BACKGROUND GUIDE

WORLD HEALTH ORGANIZATION

Agenda: Ensuring Equitable Healthcare and Vaccine Access for Marginalized and Displaced Communities.

LETTER FROM THE EXECUTIVE BOARD-

Dear Delegates,

It is our utmost pleasure to welcome you to the World Health Organization at NVMUN. As your Chairperson and Vice Chairperson, we are truly honoured to facilitate what promises to be an intellectually rich and globally relevant discussion on the agenda: ***"Ensuring Equitable Healthcare and Vaccine Access for Marginalized and Displaced Communities."***

This issue lies at the heart of global public health and humanitarian justice. While great strides have been made in advancing medical science and healthcare delivery over the past decades, these achievements remain unevenly distributed. For the world's 110 million displaced persons, including refugees, internally displaced people (IDPs), stateless individuals, and migrants, access to healthcare remains not only difficult but, in many cases, entirely inaccessible. Crises such as the COVID-19 pandemic have magnified the deep fractures in our global health infrastructure. They have revealed how political instability, poverty, systemic discrimination, and lack of documentation continue to leave millions without the most basic healthcare or life-saving vaccines.

Our committee will address not just the logistics of distribution, but the larger ethical, legal, and social questions that determine who gets access and who gets left behind. Whether we are speaking about Rohingya refugees in Bangladesh, war-affected civilians in Syria, or underserved populations in sub-Saharan Africa affected by HIV, the reality is that no nation or institution can address these challenges alone. International cooperation, innovation, and moral clarity are needed now more than ever.

As delegates, you hold the responsibility and the opportunity to reimagine a global health landscape that is truly inclusive. We urge you to approach the debate with intellectual curiosity, evidence-based thinking, and above all, empathy. Understand that every statistic in your research reflects a human life: a child without vaccines, a mother unable to access prenatal care, a community without clinics.

Throughout this conference, we hope you will engage deeply with the nuances of this issue. Consider the balance between state sovereignty and humanitarian intervention, the role of

international organizations like WHO and UNHCR, the impact of public-private partnerships, and the potential of technological innovation to overcome access barriers. Explore the structural inequalities that persist even within aid systems, and think critically about how health can be made not just available, but equitable.

Ultimately, this committee is more than a simulation, it is a space to build the future you wish to see. We are immensely excited to hear your diverse perspectives, policy proposals, and solutions. We are confident that your dedication will lead to a thoughtful and transformative discussion.

Best of luck, and may your voices echo far beyond the committee room.

Warm regards,

Mihir Kulkarni
Chairperson, WHO

Reyansh Machhar
Vice Chairperson, WHO

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INTRODUCTION TO THE COMMITTEE

The World Health Organization (WHO) is the United Nations' specialized agency for international public health. It was officially established on April 7, 1948, a date now celebrated annually as World Health Day, with the mission of ensuring the highest possible standard of health for all people, regardless of nationality, socioeconomic status, or geographic location. WHO's Constitution, adopted in 1946, defines health as a state of complete physical, mental, and social well-being not merely the absence of disease or infirmity reflecting its holistic and inclusive approach to public health.

With 194 Member States, WHO works across six key areas: strengthening national health systems, promoting lifelong health and well-being, addressing communicable and non-communicable diseases, enhancing emergency preparedness and response, setting international health standards, and coordinating partnerships with governments, civil society, and the private sector. The organization's work spans the development of health policies and guidelines, technical assistance, disease surveillance, and direct interventions in crisis situations.

One of WHO's most notable achievements was the successful global eradication of smallpox in 1980, following a decades-long immunization campaign. Another milestone was the Alma-Ata Declaration of 1978, which emphasized the importance of primary healthcare and linked health to social and economic development. These efforts laid the foundation for WHO's long-term goal of achieving universal health coverage and reducing global health disparities.

WHO is governed by the World Health Assembly (WHA) its decision-making body composed of representatives from all Member States and the Executive Board, which consists of 34 health experts nominated by Member States and elected by the Assembly. The WHA meets annually to set policies, approve budgets, and appoint the Director-General, who serves as WHO's chief technical and administrative officer. The Executive Board meets at least twice a year to implement WHA decisions and provide oversight, especially during health emergencies.

The Director-General, supported by WHO's Secretariat in Geneva and a decentralized network of regional and country offices, leads the organization's strategic and operational efforts. WHO

currently maintains six regional offices and more than 150 country and liaison offices worldwide, enabling it to respond effectively to both local and global health challenges.

WHO's funding is drawn from two main sources: assessed contributions, which are mandatory dues paid by Member States, and voluntary contributions, which are provided by governments, international organizations, NGOs, and the private sector. Over the years, voluntary contributions have significantly outpaced assessed ones, prompting reforms to ensure transparent and balanced financing. In 2011, WHO launched a Member State-led reform process to enhance the organization's efficiency, governance, and accountability. This reform focuses on priority-setting, program management, and governance structures to make WHO more responsive to emerging global health needs.

In the 21st century, WHO continues to play a central role in global health governance, particularly in managing international responses to health emergencies such as the Ebola outbreak, the COVID-19 pandemic, and humanitarian crises affecting displaced populations. It collaborates with other UN bodies like UNICEF, UNHCR, GAVI, and the Global Fund, as well as civil society, to ensure inclusive and coordinated efforts in advancing global health.

This committee, under the WHO framework, will focus on one of the most pressing and complex challenges of our time: ensuring equitable access to healthcare and vaccines for marginalized and displaced communities. Through diplomatic negotiation, policy formulation, and critical analysis, delegates will examine how WHO can further its mission of "Health for All" by addressing systemic barriers and promoting inclusive healthcare delivery on a global scale.

MANDATE OF THE COMMITTEE

The World Health Organization (WHO) serves as the primary international authority on public health under the United Nations, with a legally binding mandate established by its Constitution adopted in 1946 and effective from 1948. The WHO's mandate outlines its responsibility to act as the directing and coordinating body for health matters globally, aiming to achieve the highest possible level of health for all people, regardless of geography, nationality, or socio-economic status.

The committee's mandate includes:

1. ***Health Policy Leadership and Standard Setting:***

   WHO develops international health standards, norms, and guidelines, including protocols for disease prevention, health promotion, and treatment. This includes formulating global policies for vaccination, communicable and non-communicable diseases, and health emergencies.

2. ***Coordination of International Health Responses:***

   In times of public health crises—such as pandemics, outbreaks, and natural disasters—WHO is mandated to coordinate multi-country responses, provide technical guidance, and facilitate resource mobilization. This role is crucial to ensuring an effective and timely global response.

3. ***Technical Assistance and Capacity Building:***

   WHO provides expertise and support to member states, especially low- and middle-income countries, to strengthen national health systems. This includes training healthcare workers, improving infrastructure, and enhancing disease surveillance and reporting mechanisms.

4. ***Promotion of Health Equity:***

   A central part of WHO's mandate is to reduce health disparities, particularly among marginalized and vulnerable groups, including refugees, internally displaced persons (IDPs), migrants, and stateless populations. WHO is tasked with ensuring that health

policies and programs are inclusive and address barriers such as discrimination, lack of access, and political instability.

5. ***Facilitation of Equitable Access to Medicines and Vaccines:***
   WHO is responsible for promoting fair and equitable access to essential medicines and vaccines worldwide, advocating for initiatives such as the COVAX facility, and ensuring distribution mechanisms reach underserved and displaced communities.

6. ***Health Data Collection and Research:***
   The committee is mandated to gather, analyze, and disseminate health data globally. This evidence-based approach helps inform policies and interventions tailored to emerging and ongoing health challenges.

7. ***Collaboration with Other International Bodies:***
   WHO works closely with other UN agencies like UNICEF, UNHCR, and the Global Fund, as well as non-governmental organizations (NGOs) and governments, to coordinate health programs for vulnerable populations. This inter-agency collaboration is vital to addressing complex health needs in displaced and marginalized communities.

8. The WHO's mandate empowers it to set the agenda and mobilize the international community to address global health challenges. In this committee, delegates will explore how WHO can effectively fulfill these responsibilities, especially in ensuring equitable healthcare and vaccine access for marginalized and displaced populations, while navigating political, economic, and logistical obstacles.

9. This mandate aligns with the broader objectives of the United Nations Sustainable Development Goals (SDGs), particularly SDG 3, which calls for universal health coverage and access to quality essential healthcare services.

INTRODUCTION TO THE AGENDA

The agenda, ***"Ensuring Equitable Healthcare and Vaccine Access for Marginalized and Displaced Communities,"*** centers on reducing disparities in the availability, affordability, and quality of healthcare and vaccines for vulnerable populations. Marginalized communities include groups systematically excluded from full participation in society due to factors such as ethnicity, legal status, gender identity, disability, or socioeconomic conditions. Displaced communities refer to refugees, internally displaced persons (IDPs), migrants, and stateless individuals who are forced to flee their homes due to conflict, persecution, or natural disasters.

Ensuring equitable healthcare means guaranteeing fair and just access to essential medical services and vaccinations for these populations—regardless of their location, identity, or legal status. Such efforts are vital to promote public health, prevent disease outbreaks, and uphold the universal right to health.

Globally, 2.1 billion people lack access to essential health services (WHO, 2021). Among them are over 120 million forcibly displaced individuals, including 43.3 million IDPs, 36.4 million refugees, and 5.3 million asylum seekers(UNHCR, 2024). These populations face compounded barriers such as legal exclusion, linguistic and cultural differences, discrimination, and geographic isolation. The WHO reports that marginalized communities are up to four times more likely to experience severe health outcomes than the general population due to structural inequalities (WHO, 2020).

The COVID-19 pandemic sharply exposed these inequities. While many high-income nations reached vaccination coverage exceeding 80%, underserved and displaced populations lagged far behind—some refugee-hosting regions reported coverage as low as 5–10% during critical rollout phases (Gavi, 2022). Additionally, only 48% of humanitarian health response plans were fully funded in 2023, severely limiting access to maternal care, infectious disease prevention, and essential medicines in crisis regions (OCHA, 2024).

In this context, this agenda highlights not just a humanitarian obligation but a global health security imperative. Ensuring healthcare and vaccines for marginalized and displaced communities is

essential to preventing disease outbreaks, safeguarding global stability, and fulfilling Sustainable Development Goal 3: Good Health and Well-Being.

3: Good Health and Well-Being

SDG 3—***"Ensure healthy lives and promote well-being for all at all ages"***—directly aligns with this agenda. It prioritizes universal health coverage, access to safe, affordable, and quality healthcare services, and the reduction of health inequalities. However, the world is currently off-track to achieve SDG 3.

Although progress has been made—life expectancy has risen, maternal and infant mortality rates have declined, and deaths from HIV and malaria have been reduced by half—these advances are uneven. There remains a 31-year gap in life expectancy between the world's shortest- and longest-living populations. National averages mask the stark inequalities faced by vulnerable groups such as refugees, the stateless, and ethnic minorities.

The 2030 Agenda recognizes that good health is fundamental to sustainable development. It addresses not only traditional health burdens but also rising challenges like noncommunicable diseases, climate-related health threats, and systemic inequalities. Achieving SDG 3 will require rights-based, multisectoral, and inclusive approaches that prioritize the needs of the most vulnerable.

Without targeted action for marginalized and displaced communities, global goals for health and well-being cannot be met. Equity must be at the heart of all public health responses.

BACKGROUND OF THE AGENDA

The issue of unequal healthcare access for marginalized and displaced communities has deep historical roots. Throughout modern history, vulnerable populations—such as refugees, internally displaced persons (IDPs), migrants, and stateless people—have faced systematic barriers to health services due to discrimination, poverty, conflict, or legal exclusion. After World War II, millions of people were displaced across Europe, sparking international discussions about refugee rights and humanitarian health. However, it wasn't until the formation of the World Health Organization (WHO) in 1948 and the United Nations High Commissioner for Refugees (UNHCR) in 1950 that coordinated global action began to emerge around providing healthcare to displaced and marginalized groups. Even then, access to quality care remained fragmented and inconsistent, depending heavily on country policies, funding, and political will.

As mentioned before, Globally, 2.1 billion people lack access to essential health services (WHO, 2021). Among them are over 120 million forcibly displaced individuals, including 43.3 million IDPs, 36.4 million refugees, and 5.3 million asylum seekers(UNHCR, 2024). These populations face compounded barriers such as legal exclusion, linguistic and cultural differences, discrimination, and geographic isolation. The WHO reports that marginalized communities are up to four times more likely to experience severe health outcomes than the general population due to structural inequalities (WHO, 2020).

Major global health crises over the past few decades have exposed these disparities more clearly. Here are some case studies that will help you to understand the situation.-

Case Study 1: HIV/AIDS and Marginalized Populations

Background-

Since its discovery in the early 1980s, HIV/AIDS has disproportionately affected marginalized populations, including sex workers, transgender individuals, intravenous drug users, and people living in poverty or without stable housing.In 2023, UNAIDS reported that globally, approximately 39.9 million people were living with HIV, with 1.3 million new infections and

630,000 AIDS-related deaths that year. Since the start of the epidemic, around 88.4 million people have acquired HIV, and 42.3 million have died from AIDS-related illnesses. Women and girls accounted for 53% of those living with HIV, 44% of new HIV infections.

Challenges in Healthcare Access-

Stigma and discrimination remain among the largest barriers to equitable care. A 2021 UNAIDS report revealed that nearly 60% of key populations had experienced discrimination in healthcare settings, leading many to avoid testing or treatment. For example, transgender individuals in Southeast Asia and Africa frequently report being denied care or subjected to abuse in medical settings. Sub-Saharan Africa, a region where approximately 67% of the world's population living with HIV reside, faces significant challenges in addressing the HIV/AIDS epidemic. These include high rates of new infections, a substantial burden of AIDS-related deaths, and the need for wider access to treatment and care, particularly antiretroviral therapy. Structural inequities such as poor infrastructure, gender-based violence, and economic dependency significantly hinder treatment adherence and care access. Among displaced populations, these challenges multiply. Refugees in South Sudan, for example, experience limited access to antiretroviral therapy (ART), which is essential for managing HIV.

Efforts and Gaps-

The Global Fund, PEPFAR, and UNAIDS have provided substantial funding and programmatic support, expanding ART access and community-based outreach. However, many interventions are urban-centered and do not adequately reach rural, mobile, or displaced populations. Mobile clinics and peer-led education programs are emerging as promising approaches, but they remain underfunded.

Case Study 2: The Syrian Conflict and Internally Displaced Persons (IDPs)

Background-

Since the onset of the Syrian civil war in 2011, more than 12 million Syrians have been forcibly displaced—6.8 million internally and 5.3 million as refugees in neighboring countries like Lebanon, Turkey, and Jordan. The healthcare system, once relatively robust, has been severely damaged, with over 50% of medical infrastructure rendered nonfunctional and many healthcare workers having fled.

Barriers to Healthcare Access-

IDPs and civilians in non-government-controlled areas face near-complete isolation from healthcare services. Access to chronic disease treatment, maternal care, and vaccinations has been drastically curtailed. According to the WHO, polio re-emerged in Syria in 2013 after years of eradication due to disrupted immunization campaigns in war zones. Furthermore, cross-border humanitarian aid delivery has become highly politicized. In July 2022, the UN Security Council was forced to negotiate the extension of a cross-border aid mechanism after concerns from the Syrian government about sovereignty. This jeopardized consistent vaccine delivery and medical supply chains to rebel-held areas like Idlib.

Efforts and Gaps-

International NGOs like Médecins Sans Frontières and Syrian diaspora medical networks have stepped in, but funding volatility and safety risks restrict operations. Primary care and emergency medicine are prioritized, but mental health and chronic illness care remain under-addressed.

Case Study 3: The Rohingya Crisis in Bangladesh

Background-

Since 2017, a significant number of Rohingya Muslims, exceeding 740,000, have fled persecution in Myanmar's Rakhine State, seeking refuge in Bangladesh's Cox's Bazar district. This influx has resulted in the creation of the world's largest refugee settlement, where approximately 1 million people are living in densely packed and substandard conditions. One of the largest of these camps is Kutupalong refugee camp.

Healthcare Situation-

Rohingya refugees in Bangladesh face significant challenges in accessing healthcare due to their stateless status, limited legal rights, and strained resources. While humanitarian organizations provide primary care, access to specialized or secondary care remains limited, and maternal and child health indicators are a concern. The Inter Sector Coordination Group (IACG) coordinates these efforts, but resources are severely strained, and the situation is exacerbated by the lack of

sufficient space for sanitation and hygiene facilities. WHO reported a maternal mortality ratio of 179 per 100,000 live births among the Rohingya in 2022, higher than national averages.

Vaccination and Epidemic Response-

Due to crowded and unsanitary conditions, disease outbreaks are frequent. A major diphtheria outbreak in 2017 affected over 8,000 individuals, mainly children. Cholera and measles also remain persistent threats. Despite multiple oral cholera and COVID-19 vaccination drives, community mistrust, logistical constraints, and language barriers continue to limit full coverage.

Efforts and Gaps-

While WHO and Gavi have collaborated on mass immunization campaigns, these are often reactive rather than preventive. Sustainable health infrastructure and long-term care planning remain absent due to the "temporary" classification of the camps by the host government.

Case Study 4: COVID-19 and Global Vaccine Inequity

Background

The COVID-19 pandemic exposed stark inequities in global healthcare systems, particularly in vaccine distribution. While high-income countries vaccinated large portions of their populations rapidly, low-income countries and displaced communities were left behind. By the end of 2021, over 70% of people in high-income countries had received at least one vaccine dose, compared to less than 10% in many low-income nations (NCBI). Marginalized groups within countries—including indigenous communities, rural poor, and migrants—also saw lower vaccination rates due to digital exclusion, mistrust, and lack of tailored outreach. For example, in Latin America, indigenous groups in the Amazon basin had limited access to vaccines due to the absence of cold-chain infrastructure and political neglect. In Lebanon, COVID-19 vaccination campaigns struggled to reach over 1.5 million refugees and migrants, despite WHO-supported mobile outreach.

Global Mechanisms and Limitations-

COVAX, co-led by Gavi, WHO, and CEPI, was launched to ensure equitable vaccine access. However, as of 2022, it faced criticism for delivering fewer doses than pledged due to supply chain

delays and wealthy nations stockpiling vaccines. Additionally, intellectual property restrictions and lack of technology transfer prevented local manufacturing in many developing countries.

Consequences and Lessons-

The unequal vaccine rollout led to prolonged pandemic waves in underserved areas, exacerbating mortality and economic hardship. It also increased the risk of new variants emerging in unvaccinated populations. Experts have emphasized the need for future pandemic preparedness to prioritize equity from the outset.

KEY STAKEHOLDERS

United States of America-

The United States is the largest donor to the World Health Organization and other health programs, including Gavi (the Vaccine Alliance), UNICEF, and the Global Fund. During the COVID-19 pandemic, the United States played a key role in COVAX, the global initiative aimed at ensuring equitable vaccine access. It has actively supported the legal inclusion of refugees and migrants in national healthcare systems and funds mobile clinics and humanitarian health teams.

It has also focused on fighting misinformation and funding cold chain logistics to improve vaccine outreach in conflict-affected and low-resource areas. However, the US has left the World Health Organization (WHO). President Donald Trump initiated the withdrawal process in 2020 and again in 2025, and it is currently set to be finalized on January 22, 2026,

United Kingdom-

The UK has been a leader in health diplomacy and emergency global health funding through its Foreign, Commonwealth & Development Office (FCDO). It actively supported WHO campaigns among displaced populations, particularly in Syria, Yemen, and certain parts of sub-Saharan Africa. During the pandemic, the UK used its position on the UN Security Council to call for temporary ceasefires to help with vaccine delivery in conflict zones. The UK also promotes public-private partnerships and supports culturally inclusive health messaging for migrants and refugees.

France-

France closely ties its foreign health policy to the Sustainable Development Goals (SDG 3 & 10) while focusing on health equity and reducing inequalities. France funds WHO field operations in Francophone Africa and provides logistical support for mobile health units and vaccine delivery in displacement camps. France emphasizes a data-driven approach, supports training for community health workers, and promotes multilingual communication in vaccine education and delivery.

Russia-

Russia engages in global health through bilateral assistance, especially in countries it has strong diplomatic ties with, such as Syria, Ukraine, and Central Asia. It has sent medical teams and

supported humanitarian corridors to allow vaccine access in conflict areas. Russia advocates for vaccine sovereignty, promoting the use of its domestically produced vaccine (Sputnik V) and encouraging solutions at the national level. Within WHO discussions, Russia supports including displaced persons in health monitoring while emphasizing respect for state sovereignty.

China-

China plays a vital role in South-South cooperation by exporting vaccines, personal protective equipment (PPE), and medical teams to lower-income countries, especially across Asia, Africa, and Latin America. During the COVID-19 crisis, China exported or donated over 1.9 billion vaccine doses and helped improve cold-chain infrastructure in countries housing displaced populations. In WHO negotiations, China supports consensus-driven solutions and advocates for fair vaccine distribution without political interference. It also funds health programs for refugees and migrants through multilateral channels.

PAST RESOLUTIONS

Over the years, the United Nations and the World Health Organization (WHO) have passed several key resolutions addressing healthcare access for marginalized and displaced populations. These resolutions lay the foundation for current international efforts to achieve equitable healthcare and vaccine distribution.

1. World Health Assembly Resolution WHA61.17 (2008): Health of Migrants-

This resolution urged Member States to promote the health of migrants through migrant-sensitive health policies and equitable access to healthcare. It also emphasized international cooperation to improve health outcomes for migrants, regardless of their legal status. The resolution called for better data collection and health system responsiveness to migrant-specific challenges.

2. World Health Assembly Resolution WHA 70.15 (2017): Promoting the Health of Refugees and Migrants-

This resolution was built upon WHA61.17, calling for a global action plan to address the health needs of refugees and migrants. It highlighted the importance of mainstreaming refugee and migrant health into national health policies, ensuring non-discriminatory access to healthcare services, and improving the social determinants of health for displaced populations.

3. United Nations General Assembly Resolution A/RES/74/306 (2020): Comprehensive and Coordinated Response to the COVID-19 Pandemic-

Adopted during the height of the COVID-19 pandemic, this resolution called for global solidarity in ensuring universal, timely, and equitable access to quality, affordable diagnostics, therapeutics, and vaccines. It emphasized that displaced and marginalized populations must not be left behind in pandemic response efforts.

4. World Health Assembly Resolution WHA74.14 (2021): Strengthening WHO Preparedness for and Response to Health Emergencies-

This resolution stressed the need to build inclusive and resilient health systems that prioritize vulnerable populations during emergencies. It recognized the disproportionate impact of

pandemics on marginalized communities and called for integrated responses, including equitable vaccine distribution.

5. Global Compact on Refugees (UNHCR, 2018) – Health Provisions-

Although not a WHO resolution, the Global Compact on Refugees includes important commitments to ensure access to national health systems for refugees and host communities. It highlights the importance of providing mental health, maternal care, and vaccination services in refugee settings.

6. World Health Assembly Resolution WHA75.6 (2022): Health Emergency Preparedness and Response – Learning from COVID-19-

This resolution called for lessons learned from COVID-19 to be applied in future global health emergency planning. It underscored the critical importance of reaching the most vulnerable—including displaced and stateless populations—with vaccines and essential health services

SUGGESTIONS

Moderated Caucas Topics:

1. The role of host governments in integrating refugees into national healthcare systems
2. Strategies to eliminate legal and documentation barriers to healthcare for displaced individuals
3. Addressing vaccine hesitancy and mistrust among marginalized communities
4. Mental health access for refugees and stateless persons in post-conflict settings
5. The impact of humanitarian funding gaps on vaccine and healthcare access
6. Public-private partnerships to expand mobile and remote healthcare services in refugee camps
7. Ethical implications of vaccine nationalism during pandemics
8. Cultural and linguistic barriers in healthcare delivery to migrants and displaced persons
9. Innovative approaches to healthcare in conflict zones and inaccessible regions
10. The role of the WHO in coordinating cross-border vaccination campaigns
11. Ensuring equitable healthcare access for internally displaced persons (IDPs) in climate-affected regions
12. Strengthening health infrastructure in temporary refugee camps and informal settlements
13. Protecting the right to healthcare for stateless children and women
14. Technology and digital health solutions to improve care for mobile/displaced populations
15. Lessons from past global crises (HIV, COVID-19, etc.) to shape equitable healthcare systems

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