ECOSOC

BACKGROUND GUIDE

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Message from the Chairs

Hi! My name is Suhani Goyal, and I am so excited to serve as your Head Chair for the very first Milpitas MUN Conference! I am currently a senior at Dougherty Valley High School, and I serve as the Vice President at DVMUN, as well as the Co-Secretary General at Tri-Valley MUN. Outside of a committee room, however, I am also a poet, writer, and reader, which means I view every global issue as a story waiting to be analyzed and rewritten. Having moved across oceans over seven times, Model UN has become a rare constant for me, travelling with me through seven years of experience. Across 30+ conferences, four of which have been as a chair, MUN has been where I've found my voice, my closest friends, and my passion. That sense of belonging is exactly what I hope to create for every delegate who finds themself in the ECOSOC committee room. I'm incredibly eager to see the diverse perspectives and unique voice each of you will undoubtedly bring to our committee, and I look forward to meeting all of you on the conference floor! If you have any questions while researching or preparing for the conference, please feel free to reach out to me at suhanigoyal1864@gmail.com.

Hello! My name is Siyan Mu, and I will be your co-chair for MMUNC I. As this is my first time chairing, it will be a learning experience for me in cooperation with you. In the past I have attended seven different conferences, and I also have organization experience as the Secretary General of SCVMUN (check it out!). The subjects I love focusing on are history, economics, and data science; I am keen on learning about social problems through a mixture of quantitative and qualitative skills. For me, MUN is an analysis of the world around us, but also a microcosm for human behavior. It is my absolute honor to be chairing for you and viewing the room from a new perspective at MMUNC I!

Hi! My name is Liliana Chai, and I am your co-chair for MMUNC I. I am so excited to learn and grow with you all as a first time chair. I have done MUN all four years of high school and attended a variety of conferences such as SCVMUN, South Bay MUN, and NextGen. One of the things I love most about MUN is that no two committees unfold in the same way. Every committee has given me the opportunity to better understand the different perspectives that ultimately come together to reach meaningful compromise. Outside of MUN, I enjoy connecting with others as a musician and artist, and as an editor for my school newspaper, I use storytelling to share the voices that make up our school community. Whether it is your first time debating or as an experienced delegate, I hope each of you can bring creativity and thoughtful discussion to ECOSOC and I am looking forward to a fun and memorable experience together!

Topic Background

Established in the wake of the Second World War, the United Nations is an organization which arose to address the various issues caused by conflict and diplomatic breakdowns. One of the primary objectives was the insurance of proper health worldwide, regardless of economic status. Furthermore, the destruction of the two World Wars created a high demand for medicine, both to treat battlefield wounds and to prevent the epidemics that inevitably followed, like the Spanish Flu.[1] Due to this gruesome reason, the 1940s saw a huge explosion in medical technology, specifically chemicals designed to combat transmitted diseases. Penicillin, for example, saw widespread commercial production when the war started.[2] By the time the fighting ended in 1945, there existed far more resources to cheaply treat global pandemics than ever before, but the institutions to distribute them had been shattered in many places. This phenomenon created a unique need for collaboration, especially since the Spanish Flu had proved local containment alone to be insufficient: human health is a global issue.[3]

Answering this was the UN, which in 1948 wrote the Universal Declaration of Human Rights (UDHR), along with establishing the World Health Organization. The latter specialized body has, since its inception, carefully monitored disease across borders, being present in every combative effort. Meanwhile, the duty of UN General Assemblies, including the Economic and Social Council, is to promote the insurance of human health in collaboration with other

[1] "Purple Death: The Great Flu of 1918 - PAHO/WHO | Pan American Health Organization," accessed July 16, 2026, https://www.paho.org/en/who-we-are/history-paho/purple-death-great-flu-1918.
[2] "The Scientific and Technological Advances of World War II," The National WWII Museum | New Orleans, July 30, 2020, https://www.nationalww2museum.org/war/articles/scientific-and-technological-advances-world-war-ii.
[3] "75 Years Later: The Birth of the World Health Organization," accessed July 16, 2026, https://www.gavi.org/vaccineswork/75-years-later-birth-world-health-organization.

agencies.[4] According to the UDHR, Article 25, access to resources for healthy living is an absolute human right.[5]

Lamentably, despite nearly eight decades of effort, the United Nations has not eliminated poverty and conflict driven health problems. In the early 20th century, the hunting of chimpanzees and human re-use of medical syringes led to the proliferation of the Human Immunodeficiency Virus in Cameroon. This virus would not be officially discovered until 1983, and international efforts failed entirely to stop its spread beyond Central Africa in the 1960s.[6]

Beyond economic factors driving the lack of medical infrastructure and health problems, war has also created or exacerbated issues. The year 1991 saw a coalition force launch an attack against Saddam Hussein's forces, who had invaded Kuwait. While the conflict only lasted 43 days with minimal losses for the 35 country coalition, the destruction of weapons depots caused the release of the toxic gas sarin.[7] On both sides, but especially in the US, this toxic gas created significant long term impacts for veterans. They often experienced medically unexplained health issues, which ranged from children with birth defects to pain and memory loss.[8] While US combat veterans received medical attention and compensation, nearby civilians and Iraqi troops were not provided the luxury, making the burden of conflict fall unequally on local populations. More than a decade before this, the Soviet Union also began an invasion of a Middle Eastern country, namely Afghanistan. Lasting from 1979 to 1989, the conflict led to the direct

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[4] "Health, Right to, International Protection," Oxford Public International Law, accessed July 16, 2026, https://opil.ouplaw.com/display/10.1093/law:epil/9780199231690/law-9780199231690-e806?prd=EPIL.
[5] United Nations, "Universal Declaration of Human Rights," United Nations, United Nations, accessed July 16, 2026, https://www.un.org/en/about-us/universal-declaration-of-human-rights.
[6] "Where Did HIV Come From?," Aidsmap.Com, February 2, 2023, https://www.aidsmap.com/about-hiv/where-did-hiv-come.
[7] US Department of Veterans Affairs Administration Veterans Health, "VA.Gov | Veterans Affairs," General Information, accessed July 16, 2026, https://www.publichealth.va.gov/exposures/gulfwar/sources/chem-bio-weapons.asp.
[8] N. Greenberg and S. Wessely, "Gulf War Syndrome: An Emerging Threat or a Piece of History?," *Emerging Health Threats Journal* 1 (November 2008): e10, https://doi.org/10.3134/ehtj.08.010.

destruction of Afghan medical infrastructure, the massive flow of civilians to overcrowded refugee camps, and the laying of millions of mines. Together, these factors created a rampant environment for disease and civilian injury without proper care.[9] Contemporary estimates quote at least 500,000 Afghan civilians dead during this time.[10] Unfortunately, foreign support to Afghanistan was lacking during and after the conflict, only seeing improvement with the US-led occupation post 2001.[11]

As the Economic and Social Council, it is the primary objective of this committee to develop frameworks and solutions that address both poverty and conflict's effects on healthcare. This committee should focus on designing pragmatic and lasting international systems in response to contemporary problems and in anticipation of the future. While present optimism may be powerful, the UN's past history in this topic has demonstrated that compromises and mutual satisfaction are necessary recipes for long-term sustainability.

[9] Zulfiqar Ahmed Bhutta, "Children of War: The Real Casualties of the Afghan Conflict," *BMJ : British Medical Journal* 324, no. 7333 (2002): 349–52, https://doi.org/10.1136/bmj.324.7333.349.
[10] "'Burning with a Deadly Heat': NewsHour Coverage of the Hot Wars of the Cold War," accessed July 16, 2026, https://americanarchive.org/exhibits/newshour-cold-war/afghanistan.
[11] Ahmad Najim Dost, *Aid Effectiveness in Afghanistan: The Role of Local Human Capacity in Explaining the Health Sector's Success*, n.d.

Current issue

Equitable access to healthcare is an internationally prevalent issue that has travelled across both time and borders, becoming both an infrastructural crisis and a humanitarian one. While advances in medicine have majorly improved health outcomes worldwide, billions of people, especially those living in underdeveloped regions and conflict-ridden zones, continue to face severe barriers that limit their ability to obtain even basic healthcare services. Weak healthcare infrastructure, extreme underinvestment, shortages of trained medical professionals, humanitarian blockades, and limited access to medicines and vaccines have left many health systems unable to protect the well-being of their citizens. These challenges are exacerbated by rising rates of poverty, political instability, climate crises, and high population growth.

Particularly in areas affected by armed conflict, the situation is even more severe. Hospitals and clinics are often destroyed, healthcare workers face violence and displacement, and transport is often so limited that lifesaving treatment and care is left underutilised. The collapse of healthcare systems simultaneously contributes to the rapid development of preventable disease outbreaks that rival the scale of those in international history. Vulnerable groups like women, children, refugees, internally displaced individuals, and individuals with disabilities often bear the burden of this systematic collapse.

International communities have responded through humanitarian aid, peacekeeping operations, and financial assistance to countries in need of health infrastructure. Organisations such as the World Health Organization (WHO), the International Committee of the Red Cross (ICRC), and various NGOs play major roles in addressing the gaps in national healthcare systems. However, the effectiveness of these efforts is limited by blockades in conflict zones and geopolitical tensions, alongside the constant battle between equitable healthcare access and the

protection of state sovereignty. Sustainable solutions will require international cooperation, and must address sufficient funding and access to underdeveloped regions or conflict zones that are difficult to access.

Key Terms

Healthcare infrastructure: The physical facilities, organizational frameworks, and resources required to deliver healthcare services, including clinics, laboratories, medical supply chains, and transportation networks. Effective infrastructure improves community conditions, enabling access to equitable healthcare services.

Health Equity: Equity means allocating the specific resources and support a person needs to achieve their highest level of wealth, while equality means giving everyone the same resources. This can be achieved by removing obstacles such as poverty, discrimination, and lack of access to opportunities.

Universal Health Coverage (UHC): Ensures that all people should have access to quality healthcare services they need—including prevention, treatment, rehabilitation, and palliative care—without experiencing financial hardship by minimizing out-of-pocket costs and utilizing pooled funds.

Social Determinants of Health (SDOH): The non-medical conditions in environments where people are born, live, work, and age that have a significant impact on health and well-being outcomes and risks. SDOH can be grouped into five categories: economic stability, education access, healthcare access, neighborhood environment, and social and community context.

International Humanitarian Law (IHL): The body of international law that seeks to prevent the humanitarian consequences of armed conflict. It does so by ensuring that civilians, medical

personnel, or prisoners of war who are no longer actively engaged in war receive adequate medical care while limiting the harmful means and methods of warfare.

Capacity building: The process of strengthening the skills, infrastructure, institutions, and resources of a health system so that it can effectively deliver healthcare services during crises, recover after disruption, and ensure equitable access to care, especially in conflict-affected areas.

Health system resilience: The capability of a health system to prepare for, absorb, recover from, and adapt to shocks or chronic stresses while continuing to provide essential healthcare services and maintaining core functions.

Brain drain: The large-scale emigration of skilled professionals, such as doctors, nurses, and other healthcare workers, from one country or region to another in search of better pay, safer working conditions, or greater career opportunities. This can create shortages of healthcare workers and thus reduce the quality of medical services in underdeveloped areas.

Key Countries

United States - As a highly advanced global superpower, the country relies majorly on a privatized, multi-payer healthcare system, built on employer-sponsored insurance. It leads the world in medical research, technology, and biochemical innovation. However, it faces systematic inequalities due to high costs and a lack of universal coverage, leaving millions uninsured.

United Kingdom - A highly developed European nation, the UK features the publicly funded National Health Service (NHS), providing free care at the point of use. It is also a global innovator in clinical research and genomic medicine. However, the system faces severe strain from staffing shortages, underfunding, and long wait times.

France - As a developed Western European country, France operates a multi-payer universal health insurance system known for high-quality outcomes. It also has strong medical research and a network of clinics, but it risks deficits and disparities in what many describe as rural "medical deserts."

Russia - A massive, transcontinental nation, Russia has a mandatory medical insurance system that guarantees free basic care through federal law. It maintains localized vaccine manufacturing and hospital care, but this infrastructure is often outdated in rural areas. It also faces shortages of modern imported medical equipment, especially when involved in active conflict.

China - A rapidly advancing economic superpower, China uses a state-backed medical insurance plan covering over 95% of its massive population. It has greatly expanded its urban medical

infrastructure and digital health networks, but still faces imbalances between advanced urban clinics and under-resourced rural clinics.

DRC - A severely underdeveloped Central African country, the DRC has an extremely fractured health system deeply strained by ongoing regional conflicts and extreme poverty. It has experience managing deadly epidemics like Ebola, but clinics face severe shortages of supplies, relying heavily on foreign humanitarian aid.

Kenya - As a developing East African nation, Kenya operates on a hybrid system actively transitioning towards Universal Health Coverage through the NHIF. It is also a regional leader in mobile e-health solutions. However, it struggles with a severe brain drain of medical staff migrating abroad, and high expenses.

South Africa - A polarized, middle income African nation, South Africa features a dual system: high quality private healthcare, as well as an under-resourced public system serving 80% of its citizens. It is a continental leader in HIV/AIDS research. However, the public system is overwhelmed by crumbling infrastructure and staffing shortages.

Libya - As a fragmented North African nation, Libya's healthcare system remains severely inefficient due to over a decade of civil conflict and political divisions. While public healthcare is theoretically free, active clinics face severe shortages of specialized staff and life-saving medicines, relying mostly on international NGOs.

Iran - A heavily sanctioned Middle Eastern nation, Iran utilizes a comprehensive universal health insurance network with a very effective primary rural health system. It has advanced domestic medicinal production, but strict international sanctions restrict the majority of access to imported medical technology and specialized treatments.

Sweden - A highly advanced Northern European country, Sweden has a publicly funded healthcare system with universal access. It has world class technology, but suffers from wait time issues in some regions. The country contributes heavily to medical technology and pharmaceutical breakthroughs.

Sudan - A critically underdeveloped country with a shattered medical system, and only limited local support left. There is a strong need for medical supplies and facilities; hospitals are mostly shut down due to the civil war that erupted in 2023.

Germany - The oldest universal healthcare system in the world, Germany is highly advanced, with a huge bed capacity and rapid access. However, there is a shortage of digital technology and nurses. Great contributor of medical hardware and international funding.

Thailand - Quickly developing, Thailand has a Universal Coverage Scheme for all citizens. A frequent destination for medical tourism internationally. Unfortunately, medical specialists can be lacking in rural provinces, and the country is reliant on imported technology. Air pollution and monsoon flooding sometimes strains health infrastructure.

Japan - Highly advanced, Japan has the Statutory Health Insurance System that covers the entire population. With the world's highest life expectancy, Japan boasts amazing cancer screening and technology, but the aging population places a strain on finances. A global researcher into longevity.

New Zealand - With a publicly funded healthcare system, New Zealand has good emergency response systems, but struggles to improve inequalities between indigenous populations and European descendants. Often a provider to neighboring countries, but also prone to earthquakes and volcanic eruptions itself.

Australia - Another developed country, Australia features a hybrid system of Medicare for its citizens. Features an innovative Royal Flying Doctor Service for more remote regions, which operates about 80 different aircraft, but still faces regional inequalities. Does research into bionics and skin cancer prevention.

Brazil - Somewhat developed, Brazil is constitutionally mandated to provide free healthcare, and has a great national immunization program. However, regions have severe differences in infrastructure. The country is also a leader in tropical disease research; the region is prone to mosquito-borne diseases and environmental disasters.

Cuba - With a unique government, Cuba has a completely state controlled healthcare system. A high doctor to patient ratio and effective neighborhood care model makes this country distinct.

Nevertheless, there is a chronic shortage of basic medical supplies, but doctors are often sent abroad for global relief. Vulnerable to Caribbean hurricanes.

India - Polarized, India has noticeable regional differences, especially between urban and rural areas. It is largely a private healthcare system, and a place for low-cost medical tourism. Also the largest global producer of generic medicines and vaccines, provided cheaply to developing countries.

South Korea - A highly developed nation, South Korea functions under an universal healthcare system called the National Health Insurance Service (NHIS). It is a global leader in medical technology, biotech, and health IT infrastructure, but faces rising costs and staffing shortages due to its rapidly aging population.

Spain - Spain operates a dual public-private healthcare system through its tax-funded National Health System (SNS) and is recognized for strong primary healthcare and high life expectancy. Yet, a major hurdle is long waiting lists for specialists and understaffing.

Mexico - A developing country, Mexico has a multi-tiered system split between IMSS, ISSSTE, and the IMSS-Bienestar program. It has strong urban private hospitals and medical tourism appeal, but rural and indigenous communities face severe shortages of clinics and medicine, aggravated by cartel-related violence.

Peru - Peru's system combines public insurance (SIS), social security (EsSalud), and private care. It has expanded coverage significantly in the past two decades, but its healthcare system structure has been weakened by its geographic isolation in the Amazonian, underfunding, and one of the world's highest COVID-19 mortality rates.

Iraq - A Middle Eastern nation still recovering from decades of war and sanctions, Iraq's public healthcare system theoretically offers free care yet suffers from destroyed infrastructure, a mass exodus of trained doctors, and heavy reliance on aging Soviet-era and donated equipment.

United Arab Emirates - A wealthy Gulf federation, the UAE runs a rapidly modernizing hybrid system through the combination of mandatory employer-sponsored insurance with heavy investment in private, world-class hospitals. Still, healthcare access and quality remain stratified between citizens, high-income expatriates, and the low-wage migrant labor force.

Lebanon - A small Levantine nation, Lebanon relies on a mixed public-private model hit hard by years of economic collapse, military campaigns that have targeted healthcare infrastructure, and overwhelmed facilities due to mass casualties. Thus, access to healthcare has shifted from a standard system to a fragmented emergency-only network.

Myanmar - A Southeast Asian nation under military rule since the 2021 coup, Myanmar's system has been severely disrupted by mass civil disobedience among health workers and armed conflict in ethnic border regions. Public hospitals face staff and supply shortages, forcing many citizens to rely on underfunded NGO clinics or corss-border care.

Canada - As a large, highly developed country, Canada runs on Medicare, a publicly funded universal healthcare system emphasizing equitable access regardless of income. However, millions of Canadians lack a regular family physician, and out-of-hospital services are unevenly covered.

Saudi Arabia - A wealthy Gulf monarchy, Saudi Arabia provides free public healthcare to citizens through the Ministry of Health alongside an expanding private sector driven by Vision 2030 through oil-funded investments in hospitals and medical technology. The system remains heavily reliant on foreign medical staff.

Questions to Consider

1) How can healthcare systems become more resilient during times of crisis, such as armed conflict or natural disasters?
2) How should member states balance immediate humanitarian assistance with investments in long-term healthcare system development?
3) How can the international community balance safe and equitable healthcare access for civilians in conflict zones with national sovereignty?
4) What long-term policies, funding mechanisms, and international partnerships can strengthen healthcare infrastructure in developing nations that are prone to conflict?
5) How can the safety of healthcare workers be protected during armed conflict, and how can the UN facilitate volunteers joining relief efforts?
6) What experimental medical practices and technology could help underdeveloped countries immediately? How do they help with solving the current issue?

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