WHO

Oakridge MUN 2026

World Health Organisation (WHO)

Agenda: Addressing communicable and non-communicable disease risks faced by prisoners with an emphasis on prison health systems reforms and policy

CONTENTS

1. Letter From the Executive Board

Greetings Delegates,

We are delighted to serve as the executive board for this edition of Oakridge MUN in 2026. This is a special simulation of the World Health Organisation (WHO) on an extremely relevant scientific discipline and its application in the real world, Prison Health. The WHO, through its decision-making arm the World Health Assembly (WHA), coordinates the world's response to health emergencies, promotes well-being, prevents disease and expands access to health care by connecting nations, people and partners to scientific evidence.

Occupying this chair, you will step into the shoes of world leaders who make these decisions that impact billions. Prisoners around the world suffer from poor health systems access, limited environmental safeguards such as clean water and sanitation, and immense mental health dangers given the nature of most correctional facilities. Somewhere along the way, the idea of correctional facilities has been lost; prisoners deserve a healthy environment to help them reform, just as everyone else does.

Communicable, non-communicable, mental, environmental, systemic, and lifestyle diseases make for a dangerous living standard in prisons. HIV, Hepatitis, Diabetes, Hypertension, Obesity, Schizophrenia and Psychosis are some commonly observed conditions.

We want you to focus on: international, national, and national policy reform; screening and health systems strengthening; equitable access; prison environmental reforms; financing; technology and medicines; health surveillance and monitoring; and continuity of care among other topics you may find interesting. This background guide is intended to brief you about the agenda and its intricacies, and to help establish a background for your understanding. However, this is in no way a substitute for your own research, and we encourage you to explore and come up with innovative solutions to the agenda amongst yourselves. Good luck!

Mihir Eshan - Chairperson **Pratheek Konda** - Vice Chairperson

MUN Rules Of Procedure (ROP)

1. Roll Call

- The Chair calls on each country to declare if they are "Present" or "Present and Voting." It refers to the voting procedure on the Draft Resolution, where a delegate can vote "Yes", "No", or opt to "Abstain".
- If "Present and Voting," the delegate cannot abstain from voting. If the delegate chooses to respond with "Present", they may answer with "Present and Voting" on subsequent days, but this is not permissible for "Present and Voting" as this reply must be used consistently from that point forth.

2. Setting the Agenda

- Delegates motion to set the agenda, followed by a formal debate on which topic to discuss first. This motion requires a simple majority to pass.

3. Speakers' List

- After passing a motion to enter formal debate, delegates are placed on a speakers' list to make formal speeches. Time limits are set, and the Chair calls on delegates to speak in order.
- A delegate must raise their placard if they wish to add their name to this list. They can be on this list only once on any occasion.

4. Points

- **Point of Order:** To correct a procedural error by the Chair.
- **Point of Personal Privilege:** For personal discomfort (e.g., if the room is too cold, or if a fellow delegate cannot be heard).
- **Point of Inquiry:** To ask questions about discussion or statements in committee.
- **Point of Parliamentary Inquiry:** To ask questions with regard to the Rules of Procedure.

5. Motions

- **Motion to Suspend the Meeting:** To break for caucuses or adjourn the session.
- **Motion to Close Debate:** Ends the discussion on a topic and moves to voting. Requires a two-thirds majority.
- **Motion to Table the Topic:** Postpones debate on a topic. Requires a majority vote.

6. Yields

- **Yield to the Executive Board:** A delegate yields their remaining time from their speech to the Executive Board. It is to be used as they see fit.
- **Yield to Another Delegate:** A delegate yields their remaining time for another delegate to speak. (This delegate's permission must be sought beforehand)
- **Yield to Points of Information:** A delegate yields their remaining time to Points of Information to the committee.
- **Yield to Comments:** A delegate yields their remaining time to comments from the committee.

7. Caucuses

- **Moderated Caucus:** The Chair controls the speaking order with shorter, focused speeches. The topic selected is a narrowed version of the agenda, chosen by the delegate who proposed the moderated caucus.
- **Unmoderated Caucus:** Informal discussion among delegates not under the moderation of the Executive Board.

8. Draft Resolutions and Amendments

- Delegates collaborate to create draft resolutions, which are formal solutions to the discussed issue.
- **Friendly Amendments:** Accepted by all sponsors without a vote.
- **Unfriendly Amendments:** Need to be voted on to be added.

9. Voting

- **Procedural Votes:** Includes motions and amendments; all members must vote.
- **Substantive Votes:** For resolutions and unfriendly amendments; only "Present and Voting" delegates may vote, and abstentions are allowed.

2. The World Health Organisation (WHO)

A. What is the World Health Organisation?

The World Health Organization (WHO) is a specialized agency of the United Nations responsible for international public health. It is Governed by the World Health Assembly, which consists of representatives from all 194 Member States.

It works to promote health, keep the world safe, and serve the vulnerable. It develops international guidelines, provides technical assistance to countries, monitors disease outbreaks, and leads efforts to control major health challenges such as infectious diseases and environmental health risks. Through its work, WHO sets global standards for healthcare practices, helps coordinate emergency responses to crises like pandemics, and supports countries in building stronger health systems to improve the well-being of people everywhere.

B. WHO's Mandate; how does the WHO function?

"The objective of the World Health Organization shall be the attainment by all peoples of the highest possible level of health." In order to achieve its objective, the functions of the Organization shall be (the following mandate has been simplified for better comprehension):

- "Acting as the directing and coordinating authority on international health work and maintaining collaboration with the United Nations and other organizations."
- "Assisting governments, upon request, in strengthening health services and appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of governments."

- "Providing, upon the request of the United Nations, health services and facilities to special groups, such as the peoples of trust territories and maintaining such administrative and technical services as required."
- "Advancing work to eradicate epidemic, endemic, and other diseases and promoting, in cooperation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions, and other aspects of environmental hygiene."
- "Proposing conventions, agreements, and regulations, and making recommendations with respect to international health matters."
- "Promoting maternal and child health and welfare, and fostering activities in the field of mental health, especially those affecting the harmony of human relations."
- "Developing, establishing, and promoting international standards with respect to food, and further developing international standards for biological, pharmaceutical, and similar products and establishing international nomenclatures of diseases, causes of death, and of public health practices."

There are essentially two governing bodies: the World Health Assembly (the WHA) and the Executive Board.

- The World Health Assembly is the top decision-making forum, attended by all 194 Member States, meeting annually to set policies, approve the budget, and appoint the Director-General.
- The Executive Board (EB) is made up of 34 technical experts elected for three-year terms. They prepare WHA agendas and guide policy implementation.
- WHO has six region-specific offices (e.g., AFRO, EURO) that adapt global strategies to regional health needs. Along with that, WHO also has country offices that work directly with governments to support outbreak response, vaccination campaigns, health system strengthening, etc.

C. What are International Health Regulations (IHR)?

The International Health Regulations (2005) (IHR) provide an overarching legal framework that defines countries' rights and obligations in handling public health events and emergencies that have the potential to cross borders. The IHR are an

instrument of international law that is legally-binding on 196 countries, including the 194 WHO Member States. They create rights and obligations for countries, including the requirement to report public health events. The IHR require that all countries have the ability to do the following:

- Detect: Make sure surveillance systems can detect acute public health events in a timely manner.
- Assess and report: Use the decision instrument in Annex 2 of the IHR to assess public health events and report to WHO through their National IHR Focal Point those that may constitute a public health emergency of international concern.
- Respond: Respond to public health risks and emergencies.

3. About the Agenda

A. Why provide Prison Healthcare? What systems are in place?

There are two compelling reasons for providing health care in prisons. First is the importance of prison health to public health in general. Prison populations contain a high prevalence of people with serious and often life-threatening conditions. Sooner or later most prisoners will return to the community, carrying back with them new diseases and untreated conditions that may pose a threat to community health and add to the burden of disease in the community. Thus there is a compelling interest on the part of society that this vulnerable group receive health protection and treatment for any ill health.

The second reason is society's commitment to social justice. Healthy societies have a strong sense of fair play: those involved in the provision of health care are committed to reducing health inequalities as a significant contribution to health for all. It is a fact that the majority of prisoners come from the poorest parts of society, with deficiencies in education and employment experience. Their admission to prison can be the first time they have had a settled life with adequate nutrition and a chance to reduce their vulnerability to ill health and social failure. Prison health care can play an important role in reducing health inequalities.

All this underlines the need for governments to give a degree of priority to health in prisons. First, they should meet their duty of care for those deprived of their liberty. Second, they should respect prisoners' human rights, aid the protection of their

health and contribute to public health as a whole, thus making a major contribution towards reducing health inequalities in a vulnerable part of the population while society awaits the effects of action on the broader social determinants of health.

How prison health is managed globally varies by jurisdiction and region:

1. *Ministry of Health Governance:* An increasing number of countries (such as several in the WHO European Region) are transferring the oversight and administration of prison health care from Departments of Corrections or Justice to their Ministries of Health. This ensures greater clinical independence and public health integration.
2. *Joint Governance:* Some nations utilize a shared responsibility model, where the Ministry of Justice and the Ministry of Health jointly fund and manage the health systems within detention facilities.

Some frameworks that govern prison health are: (i) WHO Prison Health Framework; (ii) ICRC Guidelines; (iii) WMA Guidelines.

B. Prevalent Communicable Diseases in Prison

Many infectious diseases, such as sexually transmitted infections, HIV and hepatitis have an increased prevalence in the criminal justice system. Hammett estimated the burden of infectious diseases in released inmates as a proportion of everyone in the US with the disease and determined that 24% of all STIs, 35% of tuberculosis, 29% of Hepatitis C, 17% of AIDS, 13% of HIV, and 15% of Hepatitis B is present in the release population. As these are all communicable infections, there are three reasons to screen and treat for infection during incarceration: (1) to improve individual outcomes, (2) to minimize spread within the correctional facility and (3) to decrease the chance of transmission in the community after release. In addition, if public health officials are not performing routine surveillance of inmates and recent releases for these infections, then they will underestimate the overall reservoir of disease.

The prevalence of HIV, hepatitis B and hepatitis C is particularly high in pre-trial detention centres and in prisons.

- All modes of transmission of these diseases occurring in the community also occur in prisons: through blood, sexual activity and vertical transmission to a child.

- Guidelines and standard operating orders should be developed, in line with national guidelines and based on international guidelines, to address bloodborne viral diseases in prisons.
- All preventive, curative and supportive interventions for HIV, hepatitis C and B that are available in the community are effective, feasible and needed in prisons.
- Continuity of treatment is key in the response to HIV, including for people going into, transferring between or released from prisons.
- Measures to address HIV and AIDS in prisons also address HIV and AIDS for staff working in prisons, for people visiting prisons and for the entire community.
- HIV testing cannot be mandatory and all health interventions need to have the informed consent of the people concerned.
- People living with HIV should not be segregated.

C. Common Non-Communicable Diseases in Prison

The global burden of and threat from noncommunicable diseases (NCDs) constitute a major public health challenge that undermines social and economic development throughout the world. Prisoners are at greater risk for such diseases.

- Most information on NCDs in prisoners comes from high-income countries despite the fact that globally, 80% of these deaths from these diseases are in low and middle-income countries.
- NCDs comprise mainly cardiovascular diseases (48%), cancers (21%), chronic respiratory diseases (12%) and diabetes (3.5%). They share four key behavioural risk factors: tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. Prisoners are more likely to smoke and to drink harmful amounts of alcohol than the general population.
- Prisoners' diets are often unhealthy with either under or over-provision of calories and with excessive levels of sodium.
- The primary prevention and treatment of NCDs in prisons has largely been neglected.

D. Contribution of Social and Cultural Factors to STIs and HIV in Incarcerated Populations

Multiple social and cultural factors contribute to high rates of STIs in incarcerated populations and in communities highly affected by incarceration. Several behaviors may lead to both an increased risk of STI acquisition and incarceration. For example, substance use is associated with risk taking behavior such as unprotected sex, and also increases an individual's chance of going to jail. Commercial sex work, where sex is traded for drugs or money, also increases one's risk for both STIs and incarceration. Incarceration may disrupt primary intimate partnerships, and separated individuals may seek new sexual partnerships, which may result in concurrent or high-risk sexual relationships. In North Carolina, 52% of incarcerated men reported a primary intimate relationship prior to going to jail, and 55% stated that this relationship dissolved during incarceration. Loss of a partner due to incarceration was associated with nearly three times the prevalence of having 2 or more new partners (prevalence ratio 2.8, 1.1–6.7) in the preceding month.

E. Mental Health Disorders in Prison

- Studies have consistently shown that the prevalence of poor mental health among prisoners is considerably higher than in the community. Prison mental health services should be based on the health needs of prisoners. This might require more intensive and integrated services than in the wider community.
- Prisoners with mental health problems will often also have several other vulnerabilities, such as substance misuse problems, poor physical health, learning difficulties, poor life skills, histories of trauma, relationship difficulties, unstable housing and/or homelessness, poor education and limited experience of employment.
- Mental health treatment and care need to address all the prisoners' needs, including their social needs, and be psychosocial in nature.
- The first step in understanding the mental health situation in a prison population is to ask prisoners their views on their needs and how these might be met.
- All staff working in prisons should have an appropriate level of mental health awareness training, which should cover the specific needs of those with personality disorders.

- Maintaining links between a prisoner and his/her family can be crucial for the mental well-being of the prisoner, for a successful return to society on release, as well as benefiting the family.
- All prisoners should be screened on entry to prison for a range of mental health and related problems. There should also be other opportunities to identify needs.
- Some prisoners suffer from severe or acute mental health symptoms and may benefit from treatment in a psychiatric unit, either in the prison or in a hospital.
- The mental health needs of different groups of prisoners such as women, older prisoners, children and young people, prisoners from minority ethnic or cultural groups and foreign prisoners, may need to be addressed differently.
- Continuity of care is important for a prisoner, including the continuation of treatment that he/she was receiving prior to incarceration and the handing over of care to a community-based provider on release.

F. Other Gaps in Prison Health Systems

Incarcerated people do not have the freedom to live outside the jail; they are largely reliant on the prison diet, which often lacks adequate quality and quantity, leading to nutritional deficiencies. In underdeveloped countries, incarcerated populations are particularly vulnerable to conditions such as scurvy, vitamin A deficiency and beriberi, exacerbated by the inadequate nutrition prevalent in many African prisons.

Mortality after release from prison was also reported to be higher, particularly during the early period of release. The nutritional status directly impacts incarcerated peoples' physical and mental health development due to overcrowding caused by the large number of incarcerated people. Incarcerated individuals often exhibit poor self-perceived health status linked to lifestyle and behavioural factors. Comparatively, their physical, mental and social health is worse than that of the general population largely due to reliance on limited food options and possibly inappropriate nutritional behaviours that may arise from both institutional practices and individual choices. This not only heightens the risk of malnutrition but can also lead to aggressive and antisocial behaviours, further complicating their reintegration into society.

4. Case Studies

A. Tihar Jail, India: The Problems Faced By Overcrowded Prisons In Terms of Non-Communicable & Communicable Diseases

Systems are never meant to be overloaded; when they do overload they never function at peak performance. This should especially be applicable to those involving the humanitarian field, linking this back to our main agenda this can especially be seen in LEDCs or Lower Economically Developed Countries, where current infrastructure and resources are the limiting factor in providing care, safety, and rehabilitation. A few examples where we can see such patterns are Tihar Jail in Delhi and CECOT in El Salvador (during Covid). Both of these facilities previously held double the maximum capacity of prisoners due to a lack of housing facilities to actually place and hold them. This was especially dangerous in CECOT when there was a disease rampant that had potential to be lethal and was easily communicable. One of the biggest factors of communicable disease spread is the lack of precaution and initiatives to prevent disease spread; the official government of NCT of Delhi reports that they only have 92 doctors and 71 nursing staff to take care of the reported 18,500 inmates in the jail and a total of 300 beds under the categories of Medicine, TB, Psychiatry, De-addiction Centres and Mental Health.

The Central Jail of the Government of the NCT of Delhi reports that incidents of HIV was found to be extremely high amongst injecting drug users and most these injecting drug users, who were not aware of their HIV status, are likely to further spread HIV to their other injecting drug user partners or their spouses after release from prison. To curtail the spread of HIV, an OST programme was initiated in July 2018; these also reduce drug-seeking behaviour and incidents of misdemeanor. NDTB Centre (New Delhi Tuberculosis Centre) is a framework for TB care in prisons. Active surveillance of tuberculosis patients is being done in close assistance of the NDTB Centre.

It is also reported that 7,000 inmates have been reported for the presence of mental disorders which is an astronomical number that shows the prison's inability to provide adequate care to their prisoners and having them suffer without access to healthcare. Common mental health conditions include addiction, post-traumatic stress disorder, major depressive disorder, and psychotic disorders — all of which have been confirmed by the WHO to stem from overcrowdedness.

B. HMP Fosway, UK: The Long-term Benefits Received When Adequate Care is Taken for Prisoners

HMP Fosway is a famous prison in the UK that is known for not just maintaining great facilities to prevent communicable and non-communicable diseases, but also preparing the prisoners for the outside world when they get released by having them learn skills on simulators. By restoring the connection to the outside world these prisoners are less likely to feel isolated and develop a host of mental health disorders associated with prison. Not to mention the prison claims that the likelihood of the same prisoners who go through this experience of periodic connection with the outside world, comfortable living quarters, and the careful association with real life working skills all contribute to lower repeat offenders that continue to cause crime. Prisoners also state that it restores the feeling of belonging after their release.

There have been ten deaths in this reporting year. One was apparently self-inflicted, one apparent homicide, six were apparently from natural causes and two were apparently drug-related. Nine of the ten are subject to a coroner's inquest, with two of those inquiries having concluded. The Board is satisfied that, where proper processes had not been followed, recommendations to correct this have been implemented. Self-harm incidents saw a surge in August, September and October, but since the turn of the year, with the exception of February, have dropped to an average of between 70 and 80 per month. The actual number of prisoners self-harming is below 50 per month.

Use of force instances were generally low and comparable with other, similar, establishments. PAVA (an incapacitant spray similar to pepper spray) was drawn over 50 times in the reporting year but was not always used as a last resort. However such a standard comes at a drastic cost: even though this entire project of the prison costs upwards of 250 million Great British Pounds, its current housing capacity is 2000 — making it extremely inefficient for the same process and elements to be applicable all across the world, especially given that LEDCs have other higher priority issues that can help substantially more people with the same amount of money, such as food and clean water for its people. Not to mention that such prisons are privately owned and connected to the government, which means that not every prisoner is expected to get the same treatment in the United Kingdom.

5. Questions a Report Must Answer (QARMA)

- How do health and justice interact? Which governance bodies are involved and how?
- What are the most challenging prison health crises we are currently facing and where? What are the perpetuating and protective factors?
- How do international and national-regional health governance systems collaborate to achieve better care outcomes?
- How can prison staff health be protected in such work conditions?
- Why are sexual health diseases so common in prison? How do we curb them?
- How can lifestyle diseases like Diabetes be cared for in prison?
- How does the prison environment affect mental well-being? What are some best practices to achieve a healthy living environment?
- How should prison substance abuse (drugs, alcohol, tobacco) be mitigated healthily?
- Which communities are most affected by insufficient prison care systems? How do we safeguard their rights?
- How can we develop stronger financing methods for continuity of care? Can health insurance schemes apply during prison time as well?
- How can we provide prisoners ways to exercise their guaranteed national human rights and flag healthcare discrepancies?
- What tangible steps can be taken to support healthy reintegration of released individuals in society?

6. Important Resources and Instructions

A. What to Research

- Firstly, identify and educate yourself on the agenda.
- Secondly, educate yourself about your country. This would mean their stance with regards to issues pertaining to the agenda, the blocs they are part of, and the measures or actions they have taken.

- Thirdly, keep yourself up to date with the international response to the issues under the agenda, whether it be the actions by the international community, or the UN.
- Last but not least, make sure your research contains inventive, well-researched, and effective solutions.

B. Sources of Information

The committee recognizes the following sources as credible:

- **News Sources:** Reports from state-operated agencies or international news agencies. Examples include Reuters (reuters.com) and IRNA, Iran (irna.ir).
- **Government Reports:** Examples include government websites such as the U.S. State Department (state.gov) and the Russian Federation Ministry of Defense (eng.mil.ru). Reports from ministries of foreign affairs, such as India's (mea.gov.in) and permanent representatives to the United Nations (un.org/en/members) are also valid. Reports from multilateral organisations like NATO (nato.int) are credible.
- **UN Reports:** All reports from UN bodies, such as UNSC (un.org/Docs/sc) and UNGA (un.org/en/ga), are considered credible. Reports from affiliated UN bodies like the World Bank (worldbank.org) are also valid sources of information.

> ***Note***
>
> Absolutely no AI-generated speech or solution content will be allowed. We will be running multiple AI checks, and flagged content will be scrutinised for disciplinary action by the secretariat.

7. Documentation

> ***Note***
>
> Position papers are required to be submitted on day 1 of committee before we begin. Detailed instructions will be conveyed by the Secretariat and Executive

Board. This is a mandatory submission. The final documentation process will be explained to you in detail at the end of day 2 of committee.

Refer to this link to view how a *WHO Report* looks: https://apps.who.int/gb/ebwha/pdf_files/WHA76/A76_32-en.pdf

All the best!