacco epidemic.

[9] http://www.who.int/about/who_reform/chronology/en/
[10] http://www.who.int/about/what-we-do/en/
[11] http://www.who.int/about/agenda/en/
[12] http://www.who.int/gho/tobacco/use/en/
[13] http://www.who.int/features/qa/tobacco/en/

PAST ACTION

The World Health Organization Framework Convention on Tobacco Control (WHOFCTC)

The WHO Framework Convention on Tobacco Control (WHOFCTC) is an international treaty aimed at reducing the health and economic impacts created by tobacco. The WHOFCTC was created in 2005 as one solution to the third Sustainable Development Goal. Signed by 180 Parties, the Convention requires that action is taken by all signing Parties to prevent global tobacco consumption. The goal of the WHOFCTC is to address the causes of the global tobacco epidemic including complex factors with cross-border effects, such as trade liberalization and direct foreign investment, tobacco advertising, promotion and sponsorship beyond national borders, and illicit trade in tobacco products.[14]

MPOWER WHOFCTC

In 2008, the WHOFCTC recommitted to their goal of ending the global tobacco epidemic by introducing a practical driven solution to the main goals of the WHOFCTC. The new solution, MPOWER, focuses on the 6 major provisions of the WHO Framework Convention on Tobacco Control. The six goals of MPOWER are to **M**onitor tobacco use and prevention policies, **P**rotect people from tobacco use, **O**ffer help to quit tobacco use, **W**arn about the dangers of tobacco, **E**nforce bans on tobacco advertising, promotion and sponsorship, **R**aise taxes on tobacco.[15] The overall goal of MPOWER is to assist low and middle-income nations with implementing the provisions of the WHOFCTC while remaining practical about the capacity and resources of each individual nation.[16]

THE PROTOCOL TO ELIMINATE ILLICIT TRADE IN TOBACCO PRODUCTS

In 2012 at the fifth session of the Conference of the Parties in Seoul, the Republic of Korea, The Protocol to Eliminate Illicit Trade in Tobacco Products was established. The Protocol to Eliminate Illicit Trade in Tobacco Products focuses on measures relating to the supply chain, including the licensing of imports, exports, and manufacture of tobacco products.[17] Currently, the Protocol is open for ratification, acceptance, and approval of the Parties under the WHOFCTC. The overall goal of the Protocol is to limit the illicit production and smuggling of tobacco products in attempts to reduce its global usage.[18]

[14] http://www.who.int/fctc/WHO_FCTC_summary_January2015_EN.pdf?ua=1
[15] http://www.who.int/cancer/prevention/tobacco_implementation/mpower/en/
[16] http://www.who.int/cancer/prevention/tobacco_implementation/mpower/en/
[17] http://www.who.int/mediacentre/factsheets/fs339/en/
[18] http://www.who.int/mediacentre/factsheets/fs339/en/

KEY ISSUES

SECOND HAND SMOKE

Second-hand smoke causes 890,000 deaths per year, with twenty-eight percent of those deaths being children deaths. There is no level of exposure to second-hand smoke that is safe. Second-hand smoke is the smoke that occupies enclosed spaces following the burning of tobacco products. With over 4000 chemicals in tobacco smoke, 250 are known to be harmful, with more than 50 being known to cause cancer.[19] Second-hand smoke can lead to cardiovascular and respiratory diseases, such as but not limited to, coronary heart disease and lung cancer. The dangers of second-hand smoke are more serious for infants with the risk of sudden death, and for pregnant women, it can contribute to a low birth weight.[20]

Currently, only twenty percent of the world's population is protected by national smoke-free laws, and half of the children are regularly exposed to air polluted by tobacco smoke in public places. [21] Considering the detrimental health effects of second-hand smoke and a person's individual right to tobacco-smoke-free air, comprehensive smoke-free laws are a necessity.

ILLICIT TRADE OF TOBACCO PRODUCTS

It is estimated that 1 in every 10 cigarettes and tobacco products consumed globally is illicit.[22] The concern of the illicit trade of tobacco products is it undermines tobacco control policies, mainly high tax policies. While the tobacco industry argues that tobacco product taxes contribute to the illicit trade of tobacco, it is evident that several other factors contribute to the illicit trade. These non-tax factors include weak governance, high levels of corruption, poor government commitment to tackling illicit tobacco, ineffective customs and tax administrations, and informal distribution channels for tobacco products. These factors are more important in the contribution to the illicit trade of tobacco products when compared to high tax policies.[23]

Addressing the issue of illicit trade of tobacco products increases the benefits of tobacco control policies and public health and contributes to reducing global tobacco usage. By creating, implementing, and enforcing policies to address the non-tax factors related to the illicit tobacco trade can reduce health and economic consequences.[24]

CANCER

Thirty to fifty percent of all cancer cases are preventable.[25] With over 400 chemicals in tobacco products, and at least 50 were known to cause cancer, addressing tobacco use as a form of cancer prevention is necessary. Tobacco smoking causes many types of cancer, including cancers of the

[19] http://www.who.int/mediacentre/factsheets/fs339/en/
[20] http://www.who.int/mediacentre/factsheets/fs339/en/
[21] http://www.who.int/mediacentre/factsheets/fs339/en/
[22] http://www.who.int/mediacentre/factsheets/fs339/en/
[23] http://www.who.int/mediacentre/factsheets/fs339/en/
[24] http://www.who.int/mediacentre/factsheets/fs339/en/
[25] http://www.who.int/cancer/prevention/en/

lung, esophagus, larynx (voice box), mouth, throat, kidney, bladder, pancreas, stomach and cervix. Second-hand smoke, also known as environmental tobacco smoke, has been proven to cause lung cancer in non-smoking adults. Smokeless tobacco causes oral, esophageal and pancreatic cancer.[26]

Prevention measures are key to long-term and cost-effective strategy for controlling cancer. It is imperative that national policies are developed and implemented to control access and exposure to tobacco products to reduce cancer risk factors.[27]It is also imperative to educate populations with the information and support regarding the dangers of tobacco and provide access to tobacco cessation programs and resources.

REBIONAL/BLOC OVERVIEW

AFRICA

The Africa region is experiencing an increasing rate of tobacco use, mainly within the Sub-Saharan Africa region. The increase of larger and more accessible markets in Africa has contributed to the tobacco industry focusing on expanding into the region. Between 2002 and 2030, tobacco-attributable deaths are projected to double in low and middle-income countries (LMICs), including in Africa.[28] In addition to the overall increasing rate of tobacco use, the region has seen an increase in tobacco use among girls and women. Currently 13 million women and thirteen percent of adolescent girls use tobacco products. In the region, about 22,000 women die every year from tobacco-related diseases which are preventable.[29]

Focusing on implementing and strengthen preventative measures are a necessity for the region. One of the biggest challenges facing the African Region is adopting and accesses resources to successfully implement the measures set forth by the WHOFCTC. One area of interest is creating comprehensive monitoring. This would inform the governments on how the tobacco epidemic harms their countries and allow them to effectively allocate tobacco control resources.[30]

EUROPE

Among the WHO regions, Europe has the highest prevalence of tobacco smoking among adults and some of the highest prevalence of tobacco use by adolescents.[31] In addition to having the highest prevalence in tobacco use, the European Region has the highest rate of smoking among women aged 15 and above. Nineteen percent of women in the European Region smoke, compared to the two and three percent of women smokers in the other WHO regions.[32] The gap of smoking

[26] http://www.who.int/cancer/prevention/en/

[27] http://www.who.int/cancer/prevention/en/

[28] http://www.afro.who.int/health-topics/tobacco-control

[29] http://www.afro.who.int/health-topics/tobacco-control

[30] http://www.afro.who.int/health-topics/tobacco-control

[31] http://www.euro.who.int/en/health-topics/disease-prevention/tobacco/data-and-statistics

[32] http://www.euro.who.int/en/health-topics/disease-prevention/tobacco/data-and-statistics

prevalence between male and female smokers has also narrowed in the region, and in countries such as Denmark, Ireland, the Netherlands, Norway, Sweden, and the United Kingdom, the gap is less than five percent.[33]

When compared with the other WHO Regions, the European Region has the highest proportions of deaths related to tobacco use. Tobacco use is responsible for sixteen percent of all deaths within the region of adults over the age of thirty years.[34] This rate is alarming when compared to other regions such as the African Region, where tobacco use only accounts for three percent of deaths within the region, but also when compared to the global average of twelve percent.[35]

REGION OF THE AMERICAS

The Region of the Americans has a smoking population of 127 million smokers, nearly seventeen percent of the total adult population in the region. Tobacco use has been established as the main contributor to noncommunicable diseases which account for eighty percent of all deaths within the region.[36] Seventeen of the thirty-five countries within the region lack regulations establishing smoke-free environments in workplaces, public places, and transportation.[37]

The region has established a goal of removing the region from tobacco smoke exposure by 2022. Overall the region has established clear guidelines and goals to assist in achieving this goal. These guidelines include the inclusion of large, graphic health warnings on all tobacco packaging, raising taxes on tobacco, and a total ban on tobacco advertising, promotion, and sponsorship. Currently, 14 countries have implemented the previously mentioned policies and it is expected that the remaining countries will adopt these policies soon.[38]

EASTERN MEDITERRANEAN REGION

The Eastern Mediterranean region has a high prevalence of smoking among adults, with male-consumption in the region ranging from twenty-four to sixty-one percent and female-consumption ranging from one to seven percent.[39] The tobacco epidemic in the region is undergoing additional challenges that have not been observed in previous years, mainly the increase in tobacco usage among women and youths.[40]

The Region continues to struggle with sustaining tobacco control policies. The policies within the region are highly dependent on financial donations and the region needs additional diversion and management of resources to maintain sustainability.[41] In addition to the sustainability, other issues

[33] http://www.euro.who.int/en/health-topics/disease-prevention/tobacco/data-and-statistics
[34] http://www.euro.who.int/en/health-topics/disease-prevention/tobacco/data-and-statistics
[35] http://www.euro.who.int/en/health-topics/disease-prevention/tobacco/data-and-statistics

[36] http://www.paho.org/hq/index.php?option=com_content&view=article&id=13741&Itemid=1926
[37] http://www.paho.org/hq/index.php?option=com_content&view=article&id=13741&Itemid=1926
[3838] http://www.paho.org/hq/index.php?option=com_content&view=article&id=13741&Itemid=1926
[39] http://www.emro.who.int/emhj-volume-14-2008/volume-14-supplement/tobacco-control-in-the-eastern-mediterranean-region-overview-and-way-forward.html
[40] http://www.emro.who.int/emhj-volume-14-2008/volume-14-supplement/tobacco-control-in-the-eastern-mediterranean-region-overview-and-way-forward.html
[41] http://www.emro.who.int/emhj-volume-14-2008/volume-14-supplement/tobacco-control-in-the-eastern-mediterranean-region-overview-and-way-forward.html

that need to be addressed within the region to tackle the increasing prevalence of women and youth smokers include the price of tobacco, the rather weak/non-enforced policies of tobacco control, and the upcoming trends in tobacco use.

WESTERN PACIFIC

The Western Pacific Region has the greatest number of smokers, the highest rates of adult smoking prevalence, the greatest number of smoking-related deaths for both sexes, and one-third of the cigarettes consumed globally are smoked in the Region.[42]In addition, approximately three people die every minute due to tobacco-related diseases in the Region and thirteen percent of all deaths are caused by tobacco use.[43] The Region is expected to have an overall increase in the rate of tobacco usage, by 2025 it is projected that 3.9 million people will still be smoking within the region.

In addition to the high prevalence of tobacco use within the region, the region has a large rate of exposure to secondhand smoke. In the Western Pacific Region, the percentage of students' exposure to secondhand smoke is 44.1% at home, 47-67% in enclosed public places, and 44-66% in school.[44] Secondhand smoke exposure to tobacco causes specifically over 100,000 in the Western Pacific Region alone.[45]

The region suffers from the economic impact of tobacco usage and death related to tobacco use. Overall the region suffers from the burden of poverty, poor national development and further widening health inequities. Tobacco control within the region is extremely limited and is a public health priority and a key development issue.[46]

QUESTIONS TO CONSIDER

1) What are some social determinants of tobacco smoking and how has your Member State addressed these?
2) How does your Member State protect people from exposure to tobacco smoke? What policy implementations would your Member State like to see implemented?
3) Has your Member State banned tobacco advertising, promotion, and sponsorship in the region? If yes, how so?
4) Has your Member State implemented health warnings on tobacco packaging? Have they supported global health initiatives to further health warning on tobacco packaging?
5) How does your Member State promote tobacco cessation? Do they offer access to resources?
6) Has your Member State increased tobacco taxation?

[42] http://www.wpro.who.int/mediacentre/factsheets/fs_201203_tobacco/en/

[43] http://www.wpro.who.int/mediacentre/factsheets/fs_201203_tobacco/en/

[44] http://www.wpro.who.int/mediacentre/factsheets/fs_201203_tobacco/en/

[45] http://www.wpro.who.int/mediacentre/factsheets/fs_201203_tobacco/en/

[46] http://www.wpro.who.int/mediacentre/factsheets/fs_201203_tobacco/en/