Table of Contents

I. Letter from the Chair........................................................................................................3

II. Committee History........................................................................................................4

III. Topic Overviews..........................................................................................................6

IV. Topic A: Maternal Mortality .......................................................................................7
   A. Introduction..............................................................................................................7
   B. Background..........................................................................................................7
   C. Current Situation....................................................................................................8
   D. Possible Approaches............................................................................................8
   E. Bloc Positions.......................................................................................................9
   F. Questions to Consider..........................................................................................10

V. Topic B: Transmission of HIV/AIDS........................................................................11
   A. Introduction............................................................................................................11
   B. Background..........................................................................................................12
   C. Current Situation..................................................................................................13
   D. Possible Approaches............................................................................................13
   E. Bloc Positions.......................................................................................................14
   F. Questions to Consider..........................................................................................14

VI. Sources for Further Research..................................................................................15

VII. Bibliography.............................................................................................................16
I. Letter from the Chair

Dear Delegates,

It’s my pleasure to welcome you to SMUNC 2019! I’m Amy, a Freshman studying International Relations and Economics at Stanford University. MUN has been a very formative part of my nomadic life. While living in four different countries, I’ve been exposed to a diversity of local contexts, cultures, and paradigms, and I’ve developed a sincere appreciation for global perspectives. MUN has been one of the few constant variables in my life that gave me a platform to explore my global curiosities in the company of bright individuals. I’m honored to be chairing WHO for this year’s SMUNC, and I’m eager to oversee a weekend of rich debates on global cooperation.

The United Nations stands as an emblem of global progress, unifying nations in tackling common obstacles. Nonetheless, it has been criticized for ineffective measures and a lack of drastic actions, for it is often the case that it is faced with conflicting interests. The global crisis of HIV/AIDS and maternal mortality remain two of the persisting global issues that is yet to be resolved. This is where you, the delegates of the WHO, come in! With earnest diplomatic efforts, innovative solutions, and certainly some inevitable clashes, I expect that you will successfully address the issues at hand.

I would also like to emphasize that I am here to help you. Before and during SMUNC, please do not hesitate to reach me at sdawon01@stanford.edu with any questions or concerns.

All the best,

Amy
II. Committee History

The World Health Organization, more commonly referred to as the WHO, is a specialized body of the United Nations that was established on April 7, 1948 and focuses on improving global health. The World Health Organization is the “directing and coordinating authority on international health within the United Nations’ system” (World Health Organization, 2018). The main areas in which the WHO works include establishing and improving accessible health systems, diminishing communicable and noncommunicable diseases, promoting healthy lifestyles, construct preparedness, surveillance, and response programs, and integrate corporate services.

The WHO is made up of two main governance structures: the World Health Assembly and the Executive Board. The World Health Assembly is composed of 194 member states that set the agenda for international health policy, elect the Director General of the WHO, and oversee the organization’s finances. The Executive Board of the World Health Organization is made up of 34 health professionals that are elected to three year terms. This governance body handles the administrative responsibilities of the organization as well as ensuring that resolutions passed by the Health Assembly are executed under the powers of the WHO.

WHO’s supreme decision making body - the World Health Assembly - comes together in Geneva every year to pass resolutions on important health issues. These resolutions urge WHO’s member states and the Director general to undertake specific actions to overcome these health issues as an international community. Beyond this major meeting there are also smaller regional meetings that result in regional resolutions, which then “pertain to health technologies and medical devices”.

4
Unfortunately, WHO resolutions are not legally binding to signatory states; however, the significance of non-binding resolutions passed by the WHO lays in the fact that they force thought provoking debates that yield applicable solutions and encourage action form the international community based on these guidelines.
III. Topic Overviews

Reproductive health is one of the most pressing and complicated global health issues facing developing and developed countries today. Preventable causes of maternal mortality, for instance, is taking the life of approximately 830 women every day around the world. Despite the advancement of medical technology, the lack of skilled care, income inequality, unsanitary living conditions in rural areas and lack of education still pose a risk to women’s health in their pregnancy and childbirth. HIV/AIDS, on the other hand, continued to plague around 36.9 million people world wide. While lifelong antiretroviral therapy has allowed more patients to live, key high-risk population, especially men who have sex with men, sex workers, transgender people and people in prisons, still face various challenges to health. More culturally sensitive and effective solutions to enhance HIV/AIDS prevention and treatment amongst these high-risk groups would be necessary to prevent the dissemination of the disease.

The World Health Organization will be tasked with the objective of tackling two of the most important and complex challenges of reproductive health: maternal mortality and sexually-transmitted HIV/AIDs. Delegates are encouraged to research and evaluate country-specific solutions and craft new strategies, broad and specific, in mitigating these two crises. Delegates should receive a deeper understanding of the impact of new economic development, technological context, and political/security dynamics on reproductive health and global partnerships.
IV. Topic A - Maternal Mortality

Introduction

Background:

The WHO’s most recent worldwide account of maternal mortality reports that in 2017, 295 thousand women died during and following pregnancy and childbirth. Maternal mortality occurs as a result of complications during and following pregnancy and childbirth, of which most are preventable. Some of these complications include severe bleeding, infections, high blood pressure during pregnancy, complications from delivery, and abortion.

These fatal complications can be prevented with attention from health professionals. For instance, severe bleeding can be prevented by injecting oxytocics immediately after childbirth, and infections after childbirth can be prevented by treating symptoms in a timely manner. Unfortunately, many women in poor areas do not have access to adequate care: in fact, fewer than half of all births in low-income and lower-middle-income countries have been assisted by skilled health professionals. Maternal mortality, therefore, has been linked to poverty, distance from facilities, lack of information, inadequate services, and certain cultural practices.

Current Situation

Possible Approaches:

The Sustainable Development Goals of the United Nations have already ambitiously declared to reduce “the global maternal mortality rate to less than 70 per 100 thousand births, with no country having a maternal mortality rate of more than twice the global average.” However, much can still be done to accelerate and strengthen the WHO’s efforts. Possible solutions can vary by region, but can include...
strengthening of frameworks (such as the Every Newborn Action Plan) for sanitary and effective healthcare services, coordinating with UNICEF’s health systems strengthening efforts, and pushing for new infrastructures or modes of transportation to increase access to healthcare.

In general, delegates should focus on the WHO’s strategies in addressing disparities in access to reproductive, maternal, and newborn health services; universal health coverage; the causes of maternal mortality; data collection to respond to the needs of women; and greater accountability to improve the quality of care on the ground.

_Bloc Positions_

**North America:**

Although North America remains one of the most affluent regions, it lags far behind other affluent nations in addressing maternal mortality. There have recently been steadily rising maternal mortality rates (MMR): in the United States, it has doubled from 10.3 per 100 thousand live births in 1991 to 23.8 in 2014. This trend can be explained in part by the Cesarean-section deliveries, which carries an added risk. However, what’s alarming is the racial disparity in maternal mortality. For instance, black women are three to four times more likely to die in childbirth than white women. Furthermore, the WHO reports that MMRs for black women are nearly equivalent to the rates for women in Mexico or Uzbekistan. North America must focus on efficiently allocating its existing economic capital to support women giving birth.

**Europe:**

The progress in Europe is looking more optimistic. In fact, the WHO reports that the MMR in Europe has decreased by almost half between 2000 and 2015, from 33 deaths to 16
deaths per 100 thousand live births. However, there are foreseeable problems associated with the anti-immigrant political measures in several European countries, as they may worsen the vulnerability of pregnant migrant women, if they are unable to access healthcare resources.

Middle East:

Maternal mortality in the Middle East is a grave problem, particularly in most Islamic countries, which report around 110 deaths per 100 thousand live births as of 2015. However, even these statistical figures are unreliable, and perhaps under representing the true figures, as 70-90 percent of deliveries take place outside of hospitals. Some of the biggest challenges plaguing the Middle East have been outbreaks of diseases, such as the wild polio virus in Syria and cholera in Yemen. Nonetheless, there have been recent improvements, as the MMR has declined by 50 percent in the past 25 years.

Asia:

Because this region encompasses a plethora of countries of varying levels of economic strength, more particular and nuanced approaches will be necessary. In general, the Asia-Pacific region reported 127 deaths per 100 thousand live births in 2015. This statistic is mostly representative of countries such as Afghanistan, Bangladesh, Cambodia, India, Indonesia, Lao PDR, Myanmar, Nepal, Pakistan, Papua New Guinea, and the Philippines, which suffer from conflict, poverty, and weak infrastructures.
Questions to Consider

To write a successful position paper and form effective resolutions during the conference there are a few questions that you should consider during the process of your preparation. In the first step you should consider what the existing legal restrictions are, specifically in your designated country but also in other regions affecting your position and this issue in a greater context. However, through the current opioid crisis, it is evident that these regulations are either ineffective or are implemented incorrectly, which is why you must ask: “How can non-governmental organizations and community based organizations help prevent opioid overuse?” When you move on to developing possible approaches, you should also take your country’s unique context into account. Furthermore, you should also think about how certain regulations may be differently perceived by other countries that are affected by this crisis.
V. Topic B - Transmission of HIV/AIDS

Introduction

The human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) have emerged over the past several decades as one of the most deadly medical conditions from which people suffer. The current epidemic is thought to have begun in the mid-to-late 1970s, although individual cases had occurred beforehand. (Avert). People began suffering from cancers normally affecting older populations at young ages, as well as from powerful strains of pneumonia. In 1981, the first true AIDS case was documented.

The virus has been transmitted in a variety of ways overtime, including sexually, through needle use, and from mother to child. Homosexual and drug-user communities initially - and still do - faced immense discrimination in the midst of the unknown causes and nature of this new disease; near the beginning of the epidemic, the disease was sometimes referred to as ‘gay-related immune deficiency.’ WHO officially deemed the AIDS outbreak an epidemic in 1983, at which point AIDS had been documented in over 25 countries. In the United States, the disease had a near 100% mortality rate.

A few years later the drug Azidothymidine (AZT) proved effective at slowing the progression of AIDS in people. However, the epidemic continued to grow, as 2.5 million instances of HIV/AIDS were found around the world in 1993. Indeed, the death rate of the disease did not significantly diminish until 1997, when a universal standard of treatment was taken up.
Different nations responded very differently as the crisis grew. The United States, for example, advocated for increased health education and research under Bill Clinton’s presidency in the 1990s. Condoms and needle-exchange programs became more widespread as well. Other nations were not as progressive in this realm; many in Africa operated under laws that criminalized homosexuality, so response in this realm focused less on safe sex and needle usage and more on treatment, which was quite ineffective given the lack of research progress. (“HIV and AIDS: An Origin Story”)

Current Situation

As opposed to the terrifying growth of the HIV/AIDS epidemic in the 80s and 90s, there are now consistently about 50,000 new instances of infection per year according to the Center for Diseases Control and Prevention. This, however, is much more related to increased awareness about safe sex and drug usage, as so many people infected around the world still lack the medical care they need. (Moving Forward)

Nearly 38 million people around the world are infected with HIV/AIDS as of 2018, with 1.7 million new infectees that year. Nearly ten percent of this 1.7 million were under the age of 15. More than 20% of people with HIV lack the availability of testing services, and just over three fifths of those with HIV are receiving antiretroviral therapy (ART). The Joint United Nations Programme on HIV/AIDS (UNAIDS) warned that progress in eradicating AIDS - and the factors that would lead to such an occurrence - is not as promising as it was in previous years, as some countries are cooperating and the effort more so than others. (The Global HIV/AIDS Epidemic)
Nations such as Uganda responded well to the crisis, increasing education backed by science of the dangers of AIDS and how to go about combating it. Throughout ten years since this campaign began, the rate of HIV infections there decreased by 50%. South Africa, however, is an example of a nation that has failed to rise to the challenge of AIDS treatment. President Thabo Mbeki a reign of denial in this sense, making statements and decisions that hindered the transfer of AZT to patients that would benefit from it. His presidency ended in 2008, but by this point, more than one sixth of people ages 15-49 in South Africa had been known to have HIV. It is thus clear that progress must be made not solely in a scientific sense, but also in demonstrating to the entire international community that the crisis is as dire as science describes. (“HIV and AIDS: An Origin Story”)

**Possible Solutions**

In their resolutions, it is clear that there are a variety of elements to the situation that delegates must consider. First of all, although HIV/AIDS contamination has slowed in quickness, it is drastically far from gone considering that the epidemic truly began less than forty years ago; there is, of course, no complete cure as of today. It is imperative that members of this committee discuss advancements in scientific and technological research to learn more about how the disease can be contained and erased once and for all. They must also determine how to instill this research across the globe considering the stark differences in how much the disease has been mitigated in different nations.

Delegates should also observe the differences in infection among different populations. For instance, young Black Americans account for more than two fifths of new infections in their country, a percentage startlingly disproportionate to their overall presence in the national
population. (“Moving Forward”) Additionally, since, for example, mothers can pass the disease onto their children, people are contracting HIV/AIDS before they are learning to walk. Therefore, although progress in the disease’s growth has slowed historically, much is still to be done.

The committee must also consider the disease as it relates to the treatment of homosexuals and drug users around the world. Clearly some countries have completely accepted that honest conversations around safe sex and drug usage have to be fostered, and unfortunately, some have not. Delegates must think about what the optimal ways to ensure all people are properly educated about the disease are, particularly those who live in countries who systematically deprive their citizens of such an education.

Lastly, it is essential that delegates work together to create concrete solutions with clear direction as to how the UN will respond. In 2003, issues concerning money seriously disrupted the ‘3 by 5 Plan’ to significantly increase HIV/AIDS treatment by 2005. (“HIV and AIDS: An Origin Story”) Furthermore, UNAIDS has declared that by 2020, 90% of those with HIV will know their status, will receive ART, and will see the virus become suppressed in their 90-90-90 target. (“90-90-90 - An Ambitious Treatment Target to Help End the AIDS Epidemic”) The committee must do what it can to ensure this is the case.

Questions to Consider

- How can WHO balance ambitious goals with practical solutions in fighting this seemingly interminable epidemic?
- What can be done to convince nations who refuse to invest the necessary time and energy into treating their people?
- To what extent can combattants to discrimination against homosexuals and drug users be incorporated into solutions.
- What will be the different levels of impact and commitment between countries with different sizes of infected populations?

VI. Sources for Further Research

- WHO official website:
  - http://www.who.int/
- Information http://www.who.int/substance_abuse/information-sheet/en/
- Topic A relevant Article:
- Topic B relevant Article:
VII. Bibliography


