



World Health Organization

MACMUN 2018 | WHO Background Guide

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“We live in a complex world. The United Nations cannot succeed alone. Partnership must continue to be at the heart of our strategy. We should have the humility to acknowledge the essential role of other actors, while maintaining full awareness of our unique convening power.”
– UN Secretary General António Guterres

Committee Overview

Mandate and Function of the Committee

The goal of the World Health Organization (WHO) of the United Nations is to build a better, healthier future for people on a global scale. Headquartered in Geneva, Switzerland, with 194 member states, the organization was founded on April 7, 1948, a date celebrated globally as “World Health Day.” In 1945, diplomats met in San Francisco and agreed that there was insufficient collaboration between countries to control the spread of dangerous diseases across the world. Together, they decided on the need for a global organization overseeing global health, culminating in the creation of the WHO. Currently, the organization has six regional offices and a secretariat that works synergistically with governments and other partners, ensuring the highest attainable health for all people. The WHO strives to combat infectious diseases, like Zika, influenza and HIV, and noncommunicable ones, such as cancer and heart disease. The WHO ensures adequate air, food and water quality and emphasizes access to medicines and vaccines that populations need. By looking at health trends and new threats, it always seeks new opportunities to improve public health. It also hires top experts to examine critical health issues and identify the best solutions, as well as delivering and implementing the strongest recommendations. In this manner, it helps to prepare countries for health emergencies, such as the Ebola epidemic in West Africa, by determining necessary actions when these emergencies strike. The ultimate goal of the WHO is reflected by the statement that “no country or person should miss out on the opportunity to live a healthy life in all aspects.”

The WHO has six leadership priorities, aimed towards accelerating the new Sustainable Development Goals (SDGs) for health:

- I. Advancing universal health coverage.
- II. Achieving health-related development goals.
- III. Addressing the challenges of noncommunicable diseases (NCDs) and mental health, violence, injuries, and disabilities.
- IV. Ensuring that all countries can detect and respond to acute public health threats under the International Health Regulations.
- V. Increasing access to quality, safe, efficacious and affordable medical products (medicines, vaccines, diagnostics and other health technologies).
- VI. Addressing the social, economic and environmental determinants of health as a means to reducing health inequalities between countries.

Timeline History of the WHO

These dates are major historic accomplishments of the WHO and also help illustrate the function and significance of the WHO.

- **1948:** The WHO constitution is passed and the organization starts its work by focusing on mass campaigns against tuberculosis (TB), malaria, yaws, syphilis, smallpox and many other communicable diseases transmitted from person to another, or by animal to person.
- **1950:** The discovery of present-day antibiotics begins and the WHO starts advising countries on their controlled usage.
- **Mid 1950's:** The poliovirus vaccine is discovered by Jonas Salk and Albert Sabin, paving the way for mass global campaigns facilitated by the WHO, which have since led to the near eradication of polio.
- **1969:** The first International Health Regulations are established by the World Health Assembly (WHA), representing an agreement between the WHO Member States that enables and encourages them to work together to prevent and respond to acute public health risks with the potential to cross borders and threaten worldwide health.
- **1972:** The Training in Human Reproduction (HRP) program is created within the WHO, the sole body within the UN system that possesses a global mandate to carry out research on sexual and reproductive health and rights.
- **1975:** The programme for Research and Training in Tropical Diseases (TDR) is founded by the WHO, which helps to facilitate, support and influence efforts to combat diseases of poverty. As of 2016, five of the eight diseases that the programme was created to tackle are close to eradication.
- **1978:** The aspirational goal of the WHO, “Health for All,” is set by the International Conference on Primary Health Care (ICPHC) in Kazakhstan. This lays down the groundwork for the WHO’s first leadership priority—advancing health coverage.
- **1979-1983:** A 12-year global vaccination campaign held by the WHO against smallpox is hailed successful as the disease is eradicated. Moreover, human immunodeficiency virus (HIV), which causes AIDS, is discovered.
- **1987:** The priorities of the WHO are shifted as AIDS spreads globally; the first antiretroviral medication to control HIV infection and prevent its progression to AIDS is licensed.
- **1999:** A new partnership is formed between major players in global immunization, including the WHO, government representatives, and leaders of the vaccine industry. This is called the Global Alliance for Vaccines and Immunization (GAVI), which aims to overcome barriers and allow millions of children worldwide to receive vaccines.
- **2000:** The Millennium Development Goals (MDGs) are adopted by the largest gathering of world leaders. These goals had a set deadline for 2015 and included specific goals for health, such as eradicating poverty and gender disparities in governments. Moreover, the WHO Global Outbreak Alert and Response Network (GOARN) is established to detect and combat international spread of outbreaks. This year was arguably the most important in WHO evolution and progression.
- **2003:** The WHO’s first global public health treaty, called the WHO Framework Convention on Tobacco Control (FCTC), is unanimously adopted by the WHA. This is aimed towards reducing tobacco related deaths worldwide. A major “3 by 5” progression was also instituted

to bring treatment to three million people living with HIV by 2005, and reaches thirteen million in 2013.

- **2004:** Following the Indian Ocean Tsunami disaster, the Strategic Health Operations Centre (SHOC) is built to serve as the nucleus of the networks of emergency operations.
- **2005-2008:** The WHO's first successful campaign from its initiation is achieved, with the number of children who die before their fifth birthday declining below ten million for the first time in recent history. By 2008, NCDs, such as heart disease and stroke, emerged as the number one killers, globally. This global shift is noted by the WHO, causing it to strengthen its focus on NCDs. In 2012, global leaders signed off, for the first time in history, on global standards targeted towards controlling and preventing heart disease, diabetes, cancer, lung disease and others.
- **2009:** The first influenza pandemic since 1968 is experienced as a result of the emergence of the new H1N1 influenza virus. The WHO worked with collaborating centres on controlling the virus and developing vaccines in record time.
- **2014:** The biggest outbreak of Ebola virus disease is experienced in West Africa. The WHO Secretariat mounted an unprecedented response to the outbreak, deploying thousands of experts, support staff and medical equipment to the ground.
- **2015:** A meeting was held for delegates from around the world at the UN Summit to sign off on the 2030 SDGs, which apply to all countries worldwide and move beyond the failed MDGs. The SDGs add economic, social and environmental objectives on top of the millennium goals in the promise of a more peaceful and inclusive global community.
- **2016:** Zero cases of Ebola in West Africa are announced by the WHO, but populations are warned that the disease might flare up without caution, and countries in the region need to remain vigilant and prepared. The WHO convened the Emergency committee and concluded that the neurological birth defects that appear to be related to the Zika virus among pregnant women represent a public health emergency of international concern.

Who Pays for the WHO?

The WHO is financed in part by dues paid by Member States. The amount that each Member State pays is calculated relative to the country's wealth and population. Additional financing comes from voluntary contributions, which in recent years have accounted for more than three-quarters of the WHO's financing.

Simulation Style/Composition of the Committee

The WHO will be composed of two Chairs responsible for maintaining the course of debate in accordance with the National Model UN rules and procedures. The Chairs will open and close each meeting, recognize any points or motions on the floor, set the agenda, manage the list of speakers, and facilitate the discussion. In addition, the Chairs are given the final rule on any disputed points, and will declare when motions are to be voted on by the body. It is also the decision of the Chairs to pass any draft resolution to be introduced for debate.

The WHO will consist of 35 delegates representing their assigned Member States. Delegates are expected to research the committee topics, submit a position paper, and be prepared to debate in accordance with their country's global stance and foreign policy.

One page will be present during the meetings to pass notes between delegates. Pages will be screening notes to ensure appropriate content and to maintain a professional environment.

Each Member State of the WHO will have one vote. Matters are decided by simple majority. Decisions on important issues, such as international health coverage, admitting new members and the UN budget, are decided by a two-thirds majority.

Case Study: Vanuatu – Moving Towards an End to Yaws

Yaws is a contagious infection, transmitted by skin contact, that leads to disfigurement and disability, especially in children. The disease was once widespread in tropical countries. Campaigns in the 1950s and 1960s, in which yaws was treated with one shot of penicillin, led to a 95% decline worldwide. Half a century later, yaws made a comeback, specifically in Vanuatu. A 2011 WHO-supported survey revealed an urgent need for renewed action after demonstrating that the Tafea province was especially hard hit. In 2013, Vanuatu's Ministry of Health, assisted by WHO, reached 96% of Tafea's population with needed treatment. As one can see, the WHO is vital in integrating health coverage globally.

Sample Timeline

9:30-9:40 – Roll Call

9:40-9:55 – Setting the Agenda

9:55-12:30 – Debate on the Agenda Topic and Motions

12:30-1:30 – Lunch

1:30-4:00 – Debate on the Agenda Topic, Motions, and Draft Resolutions

4:00-4:30 – Voting on the Draft Resolutions

4:30 – Closure/Adjournment of Debate

Forming Resolutions

Resolutions represent the consolidated opinions of the United Nations body and act as proposed comprehensive solutions to the issues at hand. They are a final result of the discussions and negotiations regarding the topics, and detail recommended courses of action. A resolution is first considered a draft resolution prior to being voted on by the committee. During the course of debate, delegates may work individually or collaborate with others to write a draft resolution. The delegates writing the resolution are considered its "sponsors" and must recruit a certain number of delegates as "signatories" in order for their resolution to be introduced by the Chairs to the committee. Signatories are members who wish to bring the resolution to debate but they do not have to support the document. Once brought to debate, amendments can be made until the final resolution is voted on by the committee.

Position Papers

The position paper is a detailed essay of your country's policies and position on the topics that are going to be discussed in the committee. The creation of your position paper is an important task because it will help you, the delegate, to organize your thoughts and ideas about MACMUN topics so that you can successfully engage with the rest of the committee. Additionally, the position papers will be judged by the conference hosts, and the writer of the top position paper in each committee will be recognized at the conference award ceremony. Please note that to be considered for any award at MACMUN 2018, you must submit a position paper.

Your goals are to research your assigned country in depth, to examine the stance they take on the given topics, and to summarize this information in one position paper. The length should not exceed one page per topic, single-spaced.

A strong MACMUN position paper should include the following:

1. How your country is affected by the issues.
2. Your country's policies with respect to the issues.
3. Quotations from your country's leaders about the topics.
4. Actions that your country has taken with regard to the issues.
5. What your country believes should be done to address the issues.
6. What your country would like to accomplish in the committee's resolution.
7. Description of your relationship with other countries as it relates to the issues at hand.

Important Notes:

- Include your name, assigned country, and committee.
- Please do not include illustrations, diagrams, decorations, national symbols, watermarks, or page borders.
- Include citations and a reference page, making sure to use a standardized citation style of your choice consistently, giving due credit to the sources used in the research. Please note that the reference page is not included in the page limit.

The deadline to submit your position paper is ***January 30th, 2018 at 11:59PM***; submissions should be emailed to usgcommittees@macmun.org.

References

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Topic #1: Recurring Infectious Diseases in the Middle East and East Africa

“The cholera most forcibly teaches us our mutual connection. Nothing shows more powerfully the duty of every man to look after the needs of others.”
– Sir Titus Salt, 1st Baronet

Introduction

The World Health Organization (WHO) defines infectious disease as illnesses which are caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi; these diseases can be spread, directly or indirectly, from one person to another.¹ Despite monumental advances in sanitation and increasing antibiotic usage throughout the developed world, the developing world, most notably East Africa and the Arabian Peninsula have suffered from a multitude of infectious diseases spread by water as well as vectors such as rodents and mosquitoes. These diseases include but are not limited to cholera, the plague, chikungunya, and dengue fever which have spread due to a lack of medical care, conflict and ever-present famine. This committee’s focus will be primarily on the presence of cholera in Yemen as well as the emergence of both the bubonic and pneumonic plague in Madagascar.

History and Background

Cholera

Assumed to have to have originated in the Indian subcontinent, countries across the globe have suffered from multiple cholera outbreaks, with seven outbreaks emerging in the past 200 years. Cholera (caused by specific strains of the vibrio cholerae bacteria)² infects the small intestines of its victims. Following the ingestion of untreated, contaminated water or food (often due to poor infrastructure), symptoms arise between twelve hours and five days.³ Symptoms of the illness include severe diarrhea, cramping and vomiting. Untreated, those affected are likely to die in hours. Nevertheless, cholera is easily treatable with immediate administration of oral rehydration salts to replace lost fluids.⁴

¹ “WHO | Infectious Diseases.” *WHO*. Accessed January 1, 2018. http://www.who.int/topics/infectious_diseases/en

² Open Collections Program: Contagion, Cholera Epidemics in the 19th Century.” Accessed January 1, 2018. <http://ocp.hul.harvard.edu/contagion/cholera.html>

³ “WHO | Cholera.” *WHO*. Accessed January 1, 2018. <http://www.who.int/mediacentre/factsheets/fs107/en/>

⁴ WHO | Treatment of Cholera.” *WHO*. Accessed January 1, 2018. <http://www.who.int/topics/cholera/treatment/en/>

Case Study: The Yemen Crisis

Due to intense military conflict in the country of Yemen along with a combination of economic stagnation, lack of medical infrastructure and massive droughts that have led to famine, affected populations are intensely weak and malnourished. This allows cholera to easily proliferate throughout the population leading to deaths on a massive scale.⁵

Beginning in October 2016, the cholera outbreak has spread across Yemen, affecting the capital, Sanaa, as well as other regions. The Ministry of Public Health and Population of Yemen has reported a cumulative total of 862,858 suspected cases of cholera including 2177 associated deaths as of July 26th, 2017. Despite a low case-fatality ratio of 0.25%, the widespread impact of cholera threatens the nation's overarching healthcare system, pushing it towards collapse and allowing the disease to spread further along the peninsula. Still, the number cases and deaths appears to be decreasing slightly.⁶

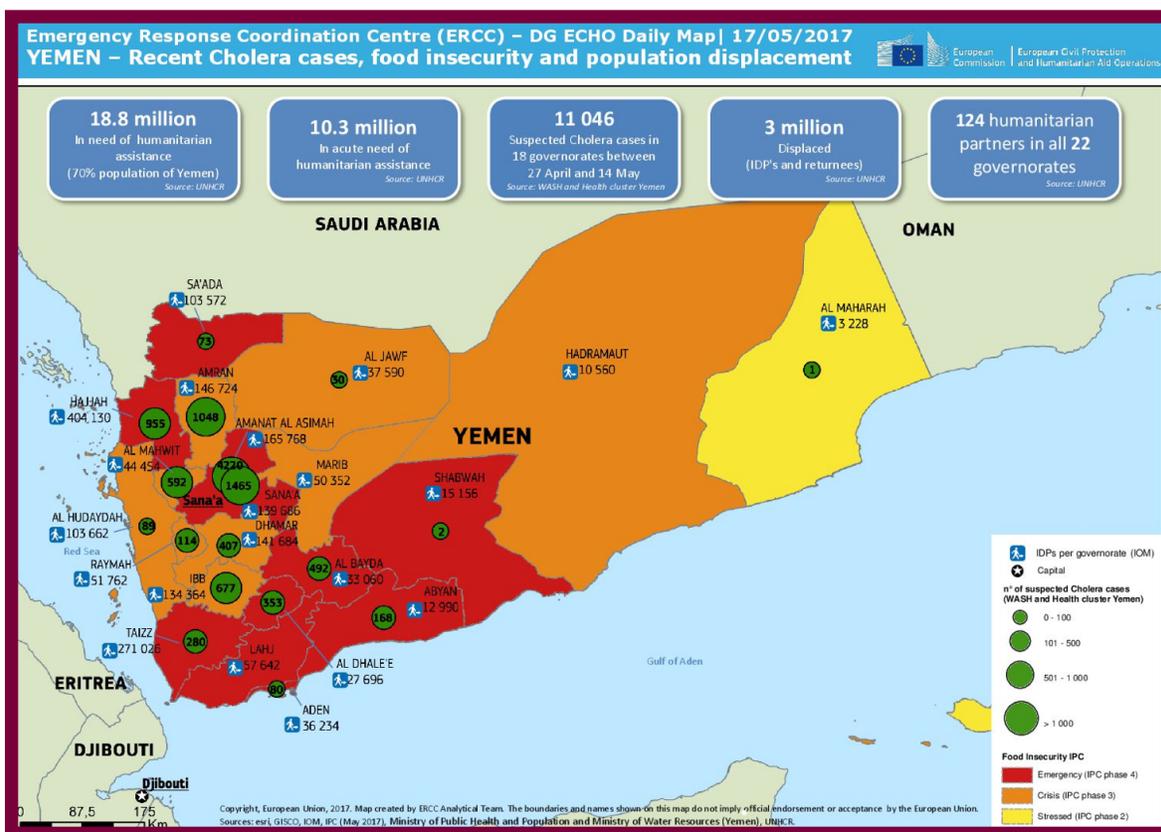


Figure 1: A map depicting the frequency of recent cholera cases in Yemen as well population displacement and food security in the region.

⁵ “Yemen and East Africa: Preventable Cholera Claiming Lives at an Alarming Rate.” *ReliefWeb*. Accessed January 1, 2018. <https://reliefweb.int/report/yemen/yemen-and-east-africa-preventable-cholera-claiming-lives-alarming-rate>

⁶ WHO EMRO | Outbreak Update - Cholera in Yemen | Cholera | Epidemic and Pandemic Diseases.” Accessed January 1, 2018. <http://www.emro.who.int/surveillance-forecasting-response/outbreaks/outbreak-update-cholera-in-yemen-26-october-2017.html>

The Plague

Bubonic plague is another infectious disease which has ravaged the developing world, specifically East Africa. Historically, the plague was referenced as the “black death” leading to over fifty million deaths in Europe during the fourteenth century.⁷ Due to the development of antibiotics and vector control, infection rates have dropped drastically over the past several centuries. The plague is caused by the bacteria *Yersinia pestis*, a species of zoonotic bacteria, typically found in small mammals and their fleas. It is transmitted between animals through fleas. Humans can be infected through both flea bites, respiratory infection or contact with body fluids of an infected individual.⁸ Symptoms of the illness include: fever, chills, weakness, fatigue, nausea and vomiting. It is important to note that the bubonic plague has two major subtypes: the bubonic plague, primarily categorized as painful swollen lymph nodes, whose human-human transmission is fairly rare, should bubonic plague not be treated, it can develop into the more virulent and severe pneumonic plague which mainly affects the lungs and is spread via droplets from the respiratory tract.⁹

Case Study: Madagascar

Beginning in early August, Madagascar has been experiencing a massive outbreak of plague. As of November 10th, 2017, a total of 2119 suspected cases of plague have been found, including 171 deaths that have been reported by the Ministry of Health of Madagascar to WHO.¹⁰ In comparison to cholera in Yemen, this illness suffers from a greater case-fatality ratio (8%). Madagascar appears to be prone to the plague and has seen over 2404 cases between 2010 and 2015 with 476 deaths among those infected (as seen in the map shown).

Madagascar’s Ministry of Public Health has actively coordinated a response, specifically in the nation’s capital, Antananarivo, as well as its second-most populous city, Toamasina.¹¹ With the use of prophylactic antibiotics as well as strict surveillance and monitoring of new, emergent cases (via screening), Madagascar, in tandem with aid organizations and leadership from the World Health Organization has been able to increase public awareness in regard to the plague.¹² The World Health Organization has advised priority countries in the region about the spread of the plague and has mobilized emergency crisis units to enhance prevention and control measures and has been effective in its endeavours.¹³

⁷ “WHO | Plague.” *WHO*. Accessed January 1, 2018. <http://www.who.int/mediacentre/factsheets/fs267/en/>.

⁸ *Ibid.*

⁹ *Ibid.*

¹⁰ “WHO | Plague – Madagascar.” *WHO*. Accessed January 1, 2018. <http://www.who.int/csr/don/15-november-2017-plague-madagascar/en/>.

¹¹ *Ibid.*

¹² *Ibid.*

¹³ *Ibid.*

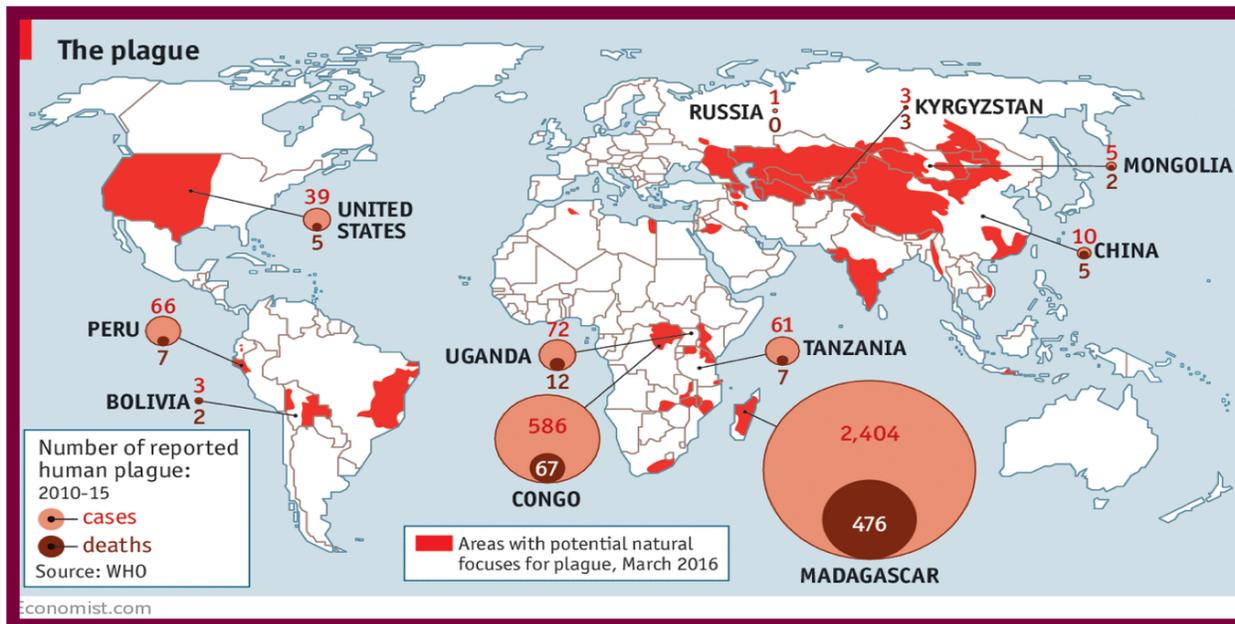


Figure 2: A map depicting the frequency of recent plague cases and deaths globally as well as regions affected by the infectious disease.

The World Health Organization has advised against any restriction on travel or trade on Madagascar. As of January 1st, 2018, there have been no reported cases related to international travel. At the moment, Madagascar’s struggle with the plague appears to be a domestic issue with minimal spread.¹⁴ Unfortunately, global spread remains a major threat.

Current Situation

Cholera

Yemen’s current situation in response to cholera is extremely dire. Approximately two in three Yemenis require humanitarian aid. After nearly three years of civil war and unrest, Yemen is faced with a multitude of problems including destroyed medical facilities, lack of access to clean water and an injured population. These three factors combined can lead to infectious disease proliferation, crippling the medical system further and straining economic resources. Sadly, despite an active response from the United Nations, Yemen’s crisis has been deemed “the worst humanitarian crisis” by the New York Times.¹⁵ Without support from the WHO, the health situation in Yemen will worsen, destabilizing the already volatile region further.

¹⁴ Ibid.

¹⁵ Almosawa, Shuaib. 2017. “‘It’s a Slow Death’: The World’s Worst Humanitarian Crisis.” *The New York Times*, August 23, 2017, sec. World. <https://www.nytimes.com/interactive/2017/08/23/world/middleeast/yemen-cholera-humanitarian-crisis.html>.

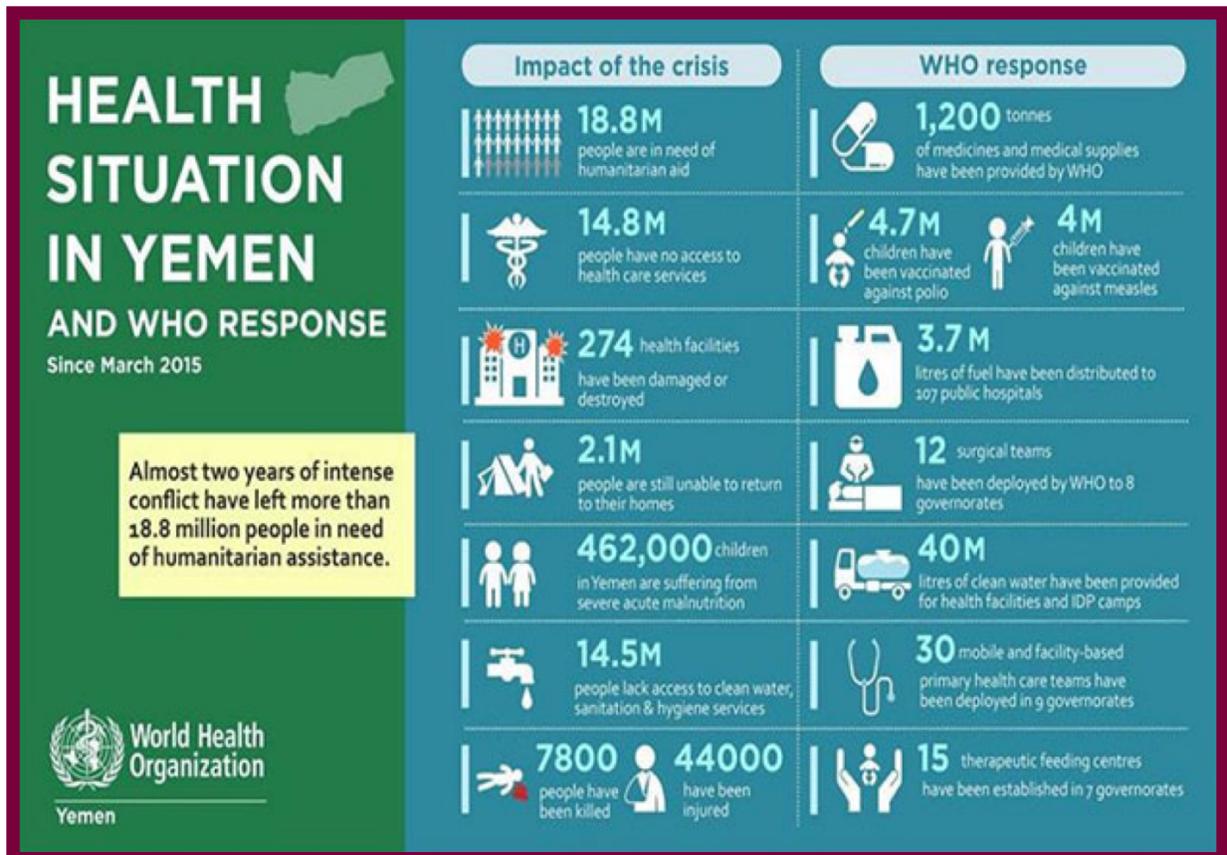


Figure 3: An infographic depicting both the impact of the health situation in Yemen as well as the WHO response to the conflict.

The Plague

While Madagascar was able to reduce the number of cases in 2017 significantly, the potential for the plague to spread continues to exist. Unfortunately, Madagascar has been continuously affected by strains of the plague and many cases remain today. Furthermore, what remains to be seen is the possibility of plague strains that are resistant to antibiotics. In 2007, a decade prior to Madagascar’s most recent plague epidemic, tests on a strain of the *Yersinia pestis*, taken from a 16-year-old boy in Madagascar revealed the bacterium has developed resistance to eight antibiotics used to treat the infection, including streptomycin and tetracyclin.¹⁶ This development suggests a future where developing nations such as Madagascar must utilize exceedingly rare and potent antibiotics to treat the plague. In recent decades the World Health Organization has observed several outbreaks in 25 countries, including populous African countries such as the Democratic Republic of the Congo, as well as nearby countries such as Tanzania and Mozambique.¹⁷ The lingering presence of such a catastrophic disease is daunting. Researcher at the Pasteur Institute in Paris, France, Elisabeth Carniel suggests that: “[The] plague is not the

¹⁶ Sample, Ian, and science correspondent. 2007. “Drug-Resistant Form of Plague Identified.” *The Guardian*, March 21, 2007, sec. Science. <http://www.theguardian.com/science/2007/mar/21/medicineandhealth.uknews>.

¹⁷ Ibid.

disease it was because of the existence of antibiotics, so if we cannot use antibiotics any more, or if we have only a very limited range of drugs that work, that will make the disease much more dangerous."¹⁸

Committee Mission

As the World Health Organization, it is the responsible of this council to ensure that both the spread of cholera and the bubonic plague are halted. In collaboration with fellow member states, an action plan must be established that takes into account socio-economic, political, and medical decisions. As a committee, it is therefore imperative to preserve as much human life as possible in order to ensure a sustainable future for the region at hand.

Research Questions

1. How does infectious disease affect the population of your country? Do socio-economic factors play a role in mediating the impact of these illnesses on your populace?
2. Has your country pledged financial, medical or technological aid to Yemen, Madagascar or other affected countries? If so, what has it done, if not, what future plans does your government have regarding this issue?
3. If certain infectious diseases have the ability to be eradicated entirely why has the global community been unable to do so? Why do certain countries invest in treating certain illnesses while ignoring others? Furthermore, what illnesses should be deemed a priority by your country, which should be disregarded?
4. How will your country prevent the spread of infectious disease in the surrounding regions as well as in its own territory?
5. To what extent, if at all, must the conflict in these nations be controlled in order to ensure the safety and health of the citizens of affected countries?
6. Which disease does your country deem as a major threat and how does it approach disease control?

¹⁸ Ibid.

Topic #2: Aboriginal Health

"Indigenous peoples remain on the margins of society: they are poorer, less educated, die at a younger age, are much more likely to commit suicide, and are generally in worse health than the rest of the population"
– *The Indigenous World, 2006*²⁰

Introduction

The World Health Organization (WHO) does not have an official definition of “indigenous” due to a large amount of diversity among the world’s Indigenous peoples. A recently developed inclusive and changing definition includes people who: identify themselves as Indigenous, have strong links to territories and natural resources, have distinct languages, cultures and beliefs, demonstrate historical continuity with pre-colonial/pre-settler societies and form a non-dominant group. It has been estimated that there are around 370 million Indigenous peoples situated throughout 70 countries worldwide.¹⁹ “Indigenous peoples” is the generic term used, however, regions around the world have varying terms and preferences which include but are not limited to first peoples/nations, aboriginals, ethnic groups. Indigenous peoples, similar to other marginalized populations, often suffer from: a lack of political representation, poverty, lack of access to social and healthcare services and discrimination.

Background

Despite remarkable global attempts to improve population health, there remains poor health status of Indigenous populations across the world in both countries that are wealthy and those that are less wealthy. Profound inequities in social and health services exist in Indigenous populations when compared to non-indigenous ones. Indigenous populations in many regions such as China, Brazil, Peru and more are growing rapidly, have higher death rates at younger ages and a higher child to adult dependency ratio. In wealthy nations, Indigenous peoples show alarming health disadvantages such as infant mortality, diabetes, cancers and mental illnesses.²¹ Figure 4 highlights the average infant mortality per 1000 people in indigenous communities and as seen in the figure the average infant mortality among Indigenous children in Panama is greater than 3x in comparison to the overall population.²² The causes of poor health are complex but can be narrowed down to social determinants of health including income, education, living conditions, social support and access to health services. Indigenous health is also affected by

¹⁹ World Health Organization. "Health of Indigenous peoples." <http://www.who.int/mediacentre/factsheets/fs326/en/>. (October 2007)

²⁰ United Nations Permanent Forum on Indigenous Issues, Fourth Session, UN Document E/C.19/2005/2, Annex III, Item 13

²¹ Stephens, Carolyn, Clive Nettleton, John Porter, Ruth Willis, and Stephanie Clark. "Indigenous peoples' health—why are they behind everyone, everywhere?" *The Lancet* 366, no. 9479 (2005): 10-13.

²² *Health in the Americas*, Volume 1, 2002 Edition, Pan American Health Organization, p.181.

cultural factors, notably racism, loss of language and connection to land, environmental deprivation and overall isolation.²³

Case Study: Australia

The two major Indigenous groups of Australia are the Aboriginal and Torres Strait Islander peoples who have been present on the continent for an estimated period of 50 000-70 000 years. As of 2008, these two groups account for 2.5% of the overall Australian population. Around 31% are residing in major cities, whereas 15% are found in very remote geographic locations.²⁴ The Australian Bureau of Statistic reported that the two Indigenous group's life expectancy was estimated to be 11.5 years lower for Indigenous males and 9.7 years lower for Indigenous females when compared to non-Indigenous males and females.²⁵ It has also been reported that the death rates among middle-aged Aboriginal and Torres Strait Islander people are five to six times higher when compared to non-indigenous counterparts.²⁶ These groups are experiencing multiple risk factors for physical and mental illness, exacerbated by poor access to health services and environmental conditions which facilitate the spread of disease. Cardiovascular disease is the leading cause of premature death, in addition, the burden of chronic infectious diseases remains high. Infections are experienced repeatedly in childhood because of the poor conditions that exist within the communities such as overcrowded housing, inadequate clean water and appropriate sanitation, substandard and expensive food supplies. In addition, the Indigenous groups face economic barriers to preventing and treating health conditions; for example they often cannot afford the doctor or cover travel costs to reach appropriate medical aid. Furthermore, many in rural areas do not have access to local general practitioners, pharmacies or hospitals, remote area health centres provide services to over one quarter of the indigenous peoples (versus 2.3% of non-indigenous

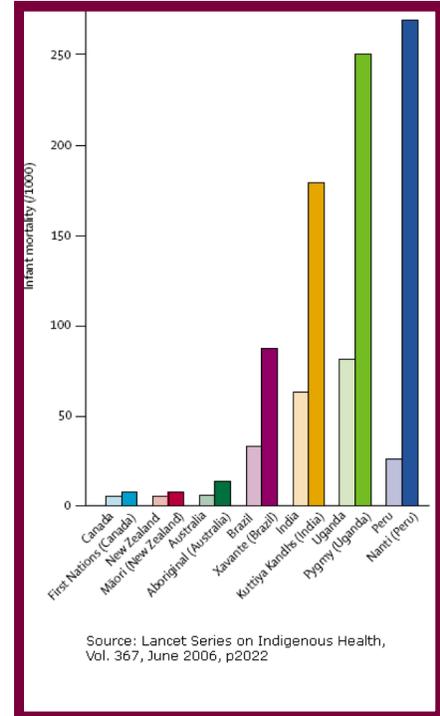


Figure 4: Infant mortality among Indigenous Populations

²³ King, Malcolm, Alexandra Smith, and Michael Gracey. "Indigenous health part 2: the underlying causes of the health gap." *The Lancet* 374, no. 9683 (2009): 76-85.

²⁴ Jackson Pulver, Lisa, Melissa R. Haswell, Ian Ring, John Waldon, Wayne Clark, Valorie Whetung, Dianne Kinnon, Catherine Graham, and Michelle Chino.

²⁵ Jackson Pulver, "Indigenous health: Australia, Canada, Aotearoa, New Zealand and the United States: laying claim to a future that embraces health for us all." (2010).

²⁶ Ibid.

Australians).²⁷ There remain many disparities between the Indigenous groups and non-Indigenous groups in Australia which need to be addressed immediately.

Case Study: Canada

In Canada, there are three politically and culturally distinct Indigenous groups - First Nations, Inuit and Metis and represent 4% (1.4 million) of the Canadian population as of 2011. 61% identify as First Nations and 32% as Metis.²⁸ The life expectancy of Indigenous populations is lower than non-indigenous populations. In addition, First Nations mothers aged 35 years and over living on a Reserve, were more likely to give birth to a baby with low birth weight compared to non-indigenous mothers. The Aboriginal people in Canada also face high rates of chronic non-communicable diseases and contagious diseases. In 2014, it was reported that Indigenous populations accounted for an overall 21% of Tuberculosis (TB) as seen in Figure 5 below. The rate of TB is almost 50 times higher than the overall Canadian rate.²⁹



Figure 5: Number of TB Cases, Canada 2014

According to Statistics Canada, First Nations men were 2x as likely compared to non-Aboriginal to die from avoidable causes, and First Nations women were 2.5x as likely.³⁰ This disparity was also seen in younger age groups, and diabetes, alcohol and drug use disorders, injuries were the causes contribution. In addition, the lack of mental health services has also been a growing challenge for Aboriginal people in Canada as there is a lack of funding and coordinated programs and a recent state of emergency was declared in 2016 amongst a First Nations community after 11 young people attempted suicide.³¹ Action needs to be taken to address these health disparities amongst Indigenous populations.

Non-communicable diseases such as heart disease are also of major concern, as Aboriginal people are 1.5 -2 times more likely to develop heart disease than non-Aboriginals in Canada.³² In

²⁷ Ibid.

²⁸ Government of Canada. 2016. Health Status of Canadians 2016: A Report of the Chief Public Health Officer.

²⁹ Ibid.

³⁰ Park, Jungwee, Michael Tjepkema, Neil Goedhuis, and Jennifer Pennock. "Avoidable mortality among First Nations adults in Canada: a cohort analysis." *Health Rep* 26, no. 8 (2015): 10-16.

³¹ "Lack of services contributing to indigenous mental health crisis: frontline workers" CTV News. <https://www.ctvnews.ca/health/lack-of-services-contributing-to-indigenous-mental-health-crisis-frontline-workers-1.3178797>. (November 2016)

³² Canadian Heart Health Strategy and Action Plan Steering Committee. Canadian Heart Health Strategy and Action Plan: Building a Heart Healthy Canada. Ottawa, Canada, 2009

addition, the rates of diabetes are 3-5 times higher than other Canadians.³³ Historically, Aboriginals in Canada had a strong relationship with nature and traditional methods such as hunting and fishing allowing for supply of nutritious food and physical activity. However, due to losses of land, urbanization and instability in housing, there are diminished dietary options for many communities, nutritious food is not available and instead store-bought high calorie food becomes the only option.³⁴ This risk factor along with others such as increased smoking and decreased physical inactivity play into cardiovascular disease (CVD). Through community based health interventions and incorporation of disease prevention models, the prevalence of CVD and other chronic diseases can be decreased.³⁵ The overall health of the Aboriginal population of Canada is of high priority in order to mitigate these effects in the population and the burden of disease.

Committee Mission

The WHO defines health as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.³⁶ The WHO aims to adopt action-oriented policies and plans, urging countries around the world to ensure equality in relation to health care access, housing and social services. The WHO also aims to bridge the information gap, as the statistical data on the health status of indigenous groups in Africa, Asia and eastern Europe is scarce. It is imperative that the highest attainable standard of health is achieved for Indigenous populations.

Focus Questions

1. Does your country or your neighbouring country have policies or plans in place to address Indigenous populations and their access to healthcare?
2. What direct actions from governments can be taken to overcome the health disparities of these populations?
3. Should countries without indigenous populations support (financially or otherwise) initiatives in neighbouring countries regarding healthcare in indigenous peoples?
4. What can be done at the international level to support the Indigenous populations of the world? What alliances and partnerships need to be made to address these issues?
5. According to your country’s economic status (i.e. developed vs. undeveloped), is it a priority to address Indigenous issues?
6. How should mental health be prioritized when related to Indigenous populations?

³³ Diabetes in Canada: Facts and figures from a public health perspective, PHAC

³⁴ Reading, Jeffrey. "Confronting the growing crisis of cardiovascular disease and heart health among

³⁵ Aboriginal peoples in Canada." Canadian Journal of Cardiology 31, no. 9 (2015): 1077-1080

³⁶ World Health Organization. "Health of Indigenous peoples." <http://www.who.int/mediacentre/factsheets/fs326/en/>. (October 2007)

Topic #3: Child Vaccinations

You can have the best vaccines for a woman or her child, but if you can't get her to come and get them then they won't work.
 – Melinda Gates, American philanthropist, former Microsoft employee, and co-founder of the Bill & Melinda Gates Foundation

Introduction

Immunizations have saved countless lives and has averted an estimated 2-3 million deaths every year. Despite this monumental victory, it is predicted that with global vaccination an additional 1.5 million deaths can be avoided. Immunization prevents deaths from diseases such as diphtheria, tetanus, whooping cough (pertussis), measles, polio, pneumococcal diseases and many other highly-infectious diseases.³⁷ Global vaccinations has reached 86% coverage, but the proportion of the world's children who receive these vaccines has stalled for some time. The worldwide coverage of vaccines can be seen in figure 6. In addition, in 2016 it was estimated that 19.5 million infants worldwide did not receive routine immunization services, and around 60% lived in the following countries many of which are developing countries: Angola, Brazil, Pakistan, South Africa, India, Indonesia, Iraq, Democratic Republic of the Congo and Ethiopia.³⁸

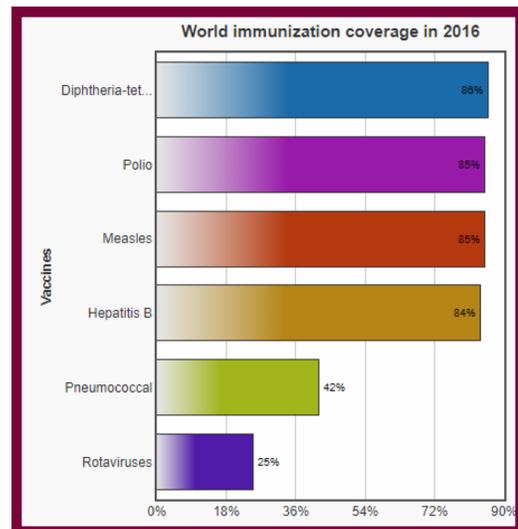


Figure 6: Global immunization coverage per vaccine.

History and Background

Whooping Cough

Pertussis (Whooping cough) is a respiratory tract disease caused by bacteria that inhabits the mouth, nose and throat. Children who contract pertussis have coughing spells ranging from four to eight weeks with a distinct inspiratory “whoop”, other symptoms include mild fever, runny nose, vomiting as well as pneumonia in complicated cases. Pertussis is highly infectious and can

³⁷ World Health Organization. "Immunization Coverage." <http://www.who.int/mediacentre/factsheets/fs378/en/>. (July, 2017)

³⁸ Ibid.

be transmitted between individuals simply by coughing or sneezing.³⁹ In 2016, there were 139 535 reported cases worldwide.⁴⁰ Infant vaccines to protect against pertussis have been highly successful and in 2008, the WHO estimated that 687 000 deaths were prevented. As seen in Figure 7, the number of whooping cough cases reported has been increasing over the past few years despite the development of vaccinations.⁴¹ It has also been reported that immunity against pertussis declines 5-10 years after the vaccinations, which has sparked interest in a new option of a booster shot for adolescents.⁴²

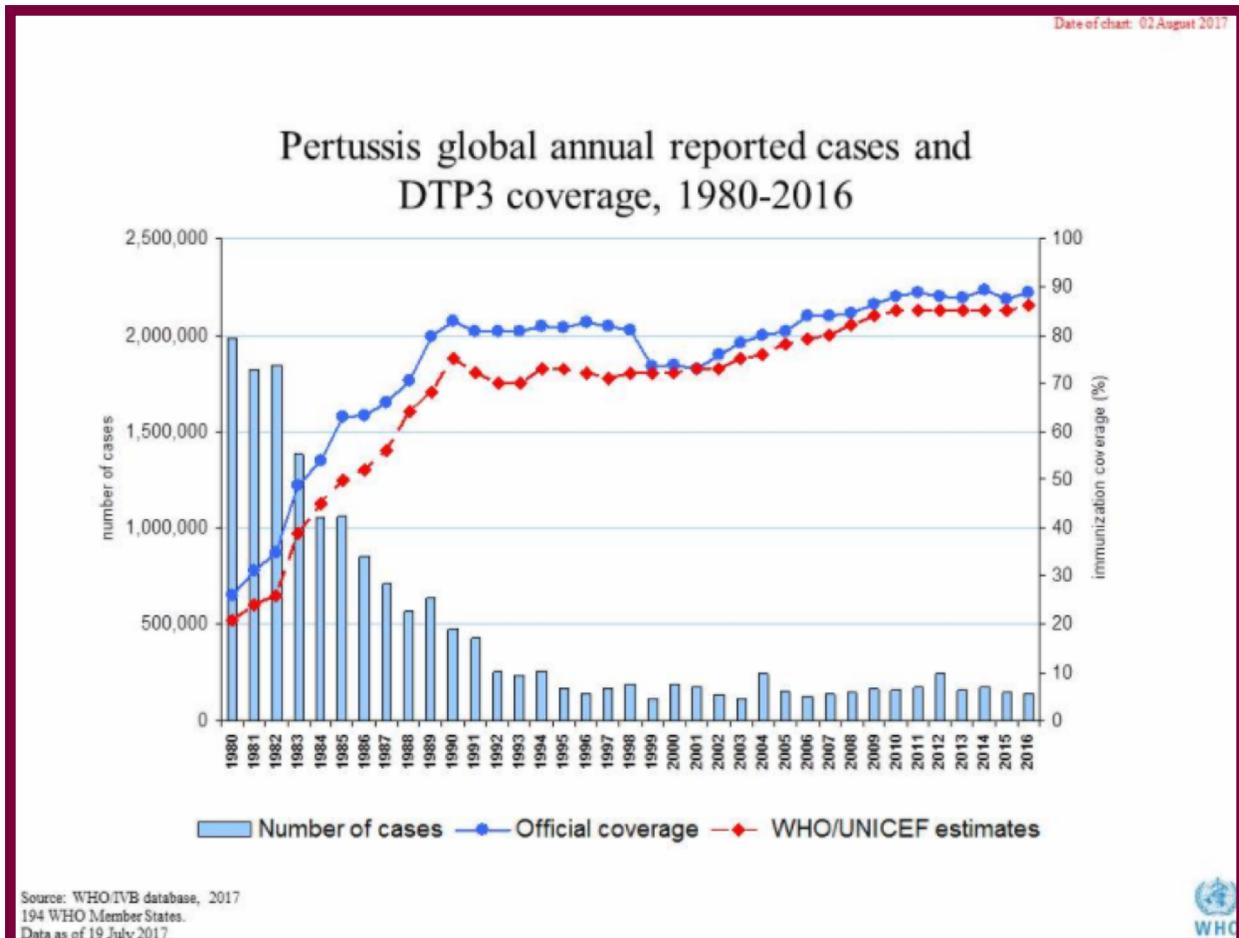


Figure 7: The number of annual reported cases and coverage of whooping cough.

³⁹ World Health Organization. "Pertussis". <http://www.who.int/immunization/diseases/pertussis/en/> (September, 2015)

⁴⁰ World Health Organization. "Pertussis". http://www.who.int/immunization/monitoring_surveillance/burden/vpd/surveillance_type/passive/pertussis/en/ (August 2017)

⁴¹ Ibid.

⁴² ABC NEWS. "Whooping Cough on the Rise". <http://abcnews.go.com/Health/story?id=116637&page=1> (July, 2014)

In 2010, there were 10 000-50 000 cases reported in the United States with mortality of 20 infants, which could have been prevented by a second dose of vaccine at month two. Immunizations given at the right time are crucial to protection of 14 serious childhood diseases including but not limited to: rubella, rotavirus, polio, hepatitis A, hepatitis B.⁴³

Measles

Measles is one of the leading causes of mortality among infants and young children. Measles is a highly contagious disease caused by a virus contracted through direct contact and infects the respiratory tract causing higher fever, rash which can then lead to other complications. Despite the availability of an effective vaccine, it remains a major cause of infant death in many developing countries in Africa and Asia.⁴⁴ In addition, countries plagued with war and natural disasters which disrupt healthcare access, are more at risk of infection.

Current Situation

The vaccine issue is very much binary. Many developing nations require a multitude of vaccines while despite advances in preventative medicine and the development of more effective vaccines, there appears to be some stagnation in developed countries rich with vaccines. While lack of medical care and infrastructure as well as education is to blame in developing nations, “anti-vaxxer” groups compounded with pseudoscience have begun to slow vaccination efforts in the developed world.

Committee Mission

As a committee, it is the World Health Organization’s responsibility to ensure that the illnesses that can be prevented are prevented by vaccines. Your role is to collaborate and develop a multi-faceted solution that targets both developed and developing countries and protects those who cannot afford vaccines as well as those who simply do not receive their immunizations. This issue remains divisive in its nature specifically in developed nations, and it is thus your responsibility as member states address the problem holistically in order to improve global health by minimizing the spread of evitable disease.

⁴³ Center for Disease Control and Protection. "Protect your Baby with Immunization". <https://www.cdc.gov/features/infantimmunization/index.html> (April, 2017).

⁴⁴ World Health Organization. "Measles". <http://www.who.int/mediacentre/factsheets/fs286/en/> (October, 2017)

Research Questions

1. Which vaccines are most at risk from anti-vaxxer groups, does this issue target your country specifically?
2. How can your country, if at all, deliver aid to vulnerable nations, especially those with poor medical infrastructure?
3. Should the WHO invest more or less resources in vaccine distribution and how can it help maximize vaccine production globally?