World Health Organization

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Letter From The Chairs

Dear Delegates,

Welcome to LTMUN I! Our names are Joc Krysik and Mila Kinsells, and we will be your head chairs for this WHO committee. We are both juniors here at Lane Tech and have been participating in Model UN since our freshman year. We both love baking, going to concerts, and participating in various conferences around Chicagoland. Both of us have participated in WHO committees multiple times and we have really enjoyed them!

The World Health Organization is a very important and impactful committee that makes real, meaningful decisions that affect millions of people; we hope that you all learn more about it and enjoy the committee as much as we will. We encourage you to participate fully and develop creative solutions to combat the opiod epidemic and reduce rates of infanticide. We look forward to seeing you in committee!

If you have any questions, please feel free to contact us at: jakrysik@cps.edu and mrkinsella@cps.edu

Sincerely, Joc Krysik and Mila Kinsella

Committee Overview:

The World Health Organization (WHO) is the leading international body for global public health and a specialized agency of the United Nations system. Established on 7 April 1948, the WHO was founded on the principle that “health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” Its creation marked a critical moment in recognizing health as a fundamental human right and as a necessary foundation for development, peace, and social stability. With 194 Member States, the WHO’s mandate encompasses health emergencies, communicable and non-communicable diseases, nutrition, sanitation, mental health, health system strengthening, and the promotion of universal health coverage.

The WHO’s role is both technical and political. It serves as the world’s primary health authority, developing evidence-based guidelines and standards, assisting countries with policy development, monitoring global health trends, and coordinating emergency responses. Simultaneously, it must navigate political tensions, resource limitations, and diverse national priorities. Programs such as the Expanded Programme on Immunization, the Global Polio Eradication Initiative, and the COVAX COVID-19 response demonstrate their ability to mobilize international cooperation in the face of health crises. Yet, the WHO has faced criticism during outbreaks such as Ebola and

COVID-19 for delayed responses, funding shortfalls, and challenges in securing state cooperation, highlighting the delicate balance between respecting national sovereignty and ensuring global accountability.

As a committee, the WHO provides delegates with a unique opportunity to address issues at the intersection of science, ethics, and diplomacy. Health is inherently multidimensional, intersecting with education, poverty, conflict, climate change, misinformation, and access to technology. Delegates are expected to propose solutions that are scientifically grounded, country-specific, and internationally viable. Whether debating vaccine equity, disease prevention, antimicrobial resistance, or the health impacts of climate change, delegates act as stewards of global health governance, shaping policies that can have far-reaching consequences for the well-being of populations worldwide.

Topic A: Combating the Opioid Epidemic:

History of the Issue:

The global opioid epidemic is a public health crisis shaped by decades of medical practice, pharmaceutical policy, and unequal access to healthcare. Opioids have long been recognized by the World Health Organization as essential medicines for pain relief, particularly for surgical care, cancer treatment, and palliative medicine. Substances such as morphine have been included on the WHO Model List of Essential Medicines for decades. However, the expansion of synthetic and semi-synthetic opioids in the late 20th century dramatically altered global patterns of use, dependence, and harm.

During the 1990s and early 2000s, changes in pain management philosophy—especially in high-income countries—encouraged more aggressive opioid prescribing for chronic, non-cancer pain. Pharmaceutical companies promoted opioids as safe and effective, minimizing addiction risks. These practices, combined with insufficient regulatory oversight and limited prescriber education, contributed to widespread misuse and dependence. As prescription opioid use increased, so did opioid-related morbidity and mortality, eventually leading to large-scale public health emergencies, particularly in North America.

As governments responded by tightening prescription regulations, many individuals with opioid dependence transitioned to illicit opioids such as heroin and, later, highly potent synthetic opioids like fentanyl. These substances are often produced and trafficked through complex international supply chains, complicating prevention efforts. The WHO has increasingly emphasized that opioid dependence is a chronic, treatable health condition rather than a moral failing or purely criminal issue. This marked a shift away from punitive approaches toward evidence-based prevention, treatment, and harm reduction.

At the same time, the WHO has highlighted a critical global imbalance: while some countries face widespread overprescription and opioid-related deaths, most low- and middle-income countries suffer from severe under-access to opioid medications for legitimate medical use. Due to restrictive drug control policies, stigma, lack of training, and weak health systems, millions of patients worldwide are unable to access adequate pain relief. This dual crisis—excess in some regions and scarcity in others—lies at the core of the WHO's concern regarding the opioid epidemic.

Current Situation:

The opioid epidemic remains a major global health challenge, with opioid overdoses causing hundreds of thousands of deaths each year. Synthetic opioids, particularly fentanyl and its analogues, are responsible for rising mortality rates due to their high potency and unpredictable composition. While the crisis is most visible in North America, opioid misuse and opioid-related harms are increasingly reported in parts of Europe, Asia, Latin America, and Africa as pharmaceutical markets expand and illicit substances circulate more widely.

From a WHO perspective, major challenges include inconsistent prescribing practices, inadequate surveillance systems, and unequal access to prevention and treatment services. Many countries lack reliable data on opioid use, overdose deaths, and treatment coverage, making it difficult to design effective public health responses. Medication-assisted treatment (MAT), including methadone and buprenorphine—both recognized by the WHO as essential medicines—is unavailable or heavily restricted in many regions. Naloxone, a life-saving opioid overdose reversal medication, remains inaccessible or unaffordable in numerous low- and middle-income countries.

Health inequities further exacerbate the crisis. Rural populations, Indigenous communities, migrants, and people living in poverty often experience higher exposure to opioid-related harms while facing barriers to care such as stigma, cost, and limited health infrastructure. Women and adolescents may avoid seeking treatment due to fear of discrimination or legal consequences. The COVID-19 pandemic intensified these challenges by disrupting health services, increasing mental health stressors, and interrupting treatment continuity.

The WHO continues to promote a public health–oriented approach that prioritizes prevention, treatment, harm reduction, and human rights. However, limited funding, political resistance, and the persistence of punitive drug policies in some Member States have slowed

progress. The current situation highlights the need for stronger international cooperation, more consistent implementation of guidelines, and continued focus and investment in health system strengthening, under WHO leadership.

Subtopic 1: International Regulation of Pharmaceutical Supply Chains and Prescription Practices

The WHO plays a central role in developing international guidelines for the safe, rational, and equitable use of opioid medicines. Weak regulation of pharmaceutical supply chains—including manufacturing, distribution, and prescribing—has contributed to both opioid overuse and diversion in some countries, while overly restrictive controls have limited access to essential pain medication in others. This imbalance reflects gaps in regulatory capacity, prescriber education, and international coordination.

Prescription practices are a key concern. Inadequate training of healthcare professionals can lead to inappropriate opioid prescribing, increasing the risk of dependence and overdose. The WHO has issued clinical guidelines on pain management and the treatment of opioid use disorders, but implementation varies widely among Member States. In many low-resource settings, a lack of trained providers and regulatory clarity results in under-prescribing, leaving patients to suffer untreated pain.

Global pharmaceutical supply chains further complicate regulation. Opioid production and distribution often span multiple countries, making monitoring and accountability difficult.

The WHO supports improved data collection, pharmacovigilance, and international cooperation to prevent diversion while safeguarding medical access. This subtopic calls on delegates to examine how WHO guidelines, technical assistance, and collaboration with national health authorities can strengthen regulation without undermining the right to health.

Subtopic 2: Demographic Disparities in Opioid Impact and Access to Care

Reducing health inequities is a core mandate of the World Health Organization, and demographic disparities are central to the opioid epidemic. Socioeconomic inequality, geographic isolation, and systemic discrimination shape who is most affected by opioid-related harm and who receives care. Rural communities often face limited access to healthcare facilities, addiction specialists, and emergency services. Marginalized racial and ethnic groups may experience higher rates of overdose alongside lower access to evidence-based treatment.

Globally, disparities are even more severe. Many low-and middle-income countries lack national strategies for opioid dependence treatment, harm reduction services, or mental health care integration. Vulnerable populations—including women, youth, refugees, and incarcerated individuals—are frequently excluded from public health interventions. Stigma surrounding substance use disorders discourages help-seeking and reinforces cycles of illness and social exclusion.

The WHO advocates for integrated, people-centered care models that address both physical and mental health needs. This subtopic asks delegates to consider how WHO Member States can implement inclusive health policies, expand community-based treatment, and ensure universal access to essential medicines. Addressing demographic disparities is essential not only for reducing opioid-related deaths but also for advancing health equity and the WHO's goal of universal health coverage.

Questions to Consider:

1. How can the WHO strengthen international guidelines on opioid prescribing while respecting national sovereignty and differing health system capacities?

2. What role should the WHO play in improving access to essential opioid medicines for pain relief without increasing the risk of misuse?

3. How can WHO Member States expand access to medication-assisted treatment and naloxone as part of universal health coverage?

4. What strategies can reduce demographic and geographic disparities in opioid-related harm, particularly for rural and marginalized populations?

5. How can data collection and surveillance systems be improved under WHO coordination to better track opioid use and outcomes?

6. In what ways can the WHO promote harm reduction and human rights–based approaches in countries that rely on punitive drug policies?

Topic B: Reducing Rates of Infanticide:

History of the Issue:

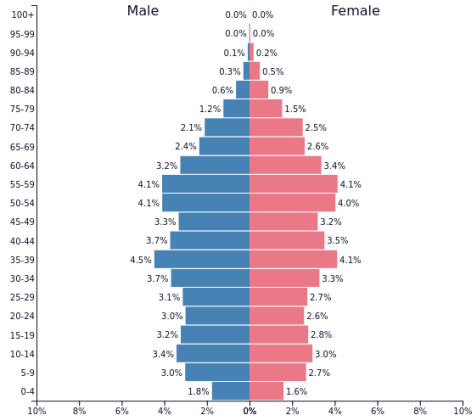
Infanticide is defined as “the crime of killing a child within a year of its birth” and has been a global issue throughout history. Infanticide has occured throughout history for many reasons, including gender discrimination, sexual violence, eugenics, social stigma, poverty, and more. Infanticide rates have began to decline in the last century, going from 222.2 out of 100,000 children being killed to 74 between 1998 and 2017. However, the risk of homicide during the first year of life remains significantly higher than at any other stage of life.

A main cause of infanticide is sexual violence and gender discrimination. Often times families will have a gender preference, resulting in increased infanticide rates for girls. This is sometimes referred to as “gendercide”. Another cause of infanticide is eugenic ideals. In the early 1900s, a doctor named Harry Haiselden began to tell parents whether or not their infant child should receive life-saving surgery. He claimed that some would grow up to be idiotic, and not worth spending money and time saving, while others would be smart and strong. He even went so far as to prescribe a child drugs to reduce their appetite and make them starve to death. His actions were extremely controversial and received a lot of news coverage, but they were not the first of their kind. In ancient Greek and Egyptian societies, children deemed unfit and weak were typically killed or sacrificed to a god in the hopes that it would bring their society prosperity. Infanticide has been an issue for centuries, so solutions need to be extremly effective and long term in order to make an impact.

There are many differing views on infanticide and they are usually influenced by regional and cultural factors. Less developed countries tend to have higher rates of infanticide than more developed countries, which means that economics also play into it. Lower income families sometimes view children as economic burdens, rather than assets. This can result in infanticide if the family truly cannot afford to support the child. These historical, cultural, and economic factors have contributed to persistent global rates of infanticide.

Current Situation:

Although infanticide has existed for centuries, it remains a serious issue in modern day. As access to safe abortions is limitedin countries like the U.S., people are more drawn to infanticide than ever before. Without medical options, women are forced to give birth to children that they cannot support financially and are not capable of taking care of. Not only does this give them an extreme economic burden, but it also takes a toll on their mental health. 20% of mothers in developed countries experience post-partum depression. Other mental-health disorders may also develop or worsen during pregnancy due to psychological stress and societal pressures. These disorders can lead to suicide, and in extreme cases, infanticide due to beliefs that the child caused these problems. Currently, access to maternal mental-health support remains limited in many regions, but the WHO is considering Universal Health Coverage (UHC) and proposing Healthy Life Expectancy (HLE) to combat this issue.



Abortion rights and mental health both have a significant effect on infanticide rates, but general access to healthcare plays a large role. Many countries lack affordable healthcare, which discourages people from visiting doctors and hospitals, even in dire situations. This results in pregnant women who need care not receiving it, sometimes making them incapable of caring for a child. Infanticide is not always driven by anger. In some cultures if a baby cannot be cared for, it is let starve. If the women were to have had more access to healthcare, they would not be in the position of not being able to take care of their child.

Additionally, infanticide is often a result of sexual violence and is done to female children specifically due to a society's preference for male children. When a family in certain less developed countries has a daughter, there is an expectation that they need to conform to traditional societal roles by doing things like arranging a marriage and paying a dowry, which they typically cannot afford. While China's One Child Policy ended in 2021, the effects of it were lasting. During the policy, families would often abandon or kill their female child to try again for a male. This led to an unbalanced society with more men than women, and will cause problems in the future if it does not even out. When there are too many men compared to women, they may begin to migrate elsewhere to find a wife, sometimes resulting in brain drain. This can be harmful for the country's economy and cause or contribute to long-term demographic and social challenges.

Questions to Consider:

1. What is the best way to combat infanticide in a way that not only reduces the murders but also helps the mothers in need?

2. How does a solution need to differ between countries in different levels of development?

3. Does your country have a particularly high or low rate of infanticide? If so, why?

4. What are some solutions that are effective in reducing infanticide without just giving out harsher punishments?

5. Does your country have any precautions already in place?

6. Does your country have cheap or free healthcare systems? If not, is that contributing to the problem?

Position List:

1. Afghanistan
2. Canada
3. Cuba
4. Democratic People's Republic of Korea
5. Democratic Republic of the Congo
6. Egypt
7. France
8. Germany
9. Greece
10. Guatemala
11. Haiti
12. Iceland
13. India
14. Iran
15. Ireland
16. Italy
17. Japan
18. Kenya
19. Mexico
20. Morocco
21. Nicaragua
22. Norway
23. Pakistan
24. Poland
25. Russia
26. South Africa
27. Thailand
28. Turkey
29. Ukraine
30. United States of America

Bibliography:

https://www.who.int/teams/mental-health-and-substance-use/promotion-prevention/maternal-mental-health

https://www.britannica.com/topic/infanticide

https://pmc.ncbi.nlm.nih.gov/articles/PMC2174580/

https://www.psychologytoday.com/us/blog/genetic-crossroads/201605/the-blurry-boundaries-of-eugenic-infanticide

https://www.cdc.gov/mmwr/volumes/69/wr/mm6939a1.htm

https://pmc.ncbi.nlm.nih.gov/articles/PMC4448612/