WORLD HEALTH ORGANIZATION

Welcome Delegates,

My name is Fernanda Mier, and I am really excited to be your chair in the World Health Organization (WHO) for this year's CancunMUN conference. I am 17 years old and currently a junior at the International American School of Cancun. In my free time I really enjoy indoor cycling, pilates, singing, and hanging out with the people I love. After graduating, I am interested in studying psychology or performing arts, and hope to continue my studies in New York City.

This will be my second MUN conference, and during my experience as a delegate I have learned how important preparation, team work, and respectful debates are. Being in MUN has helped me grow a lot and that's why I am thrilled to be your Chair now. The World Health Organization focuses on improving global health, responding to health emergencies, and promoting well-being around the world. In this committee, we will be addressing important global health topics that require cooperation, critical thinking, and realistic solutions.

As your Chair, I expect delegates to come prepared, participate actively, and be open to different points of view. This committee should be a space where you feel comfortable speaking up, making mistakes and learning. Please remember that the background guide is only a starting point, so make sure to research further and stay informed. I am really looking forward to meeting you all and working together to make this a great committee experience! If you have any questions or concerns please feel free to contact me at fernanda.mier@ciac.edu.mx .

Fernanda Mier, Chair

World Health Organization

Welcome Delegates,

My name is Frida Loera, and I am pleased to be hosting you as your Co-Chair for the World Health Organization Committee (WHO) for the 23rd CancunMun Conference! I am 16 years old and currently a junior at International American School of Cancun. In my free time, I truly enjoy playing flag football, travelling to different countries for flag tournaments and eating strawberries and cream. After graduating, I am inspired to study something related to marketing and sports journalism, to pursue a career in sports broadcasting, ideally ESPN.

This will be my third MUN experience, I have been a page and a delegate in MUN, once in AD-HOC and the other in UNESCO. I am excited to be part of WHO, a committee which focuses on promoting global public health by preventing diseases, responding to health emergencies, and strengthening healthcare systems all around the world. It is vital for all the delegates to debate and search for solutions to important health issues that are happening nowadays.

This year, I expect all delegates to come prepared, remain respectful, and actively participate and search for solutions through the debate. I look forward to working with all of you! Please, remember that background guides should not be your only resource of information, research and independent investigation are important for a successful committee. If you have any doubts or concerns, feel free to contact me at frida.loera@ciac.edu.mx see you soon!

Frida Loera, Co-Chair
World Health Organization

COMMITTEE MISSION

The World Health Organization (WHO) is the specialized agency of the United Nations that's responsible for directing and coordinating international health within the UN system. Founded in 1948, WHO was founded on the principle that health is a fundamental human right and that the highest achievable standard of health is a fundamental right to all people. WHO sets global health standards, provides technical assistance, monitors public health trends, works to promote universal health coverage, responds to health emergencies, sets global health standards, and supports countries by strengthening their healthcare systems. The organization works through collaboration with member states, health experts, nongovernmental organizations (NGOs), and other international bodies to reduce health inequalities, strengthen healthcare systems across diverse political,economical, and social contexts, and address both ongoing and emerging global health challenges.

Topic A: Health and Well-Being of People in Prisons

Introduction:

Across all regions of the world, prison populations experience overcrowding, limited sanitation, insufficient medical infrastructure, and inadequate access to preventive and emergency healthcare services. Currently, more than 11 million people are incarcerated worldwide, and the prison population continues to grow in many regions. Around 60% of countries report severe overcrowding rates, contributing to the quick spread of infectious diseases such as tuberculosis, HIV/AIDS, hepatitis, and most recently COVID-19 (Institute for Crime and Justice Policy Research; World Health Organization). In many low and middle income countries, prison health systems operate independently from national healthcare systems, creating structural barriers that prevent continuity of care before, during and after incarceration.

Beyond infectious diseases, incarcerated individuals frequently face disproportionately high rates of mental health conditions. Studies show that a significant proportion of prisoners experience depression, anxiety, substance use disorders, chronic illnesses, and untreated disabilities (World Health Organization). Limited access to trained healthcare professionals, inadequate mental health services, and stigma toward incarcerated populations make these conditions even worse. Because prisons are not isolated from society staff, visitors and release individuals move between prisons and communities. Prison health impacts directly on national and global public health outcomes. Therefore, addressing the health and well-being of people in prisons is not only a matter of criminal justice policy, but a fundamental public health and human rights obligation that requires coordinated international action.

History:

International concern regarding the treatment and health conditions of incarcerated individuals started to gain global attention in the twentieth century as international human rights law developed after World War II. The 1948 Universal Declaration of Human Rights established a critical precedent by asserting that every individual is entitled to dignity, humane treatment, and fundamental rights, regardless of their legal standing. While this foundational document did not explicitly outline prison healthcare, it established the basic ideas about rights, fairness, and laws for the international standards that would eventually protect those deprived of their liberty, including their right to healthcare. As prison populations increased globally throughout the twentieth century, it became extremely clear, to both governments and international bodies, that formal guidelines were necessary to ensure that detention facilities maintained adequate living conditions and consistent access to medical care.

By 1955, the United Nations adopted the Standard Minimum Rules for the Treatment of Prisoners, making it the first time the international community established a comprehensive framework for the life of prisoners. These rules made guidelines regarding sanitation, access to healthcare, nutrition, and treatment of captives. These rules made clear that prisons should provide medical services that are similar to the ones available for the general public and that there should be qualified professionals in medical care. In 2015, the United Nations General Assembly updated these guidelines and renamed them the Nelson Mandela Rules to honor former South American President Nelson Mandela, who spent 27 years imprisoned and later became a global advocate for human rights and prison reform. During the 1980s and 1990s, the HIV/AIDS epidemic brought renewed attention to prison health conditions. Studies revealed that infection rates within prisons were often significantly higher than those in the general population due to overcrowding, limited access to medical services, and unsafe living conditions (World Health Organization, Joint United Nations Programme on HIV/AIDS, and United Nations Office on Drugs and Crime).

In response, organizations such as the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the United Nations Office on Drugs and Crime (UNODC) began collaborating to develop programs focused on disease prevention, testing, and treatment within detention facilities. These efforts emphasized education, improved access to healthcare services, and policies aimed at reducing the spread of infectious diseases.

Non-governmental organizations have also played an important role in bringing attention to the issue. Groups such as Amnesty International, Human Rights Watch, and Penal Reform International have published numerous reports documenting overcrowding, violence, poor sanitation, and inadequate medical care in prisons around the world (Penal Reform International; Amnesty International). Their work has helped pressure governments and international institutions to adopt reforms and improve oversight of detention facilities.

More recently, global health emergencies have further highlighted the vulnerabilities of incarcerated populations. The COVID-19 pandemic demonstrated how quickly diseases can spread in crowded prisons where social distancing and adequate hygiene are difficult to maintain. Many governments were encouraged by international organizations to implement preventive measures such as testing programs, improved sanitation practices, and in some cases the early release of non-violent offenders to reduce overcrowding. Despite these initiatives, many prison systems around the world still struggle with limited healthcare resources and outdated infrastructure, demonstrating that prison health remains an ongoing international challenge.

Current Situation:

Today, the health and well-being of incarcerated populations continues to be a significant global concern. According to international prison monitoring organizations, more than 11 million people are currently incarcerated worldwide, and many prison systems operate beyond their intended capacity. Overcrowding remains one of the most common challenges facing correctional facilities, particularly in regions such as Latin America, Africa, and parts of Asia.

When prisons exceed their capacity, it becomes increasingly difficult to maintain sanitary conditions, provide adequate medical attention, and prevent the spread of infectious diseases.

In many countries, prison healthcare systems suffer from limited funding, shortages of medical personnel, and insufficient mental health services. Research has shown that incarcerated populations often experience higher rates of diseases such as tuberculosis, hepatitis, and HIV compared to the general population. Mental health disorders are also significantly more common among prisoners, with many individuals experiencing depression, anxiety, substance use disorders, or other psychological conditions that often remain untreated due to limited access to mental health professionals (World Health Organization).

International organizations continue to work toward improving healthcare conditions in prisons. The World Health Organization has promoted the integration of prison healthcare into national public health systems in order to ensure continuity of care before, during, and after incarceration. Programs developed by WHO, UNODC, and UNAIDS focus on disease prevention, vaccination campaigns, mental health services, and access to essential medical treatment within detention facilities. These organizations also encourage governments to collect better data on prison health in order to design more effective public health policies.

However, progress remains uneven across different countries and regions. While some nations have taken steps to improve prison healthcare and reduce overcrowding, others continue to face significant structural and financial barriers. As a result, many incarcerated individuals around the world still experience limited access to healthcare, unsafe living conditions, and inadequate mental health support. Addressing these challenges will require stronger international cooperation, increased investment in prison healthcare systems, and a greater recognition that protecting the health of incarcerated populations is an essential part of protecting public health as a whole.

Points To Consider:

- How can governments reduce the spread of infectious diseases such as tuberculosis, HIV, and hepatitis within prisons?
- What policies can ensure that incarcerated individuals receive healthcare services comparable to those available in the general population?
- How can prison healthcare systems be integrated into national public health systems to ensure continuity of care?
- What role should international organizations play in monitoring prison health conditions and supporting reform efforts?
- How can countries address prison overcrowding while maintaining public safety?

Useful links:

https://youtu.be/gDljALWVEAM?si=vowf1KJ6MzMqgxq-

https://youtu.be/_cIiaAsXf8o?si=CFcP6v9yOmMiswHb

https://www.prisonstudies.org/

https://www.penalreform.org/

https://www.unodc.org/

https://www.ncbi.nlm.nih.gov/books/NBK555719/

https://www.prisonpolicy.org/health.html

https://www.nami.org/advocacy-at-nami/policy-positions/improving-health/mental-health-treatment-while-incarcerated/

Country Box

Argentina
Commonwealth of Australia
Belgium
Brazil
Canada
People's Republic of China
Denmark
Ethiopia
French Republic
Federal Republic of Germany
Greece
Republic of India
Ireland
Italian Republic
Japan
United Mexican States
Netherlands
Norway
Republic of Poland
Portuguese Republic
Russian Federation
Republic of Austria
Republic of South Africa
Spain
Sweden
Swiss Confederation
Kingdom of Thailand
Republic of Turkey
United Kingdom

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World Health Organization. *Health in Prisons: A WHO Guide to the Essentials in Prison Health*. World Health Organization. https://www.who.int/europe/publications/i/item/9789289050593

World Health Organization. *Preparedness, Prevention and Control of COVID-19 in Prisons and Other Places of Detention*. World Health Organization. https://www.who.int/publications/i/item/WHO-2019-nCoV-Prisons-2020.1

World Health Organization, UNAIDS, and United Nations Office on Drugs and Crime. *HIV Prevention, Treatment and Care in Prisons and Other Closed Settings*. World Health Organization. https://www.who.int/publications/i/item /9789241504744

Topic B: Healthcare Rights of Migrants and Undocumented Individuals

Introduction

Undocumented immigrants cannot get federal government health insurance, which has been the case for many years. The right of physical and mental health is an important human right that must be guaranteed to every individual, no matter of their nationality, their history or migratory status. It is estimated that there are over 281 million international migrants, a portion of whom face systemic barriers that prevent them from accessing basic health services[1]. In regions such as Southeast Asia, the Middle East, and Latin America, the lack of legal frameworks forces undocumented people to avoid medical care due to the fear of deportation, weakening public health systems by blocking the control of diseases and the treatment of chronic conditions[2].

The relevance of this problem lies in the disconnect between international treaties, such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), and national legislations that actively restrict health access based on legal status. The WHO indicates that migrants in transit and those without documents experience disproportionately high mortality and morbidity rates due to precarious living conditions, malnutrition, and exposure to violence during their journeys. Furthermore, administrative and linguistic barriers, combined with the high cost of private services, create a system of poverty and illness that affects women and children, who make up nearly 40% of the forcibly displaced population[3].

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[1] International Organization for Migration. "World Migration Report 2024." *IOM UN Migration*, IOM UN Migration, 2024, worldmigrationreport.iom.int/msite/wmr-2024-interactive/.

[2] Hacker, Karen, et al. "Barriers to Health Care for Undocumented Immigrants: A Literature Review." *Risk Management and Healthcare Policy*, vol. 8, no. PMC4634824, 30 Oct. 2015, p. 175, https://doi.org/10.2147/rmhp.s70173.

[3] Chalouhi, Jinane, et al. "The Health and Well-Being of Women and Girls Who Are Refugees: A Case for Action." *International Journal of Environmental Research and Public Health*, vol. 22, no. 2, 31 Jan. 2025, p. 204, www.mdpi.com/1660-4601/22/2/204, https://doi.org/10.3390/ijerph22020204.

The lack of universal health coverage represents a risk to global health security by leaving millions of people outside of epidemiological surveillance systems, and ignoring the sanitary needs of migrants, generates long-term economic costs for host States, as emergency interventions are more expensive than preventive medicine and primary care. This information will help delegates analyse and examine the legal obstacles that prevent effective access to healthcare in order to propose international cooperation mechanisms that ensure the fulfillment of the health rights of migrants and undocumented individuals under a framework of equity.

History:

The care of the rights of immigrants has been a huge struggle that has happened for decades. The international community has grappled with a fundamental contradiction: while medicine recognizes no borders, legal systems often do. This evolution began World War II with the 1948 Universal Declaration of Human Rights, which asserted in Article 25 that health is not a privilege of citizenship, but a right of personhood. However, it took nearly half a century for the world to move from these abstract ideals to concrete protections for those moving across borders.

An important turning point occurred in 1990 with the International Convention on the Protection of the Rights of All Migrant Workers. This landmark convention changed the international indifference to the people without legal papers, codifying the principle that life-preserving medical intervention is a right, not a legal privilege. As the new millennium began, WHO transformed the debate by arguing that excluding mobile populations from clinics wasn't just unethical, it was a strategic threat to global health security. In 2008, the World Health Assembly pushed for a systemic shift toward "migrant-inclusive" frameworks, demanding that governments prioritize a patient's clinical needs over status.

The UN, through agencies like the IOM and UNHCR, has acted as a global safety net, providing vaccinations and maternal care in regions where states have closed their doors.

Meanwhile, non-state actors like “Médecins Sans Frontières” have historically filled the gaps, often operating in "gray zones (legal and physical space where the authority of the state is unclear)" to treat those who fear that a trip to the hospital will lead to a deportation center. In recent years, the 2018 Global Compact for Migration represented historic research, and stated that health is a shared global responsibility. It acknowledged that a virus does not ask for a visa, and therefore, health coverage must be inclusive to be effective.

Historical progress in high-level diplomacy often covers a darker reality on the ground: the spread of failure to protect those most in need. In many countries, the "Chilling Effect" (meaning that despites international laws, many states have passed "reporting" laws) keeps existing as a barrier to humanity. When nurses and doctors are forced by law to act as immigration agents, the bond of medical trust is shattered. For an undocumented person, the fear of being caught overcomes the pain of their illness, transforming places of healing into symbols of state surveillance. This has caused diseases to stay hidden, so illnesses that could be treated end up becoming fatal because of a lack of trust. Furthermore, the financial burden has been unfairly distributed, with developing "transit" nations often left to manage massive health crises with little support from wealthier destination countries.

Current Situation

As of 2026, the landscape of migrant healthcare is defined by an unprecedented paradox: while the world is more technologically connected than ever, the barriers for undocumented individuals have become increasingly digital and difficult to navigate. During COVID-19 recovery, a lot of countries made it easier for everyone to get healthcare, even if they did not have legal status. Now that that emergency is over, many countries are returning to stricter systems, where your immigration status decides if you can get care. Currently, major transit routes such as the Mediterranean, the Darien Gap, and the Balkan path are witnessing a surge in medical emergencies. These are not just cases of infectious diseases, but many hidden problems that are getting worse because people live with stress from not having a clear legal status.

One of the most significant active measures today is the WHO Global Action Plan (2019-2030), which aims to integrate migrant health into national frameworks. However, its implementation remains uneven. In wealthier regions, new digital barriers are appearing. People must provide biometric data or national ID numbers to book a basic consultation, excluding undocumented individuals from the system and making them invisible in the healthcare system. Conversely, in regions like South America, initiatives like the Inter-American Press Association's health guidelines and specific national permits (like Colombia's ETPV) have attempted to regularize access, showing that when political will exists, health systems can adapt to include mobile populations without collapsing.

Furthermore, the involvement of non-state actors has shifted from simple first aid to sophisticated legal advocacy. Organizations like Médecins Sans Frontières (MSF) and the International Red Cross are currently running Safe Spaces that operate outside of government data-sharing agreements to reduce fear that stops people from seeking help. These active measures are critical because, in many jurisdictions, the fear of data-sharing between hospitals and immigration offices remains the primary reason migrants avoid life-saving care. The current situation dictates that until firewalls are legally established between health records and enforcement databases, the universal right to health will remain a privilege of those with the right paperwork.

Points To Consider:

- Should undocumented migrants be allowed to access basic healthcare even if they do not have legal status in a country? Why or why not?
- How can governments protect migrant's health while also maintaining their immigration laws?
- Why do many undocumented migrants avoid going to hospitals, and how can countries reduce this fear of deportation?
- What role should international organizations like the World Health Organization play in helping migrants receive healthcare?

- How can countries remove barriers like language, cost, or lack of identification that stop migrants from getting medical help?
- Should richer countries help support transit countries that face large migrant health crises? In what ways could they help?

Useful Links:

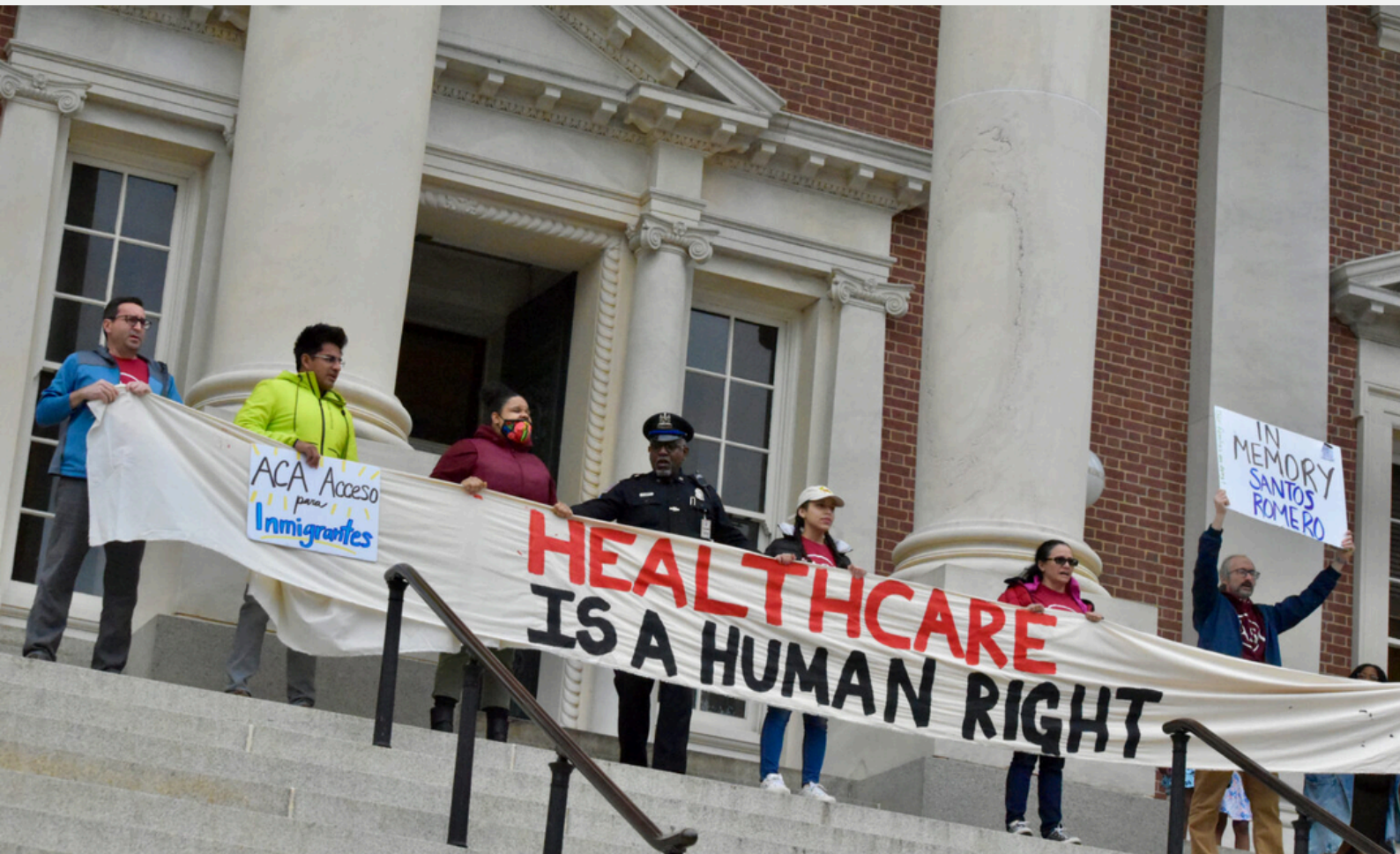
https://worldmigrationreport.iom.int/msite/wmr-2024-interactive/

https://www.unrefugees.org/refugee-facts/statistics/

https://migrationhealth.org/

https://www.ohchr.org/en/special-procedures/sr-health

https://publications.iom.int/books/world-migration-report-2022



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The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".