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1. Letter from the Secretary General

Most distinguished participants and esteemed guest, It is an extreme honor to welcome everyone of you in this particularly excellent event. I would like to start my letter with the history of this amazing club which made this conference come true.

Yucel Boru Fen Lisesi Model United Nations Club is a formation that has been established in 2019, containing the best ambassadors and greatest brains of its time. I, as the Secretary General of YBFLMUN'26 am proud of being the 7th president of this extraordinary club which has been on my side through these 3 years.

Our journey is not just a travel which is being made continuously in time but an adventure giving everyone the consciousness that they need. As the Secretary General of this exquisite event I, personally, believe this occasion will be one of the best of its kind. To be more specific I know this conference will change the life of those who attended. With the immense help of our organization team and fabulous efforts of our academy team we hope you all to have a wonderful experience, have a chance to make new friendships that will last for a long time and, who knows, maybe have an opportunity to find the true love through this collaboration.

To any delegate, any attendant and any person who considers MUN as a union just about debates or diplomatics, we would like to inform you before your ideas change. MUN is a political atmosphere yes, but every step you take in your life is politic. Thus politics can not be simplified to an ideology, politics is your life, so is MUN. With this opportunity you will have the time and the chance to express your opinions, your views and most importantly yourself.

At YBFLMUN'26 delegates will be able to express themselves without any concern. Even though these three days will pass quick everyone will remember the memories for a quite while. We assure you, in our conference which will be held between 1st and the 3rd of July, every single person on every single corner of the world is more than welcome to join us in this extreme function. Let us come together under the name of YBFLMUN'26. Let us be united under the name of UN. And I am pleased to say, welcome, to the home you never knew you had, everyone.

HİLAL YILDIRIM

1. Letter From Under Secretary Generals

Respected Delegates,

First of all, we would like to take this opportunity to welcome you all to the simulation of F-WHO in YBFLMUN 26'. We hope that this session of discussions and deliberations turn out to be beneficial in all aspects. We welcome you all delegates to our semi-crisis committee F-WHO. This study guide shall serve as the starting point of your research. At no point of time consider it to be the only sphere of discussion, kindly explore other fronts as well. This guide is just to provide you with a basic idea of what the agenda is and to remind you how crisis scenarios in this special committee could be. We expect extensive debate and analysis from you. We do not expect you to speak out facts in the committee, however, analysis of situations and argumentation shall help you proceed forward in the committee. Keep in mind the global health and Human Rights in these committees are the key points in this committee. Please consider the crisis part of the study guide. If you have any questions do not hesitate to contact us.

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Lastly it will be Doruk's first ever experience as an under secretary general in an English committee so we appreciate Hilal for inviting him and giving us this opportunity.

Best regards,

Kerem Doruk KARA

Ecesu Bilge ERYILMAZ

Co-Under Secretary Generals of F-WHO Committee

3. Introduction of the committee

The International Sanitary Conferences (ISC), the first of which was held on 23 June 1851, were a series of conferences that took place until 1938, about 87 years. The first conference, in Paris, was almost solely concerned with cholera, which would remain the disease of major concern for the ISC for most of the 19th century. With the cause, origin, and communicability of many epidemic diseases still uncertain and a matter of scientific argument, international agreement on appropriate measures was difficult to reach. Seven of these international conferences, spanning 41 years, were convened before any resulted in a multi-state international agreement. The seventh conference, in Venice in 1892, finally resulted in a convention. It was concerned only with the sanitary control of shipping traversing the Suez Canal, and was an effort to guard against importation of cholera.

Five years later, in 1897, a convention concerning the bubonic plague was signed by sixteen of the nineteen states attending the Venice conference. While Denmark, Sweden-Norway, and the US did not sign this convention, it was unanimously agreed that the work of the prior conferences should be codified for implementation. Subsequent conferences, from 1902 until the final one in 1938, widened the diseases of concern for the ISC, and included discussions of responses to yellow fever, brucellosis, leprosy, tuberculosis, and typhoid. In part as a result of the successes of the Conferences, the Pan-American Sanitary Bureau (1902), and the Office International d'Hygiène Publique or "International office of Public Hygiene" in English (1907) were soon founded. When the League of Nations was formed in 1920, it established the Health Organization of the League of Nations. After World War II, the United Nations absorbed all the other health organizations, to form the WHO.

In 1948, its presence in countries, territories and areas has been its primary mode of delivering technical cooperation to Member States. Today, WHO has dedicated staff working in 152 WHO country offices, some of which support more than one Member State. The WHO offers unparalleled global reach, legitimacy and expertise. It translates science and evidence into proven, affordable and effective solutions and action for physical and mental health. With presence in more than 150 countries, across all regions of the world, it works hand-in-hand with its 194 Member States, partners, health workers and communities to build the systems and implement interventions needed to keep people healthy and achieve health for all. Coordinating humanitarian action in emergencies, scales up in-country action for people in need, and quickly mobilizes support through trusted and committed global networks are also responsibilities of this organization.

The WHO has played a crucial role in coordinating the global response to the COVID-19 pandemic, providing essential guidelines on preventive measures, supporting research on vaccines, and facilitating vaccine distribution through initiatives like COVAX.

The WHO has an executive board and an assembly to decide and take actions about healthier life for worlds' population.

The Executive Board is composed of 34 technically qualified members elected for three-year terms. The annual Board meeting is held in January when the members agree upon the agenda for the World Health Assembly and the resolutions to be considered by the Health Assembly. A second shorter meeting takes place in May-June, as a follow-up to the Health Assembly. The main functions of the Board are to implement the decisions and policies of the Health Assembly, and advise and generally to facilitate its work.

The World Health Assembly is the decision-making body of WHO. It is attended by delegations from all WHO Member States and focuses on a specific health agenda prepared by the Executive Board. The main functions of the World Health Assembly are to determine the policies of the Organization, appoint the Director-General, supervise financial policies, and review and approve the proposed programme budget. The Health Assembly is held annually in Geneva, Switzerland.



Lastly the WHO is the only global convening place where all countries and partners committed to health come and work together for the well-being of everyone, everywhere, no matter age, income levels, gender or birthplace.

4. Introduction of the Agenda Item: Discussing Global Response Strategies to a Resistant Plague Outbreak

The Plague Unit of the Institut Pasteur of Madagascar is a WHO Collaborating Centre on Plague Control and Research. Their collaboration with WHO started in the 90s, and it has grown stronger year after year as a win-win situation for both institutions and the global fight against plague. WHO has brought the normative leadership, technical guidance and operational support needed to help the Plague Unit at the institute strengthen national and regional laboratory capacity for plague diagnosis, while the centre contributed with on the ground expertise and production capability, notably hands-on

experience in managing plague outbreaks and conducting clinical research; namely, laboratory diagnosis, pathogen characterization, epidemiology, patient care, infection prevention and control, risk communication and community engagement, and public health and social measures. With WHO's backing, the centre was able to produce and distribute rapid diagnostic tests, biological reference materials and standardized protocols, and its team played an active role in developing WHO guidelines and procedures. This combination of WHO's global mandate and the centre's technical and manufacturing capacity proved essential for detecting, investigating and managing recent plague outbreaks in Madagascar, the Democratic Republic of the Congo and countries beyond the African region. The committee will discuss measures to address potential crises in the coming years. Delegates are expected to further improve and develop the existing system and offer new solutions.

5. Key Terms

Plague: a disease that affects humans and other mammals. It is caused by the bacterium, ***Yersinia pestis***. Humans usually become infected through the bite of an infected rodent flea or by handling an infected animal.

Vector: a living organism that transmits an infectious agent from an infected animal to a human or another animal. Vectors are frequently arthropods, such as mosquitoes, ticks, flies, fleas and lice. Most of the deadly diseases travel from vectors to humans.

Corpse: the remains or body of a dead person.

Origin: The birth, existence or starting point.

Pulmonary Plague: Pneumonic plague occurs when the *Y. pestis* bacterium is inhaled. The disease may be spread through face-to-face contact when an infected person coughs or sneezes. Because it enters the body by being inhaled, pneumonic plague could be spread intentionally if the bacteria were put into aerosol form.

6. Historical Background

In this part of the study guide delegates can be informed about historical events of plague such as Black Death, 2nd Plague or 3rd (Modern) Plague.

The Black Death:

The Black Death, a pandemic that ravaged Europe between 1347 and 1351, taking a proportionately greater toll of life than any other known epidemic or war up to that time. It is estimated that 25 million people died.

The Black Death is widely believed to have been the result of plague,

caused by infection with the bacterium *Yersinia pestis*. Modern genetic analyses indicate that the strain of *Y. pestis* introduced during the Black Death is ancestral to all existing *Y. pestis* strains known to cause disease in humans. Hence, the origin of modern plague epidemics lies in the medieval period. Other scientific evidence has indicated that the Black Death may have been viral in origin. Also the origin of the bacterium is estimated 3.500 years before the Black Death. Scientists discovered ancient bodies that could be infected from *Yersinia pestis*. These studies are still continuing however this background of bacteria seems likely to be true.

Having originated in China and Inner Asia, the Black Death decimated the army of the Kipchak khan Janibeg while he was besieging the Genoese trading port of Kaffa (now Feodosiya) in Crimea (1347).



With his forces disintegrating, Janibeg used trebuchets to catapult plague-infested corpses into the town in an effort to infect his enemies. From Kaffa, Genoese ships carried the epidemic westward to Mediterranean ports, whence it spread inland, affecting Sicily (1347); North Africa, mainland Italy, Spain, and France (1348); and Austria, Hungary, Switzerland, Germany, and the Low Countries(1349).

(An image of Mongol soldiers throwing dead corpses to the Kaffa castle.)

This event mentioned here is the first example of a biological war strategy.

To try and stop the spread of Black Death, fines were introduced for people caught dumping waste in the streets. The idea was to deal with the bad smells, or miasma. This may have helped a little in that dealing with waste in the streets may have helped limit the number of the rats that were actually spreading the disease. New jobs were created in London to try and clean up towns. Muckrakers were employed to remove the waste from the streets. Latrines often emptied into pits in the ground. These would often fill up and cause awful smells, so gong farmers emptied cesspits. Surveyors of the payment collected rubbish. As this shows some people thought the cause of the disease was dirty places or rats and tried to take actions for decreasing deaths.

The consequences of this violent catastrophe were many. A cessation of wars and a sudden slump in trade immediately followed but were only of short duration. A more lasting and serious consequence was the drastic reduction of the amount of land under cultivation, due to the deaths of so many laborers. This forced employers to give more salary to the workers due to lack of human power.

As no one knew exactly what caused the Black Death, they could do little to stop future outbreaks. There were further Black Death cases throughout the Middle Ages and beyond. There was another significant **outbreak in 1665**, particularly affecting London. This outbreak shows there had been no real increase in understanding about what was really causing the disease or how to prevent it.

It wasn't until the work of Louis Pasteur and Robert Koch in the 1800s that it was discovered germs are the cause of disease. The plague bacteria was finally discovered by Alexandre Yersin in 1894. The bacteria was named after him; 'Yersinia pestis.'

The Second Plague:

The **second plague pandemic** was a major series of epidemics of plague that started with the Black Death, which reached medieval Europe in 1346 and killed up to half of the population of Eurasia in the next four years. It followed the first plague pandemic that began in the 6th century with the Plague of Justinian, which ended in the 8th century. Although the plague died out in most places after 1353, it became endemic and recurred regularly. A series of major epidemics occurred in the late 17th century, and the disease recurred in some places until the late 18th century or the early 19th century. After this, a new strain of the bacterium gave rise to the third plague pandemic, which started in Asia around the mid-19th century.

In the 16th century, the Plague hit San Cristóbal de La Laguna in the Canary Islands between 1582 and 1583.

In the 17th century, there were a series of European "great plague" outbreaks: the Great Plague of Seville between 1647 and 1652, the Great Plague of London between 1665 and 1666, and the Great Plague of Vienna in 1679. The Great Plague in the late Ming dynasty arose in Shanxi in 1633 and arrived at Beijing in 1641, contributing to the downfall of the Ming Dynasty in 1644.

In the 18th century, there was the Great Plague of Marseille, which took place between 1720 and 1722; the Great Plague of 1738, which occurred in Eastern Europe between 1738 and 1740; and the Russian plague of 1770–1772, which took place in Central Russia and particularly affected Moscow. However, the plague in its virulent form seemed to gradually disappear from Europe, though lingering in Egypt and the Middle East.

By the early 19th century, the threat of plague had diminished, though it was quickly replaced by the spread of another deadly infectious disease in the first cholera pandemic, beginning in 1817, the first

of several cholera pandemics to sweep through Asia and Europe during the 19th and 20th centuries.

The third plague pandemic hit China in the 1890s and devastated India. While it was largely contained in the East, it became endemic in the western United States, where sporadic outbreaks of plague continue to occur.

The 18th- and 19th-century outbreaks, though severe, marked the retreat of the pandemic from most of Europe (18th century), northern Africa, and the Near East (19th century). The reasons it died out totally are not well understood. It is tempting to think that the Great Fire of London the next year destroyed the hiding places of the rats in the roofs. Hence of this fire nearly 100,000 people died.

Accordingly there are 6 reasonable explanations:

1. People developed immunity.
1. Improvements in nutrition made people more resistant.
1. Improvements in housing, urban sanitation and personal cleanliness reduced the number of rats and rat fleas.
1. The dominant rat species changed. (The brown rat did not arrive in London until 1727.)
1. Quarantine methods improved in the 17th century.
1. Some rats developed immunity, so fleas never left them in droves to humans; non-resistant rats were eliminated and this broke the cycle.

The replacement of the Black rat (*Rattus rattus*), which travelled among



people and was frequently kept as a pet, by the more aggressive and prolific Norway or brown rat (*Rattus norvegicus*) was a major factor. The Brown rat, which arrived as an invasive species from the East, is skittish and avoids human contact, and its aggressive and asocial behaviour made it less attractive to humans. As

the Brown rat violently drove out the Black rat in country after country, becoming the dominant species in that ecological niche, rat-to-human contact declined, as did the opportunities for plague to pass from rat fleas to humans. But as bacteria improved itself to be deadly with a little time it also could have variantations decrease its mortality due to environmental or other factors.

The Third Plague:

The **third plague pandemic** was a major plague pandemic that

began in Yunnan, China, in 1855. Its name refers to its status as the third of at least three known major pandemics caused by the spread of the bacterium *Yersinia pestis*.

This episode of bubonic plague spread to all inhabited continents, and

ultimately led to at least 15 million deaths worldwide, including 10-12

million in British Raj India and 2.2 million in China. Though it is estimated to have killed fewer people than the second plague pandemic (and possibly the first), the third plague pandemic had one of the highest death tolls among pandemics in human history.

According to the World Health Organization, the pandemic was considered

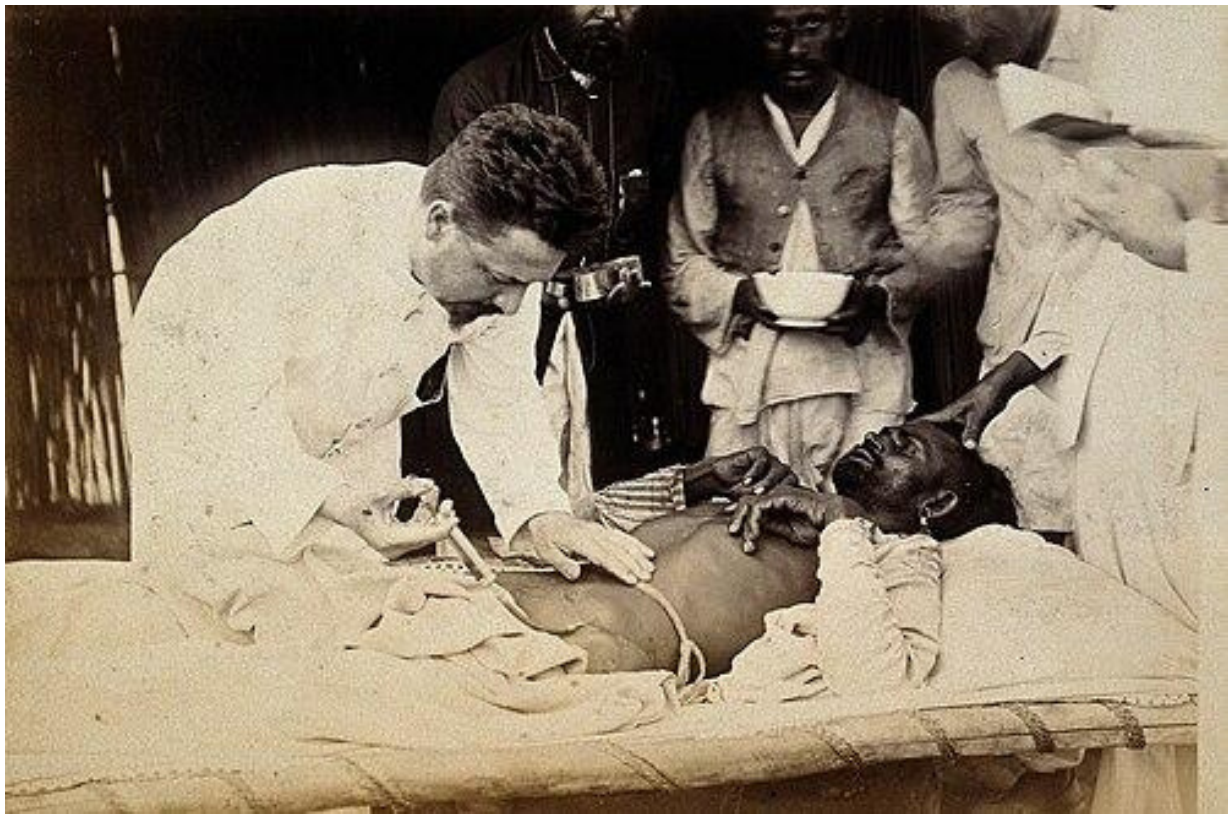
active until 1960, when worldwide casualties dropped below 200 per year.

Researchers working in Asia during the "Third Pandemic" identified plague vectors and the plague bacillus. In 1894, in Hong Kong, Swiss-born French bacteriologist Alexandre Yersin isolated the responsible bacterium (*Yersinia pestis*, named for Yersin) and determined the common mode of transmission. His discoveries led in time to modern treatment methods, including insecticides, the use of antibiotics and eventually plague vaccines. In 1898, French researcher Paul-Louis Simond demonstrated the role of fleas as a vector.

The disease is caused by a bacterium usually transmitted by the bite of fleas from an infected host, often a black rat. The bacteria are transferred from the blood of infected rats to fleas (*Xenopsylla cheopis*). The bacillus multiplies in the stomach of the flea, blocking it. When the flea next bites a mammal, the consumed blood is regurgitated along with the bacillus into the bloodstream of the bitten animal. Any serious outbreak of plague in humans is preceded by an outbreak in the rodent population. During the outbreak, infected fleas that have lost their normal rodent hosts seek other sources of blood.

The British colonial government in India pressed medical researcher Waldemar Haffkine to develop a plague vaccine. After three months of persistent work with a limited staff, a form for human trials was ready. On January 10, 1897, Haffkine tested it on himself. After the initial test was reported to the authorities, volunteers at the Byculla jail were used in a control test. All inoculated prisoners survived the epidemics, while seven inmates of the control group died. By the turn of the century, the number of binoculars in India alone reached four million.

All of these epidemics show us how unknown vectors or causes of diseases could possibly affect human health and global health.



7. Current Situation

Plague is a fatal disease that requires very early diagnosis and effective treatment. Bubonic plague might be easy to identify and diagnose due to the presence of enlarged buboes, which contain high quantities of the plague bacillus that can be extracted to perform classical microbiological tests or molecular analyses. On the other side, pulmonary plague is more difficult to diagnose, as lungs are not sterile organs and obtaining good sputum samples (particularly from children) can still be challenging even with modern technologies. The development of rapid diagnostic tests for pulmonary plague is therefore a major defiance, as evidenced during the pulmonary plague outbreak which took place in Madagascar in 2017.

Several antibiotics can efficiently kill the plague bacillus, but antibiotic resistances have been identified in *Y. pestis*. Vaccines could help face emerging resistances to antibiotics, but no vaccine is currently approved worldwide. Several molecular vaccines based on single *Y. pestis* antigens have been explored, with mixed results until now. Last but not least, *Y. pestis* is one of the most recently emerged bacterial pathogens, and understanding the molecular events that led to the very rapid evolution from its ancestor *Y. pseudotuberculosis* to the current plague bacillus remains a great challenge for biologists, a challenge that might allow to better understand past and current pandemics and to prevent future ones.

In today's world biologists and scientists discovered a new and a different DNA and RNA based variant of *Y. pestis*. In the early phases they thought it as a normal variant just to help the bacteria to survive from modern dangers that increased because of the inventions of antibiotics and vaccines. Although some scientists said the world has nothing much to worry about, the World Health Organization was alerted due to surprising symptoms that have never been seen in world history. But the biologists couldn't verify these symptoms because of the lack of equipment and variety of

symptoms. Also the symptoms were similar to normal diseases in the beginning phase such as fever and the flu. Here is the symptoms:

→ Fever

→ Headache

→ Chest pain

→ Coughing

→ Shortness of breath

And for the worst cases

→ Coughing up blood

Scientists were victorious to find this new variant is a member of pneumonic plague. They rapidly alerted the World Health Organization to take measures. This variant didn't kill a lot of people right now but that doesn't mean it won't. However these alerts keep on coming from different regions such as in Europe (Russia, Ukraine and places nearby) in Africa (South African Republic and places nearby) in Asia (Mongolia) in America (Mexico and Venezuela also some doctors reported similar symptoms to the United States Ministry of Health) It could be a starting global pandemic, regional disease or just a periodic improvement of bacteria itself. Although the WHO should be careful that every second counts and every prevention before a possible global pandemic would be beneficial and helpful to human life and civilization.

7.1 Organizations

The Pandemic Fund

The Pandemic Fund is the first multilateral financing mechanism dedicated exclusively to strengthening critical pandemic prevention, preparedness, and response (PPR) capacities at the local, regional, and global levels, with a focus on low- and middle-income countries. Recognizing the need to address chronic underinvestment in pandemic PPR capacity, particularly in low- and middle-income countries, the G20 Finance Ministers and Central Bank Governors requested in April 2022 that the World Bank explore the establishment of a new financing mechanism. With broad support from the G20, other founding donors, civil society, and other stakeholders, the World Bank's Board of Directors approved the proposal to establish the Pandemic Fund on June 30, 2022. The Pandemic Fund was **officially established** by its [Governing Board](#) at its annual meeting on September 8-9, 2022. The World Bank serves as Trustee and hosts the Fund's Secretariat.

The Pandemic Fund's founding financial contributors are: Australia, Canada, China, European Commission, Germany, Indonesia, Italy, Japan, Republic of Korea, New Zealand, Norway, Singapore, Spain, United Arab Emirates, United States, Bill and Melinda Gates Foundation, Rockefeller Foundation, and Wellcome Trust. The founding donors, joined by Austria, Denmark, France, India, Netherlands, Portugal, Saudi Arabia, South Africa, Switzerland, and the United Kingdom, have committed over US\$2.1 billion in financial contributions to date. The Pandemic Fund continues to raise funds for its work from both sovereign and non-sovereign contributors. The Pandemic Fund can receive funding from World Bank **member countries**, intergovernmental entities, and non-governmental entities such as philanthropies, foundations and the private sector, subject to approval from the Governing Board and the World Bank as its Trustee. This organization aims to:

- Country-led, aligned with national and regional PPR priorities and plans
- Catalytic, mobilizing additional co-investments and co-financing from domestic and international sources—achieving a 1:7 leverage ratio Streamlined and cohesive,
- Promoting more effective and coordinated financing for pandemic preparedness
- Collaborative, fostering coordination across sectors, partners, and borders while operationalizing multisectoral One Health approaches
- Cost-efficient, with an operating model and administrative structure designed to minimize overhead.

Polaris II Exercise

The World Health Organization (WHO) wrapped up Exercise Polaris II, a 2-day high-level simulation exercise, based around an outbreak of a fictional new bacterium spreading across the world. Bringing together 26 countries and territories, 600 health emergency experts and over 25 partners, the exercise, which took place on 22 and 23 April, allowed countries to test their preparedness for pandemics and other major health emergencies, including activating their emergency workforce structures, information flow and coordination with each other, partners and WHO.

Building on the success of Polaris I held in April 2025, which centered on a fictional virus, each participating country activated its emergency coordination structure and worked under real-life conditions to share information, align policies and surge their workforce.

The simulation put two key WHO frameworks into practice, the Global Health Emergency Corps (GHEC) framework and the National health emergency alert and response framework, and explored the use of AI-enabled tools to support workforce organization and planning.

The GHEC framework, published in June 2025, provides guidance on how countries can strengthen their health workforce to respond to emergencies based on the principles of sovereignty, equity and solidarity. It improves collaboration between countries by supporting information exchange and strengthening the deployment of regional and global emergency personnel when needed.

The National health emergency alert and response framework, published in October 2025 outlines the key functions, coordination systems and actions needed for an effective response at local, sub-national and national levels.

This Exercise provided a vital platform to operationalize and practice emergency frameworks under real-life conditions, ensuring that collective readiness is not a periodic effort, but a continuous investment in global health security.

Conclusion:

As the delegates could address from this Exercise and the Organization, every medical step for prevention and implementation took and will be taken with the cooperation of every World Health Organization member states. Everything is stronger with cooperation.

8.Explanation of Crisis Events and Procedure

This committee will simulate a high-stakes, high-speed global response to the Plague outbreak. Unlike conventional MUN committees, delegates here won't just debate; they'll act. Through a dual-track format that blends General Assembly type deliberation with live crisis mechanisms, the delegates are expected to navigate a landscape where political, scientific and technological dimensions of the disease are impossible to separate.

Other than the deliberative General Assembly procedure, this committee will also follow a crisis mechanism. Throughout the conference, the delegates will be "interrupted" with new breakthroughs or developments. Delegates will need to respond in real time through crisis directives, shifting from deliberation to immediate action without losing the sight of the deliberative process. Crisis updates will be given by the dais and will demand immediate, coordinated responses.

The tension between those two tracks is intentional. Long-term frameworks that ensure governance are worthless if they can't hold under pressure; and crisis responses mean nothing if they are not grounded with coherent policies. Delegates will be pulled between the slow, careful work of consensus building and the fast, high-stakes environment of the crisis. Being able to operate in both modes simultaneously is part of what this committee is designed to test.

8.1 Committee Structure

The F-WHO committee will function as a semi-crisis committee. And what that means in practice is a deliberate friction between two distinct parts of operation: the Frontroom and the Backroom.

The Frontroom is the public stage where you give speeches, argue or debate on a matter, build alliances and write documents such as a draft resolution. This is where you build your public image. On the other hand, there's the Backroom. Managed by the crisis staff, the Backroom is where you

give immediate responses to the crises that need immediate action. The success of the delegate is measured by how well they harmonize these two tracks.

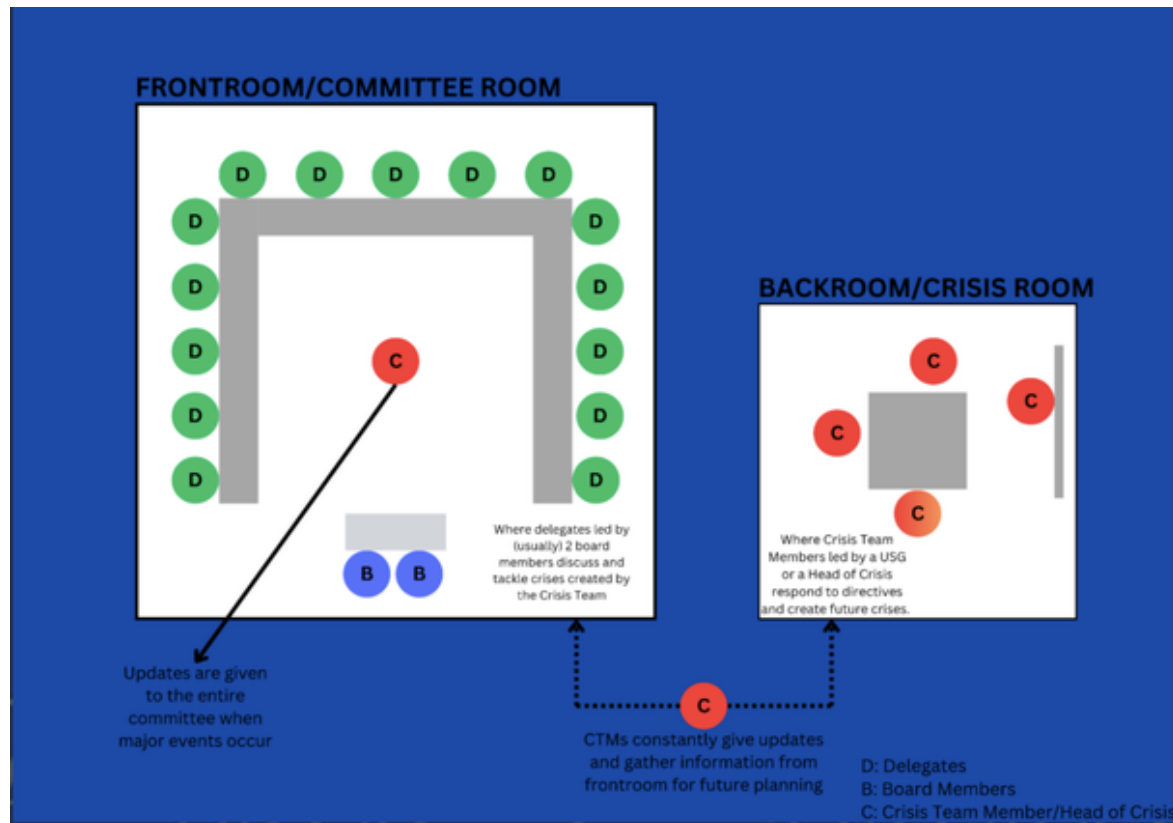


Figure 9.1.1. Explanatory imagery of how the crisis structure follows.

8.2 Directive System

In this committee, the power of a delegate will also be measured by their ability to shape events through directives.

The primary way you will influence the proceedings is through Directives, which are written documents sent to the Crisis Team for evaluation and response. Your success as the architects of a new state depends on your ability to use the following different types of directives strategically:

8.2.1. Information Directives

In a rapidly evolving health crisis, information is one of the most valuable tools available to delegates. Information Directives allow delegates to request intelligence, scientific analysis, classified reports, or epidemiological data in order to better understand the outbreak and its effects. Since crisis updates

may not always fulfill your desired needs for your information, delegates are encouraged to use these directives to close gaps in knowledge before taking action.

8.2.2. Action Directives

Action directives are the type of directive where you take an action in order to solve a crisis or implement something entirely new as an individual, more than 2 people or a committee as a whole. The types of action directives are Personal Directive, Press Release, Joint Directive and Committee Directive. You can find further explanation below;

Personal Directives (Including Press Releases): Personal Directives are actions taken independently by a delegate using the authority and resources of their assigned country. These directives are submitted to the Crisis Staff and may involve actions such as mobilizing medical teams, funding research, strengthening border controls, securing laboratories, or coordinating emergency responses. Within this category, Press Releases are the only directives that get announced to the public. Unlike standard personal actions, Press Releases are intended to shape public opinion, control panic, influence the opinion of international society, or pressure other actors during the crisis.

Joint Directives: Joint Directives are collaborative actions submitted by two or more delegates working toward a shared objective in order to find a solution to a crisis. In a global plague outbreak, cooperation between governments and national institutions is often necessary for effective and long-term action. Because they combine multiple forms of authority and resources, Joint Directives carry greater political and operational weight than individual actions and are significantly harder to undermine.

Committee Directives: Committee Directives represent the official decision of the committee and must be debated and voted upon in the Frontroom before further implementation. These directives are designed for large-scale international actions requiring broad cooperation and legitimacy, such as establishing global response mechanisms, coordinating international research efforts, or implementing worldwide health regulations. Although they take longer to pass, their impact is far more extensive than other forms of directives.

While writing a directive, it is very important to find proper answers to the -wh questions, which can be stated as:

-Who?

-What?

-Where?

-Why?

-How?

-When?

If a directive has proper answers to the mentioned questions and is not out of the scope of the crisis given, the directive is most likely to succeed and have a positive update, which will result in a benefit for the committee, raising your delegate profile.

Another important matter that the delegates must keep in mind is that storytelling is highly not advised while writing a directive. You must think about every perspective an action can bring, and write your directive acting accordingly to that. A more comprehensive introduction to the crisis structure will be

given in the first sessions of the conference to ensure delegates do not get lost during the conference.

Bibliography

<https://cdn.who.int/media/docs/default-source/documents/about-us/modernizing-who-headquarters.pdf>

<https://portlandpress.com/biochemist/article/45/2/1/232937/Yersinia-pestis-and-plague-in-the-21st-century>

<https://www.who.int/news-room/feature-stories/detail/a-long-standing-partnership-strengthening-the-global-fight-against-plague>

<https://www.who.int/news/item/27-04-2026-practicing-today-for-tomorrow-s-emergencies-who-convenes-countries-and-partners-to-simulate-response-to-major-disease-outbreak>