

Akshat
[Company Name]

WHO Background Guide



Letter from the Executive Board

Distinguished delegates,

As the world population rises and development continues to be uneven, new diseases have the potential to cause widespread damage to vulnerable regions and demographics. Issues like Ebola and HIV need a concerted and effective international response, and the WHO is one organization that can make a difference.

On behalf of the entire Secretariat, we sincerely welcome you to this meeting of the World Health Organization at the 2015 edition of MITMUNC. Here, you will step in the shoes of international policymakers, and you will get the chance to have your country's voice heard. With effective diplomacy and innovative thinking, you will hopefully find new solutions to these pressing issues.

We expect only the highest standards of diplomatic conduct, research, and debate from you. The health and wellbeing of millions depends on the proceedings of this council. In this simulation, the success of the council depends on all of you.

With high expectations,

The Executive Board,
World Health Organization, MITMUNC 2015

Akshat Bubna is a mathematics, physics, computer science major from New Delhi, India. He wants to research quantum algorithms, but is also heavily interested in world politics, especially the Middle East. His ninth Model UN, he looks forward to directing fruitful debate and arriving at meaningful resolutions.

Sue Liang is a pre-med freshman who is considering majoring in EECS. This is her first Model UN, and she has made her way here by following her interests in ethics, humanity, diseases, policy, and interdisciplinary solutions among other things. She looks forward to learning alongside all of you.

The World Health Organization



The World Health Organization (WHO)¹ is a specialized agency of the United Nations that is concerned with international public health. It was established on 7 April 1948, headquartered in Geneva, Switzerland. WHO is a member of the United Nations Development Group.

Since its creation, the WHO has played a leading role in the eradication of smallpox. Its current priorities include: communicable diseases, (focusing on HIV/AIDS², Ebola, malaria and tuberculosis; the mitigation of the effects of non-communicable diseases), sexual and reproductive health (focusing on development, and aging), nutrition (focusing on food security and healthy eating), occupational health, substance abuse. In addition to its focus on current health concerns, the WHO strives to drive the development of health reporting, publications, and networking in order to aid the future of world health.

As of 2014, the WHO has 194 member states. WHO Member States appoint delegations to the World Health Assembly, the WHO's supreme decision-making body. All UN Member States are eligible for WHO membership, and, according to

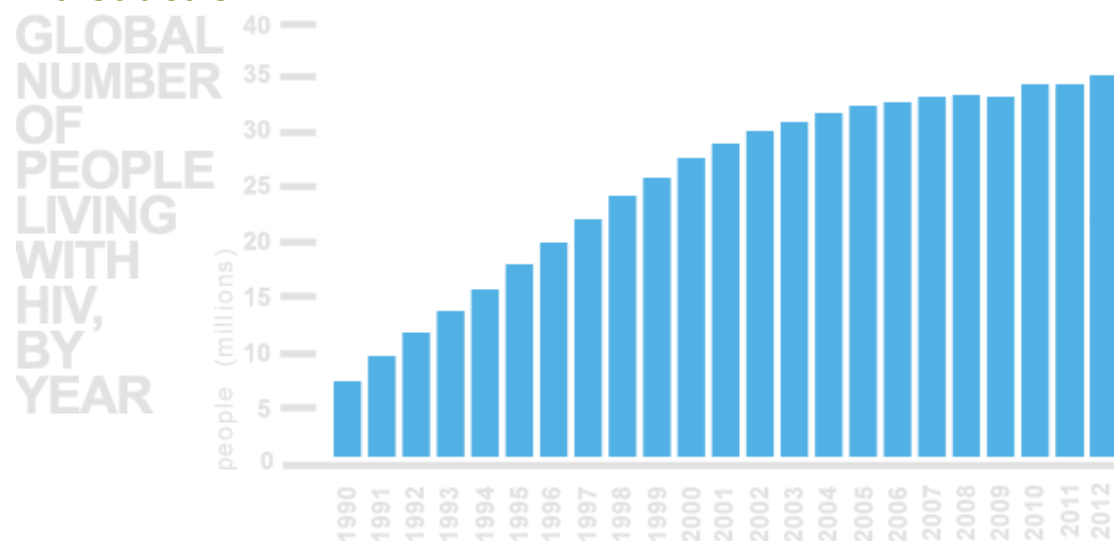
¹ http://www.who.int/governance/eb/who_constitution_en.pdf

² <http://www.un.org/ga/aids/docs/aress262.pdf>

the WHO website, "other countries may be admitted as members when their application has been approved by a simple majority vote of the World Health Assembly"¹.

Topic A: HIV and Youth

Introduction



Since the first reported incident of AIDS in 1981, it has spread to an estimated 34 million people³. More than 2 million adolescents between the ages of 10 and 19 years are living with HIV, and many do not receive the care and support that they need to stay in good health and prevent transmission. Millions more adolescents are at risk of infection⁴.

“Adolescent girls, young men who have sex with men, those who inject drugs or are subject to sexual coercion and abuse are at highest risk. They face many barriers, including harsh laws, inequalities, stigma and discrimination which prevent them from accessing services that could test, prevent, and treat HIV,”

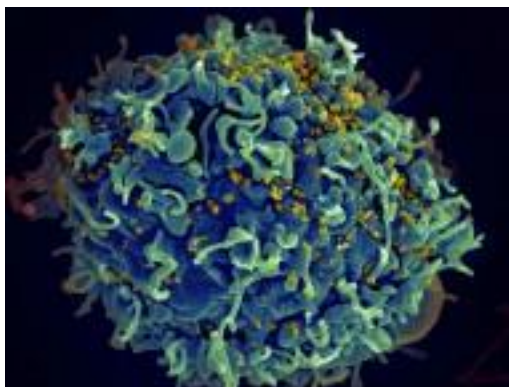
³ <http://www.avert.org/worldwide-hiv-aids-statistics.htm>

⁴ <http://www.who.int/mediacentre/news/releases/2013/hiv-adolescents-20131125/en/>

says Craig McClure, Chief of HIV programmes for UNICEF. “About one-seventh of all new HIV infections occur during adolescence. Unless the barriers are removed, the dream of an AIDS-free generation will never be realized.”⁴

Studies show that the risk factors for this demographic are steadily increasing. Between 2005 and 2012, HIV-related deaths among adolescents increased by 50%, while the global number of HIV-related deaths fell by 30%. This increase is due primarily to poor prioritization of adolescents in national HIV plans, inadequate provision of accessible and acceptable HTC and treatment services, and lack of support for adolescents to remain in care and adhere to antiretroviral therapy (ART)⁵.

What is HIV?



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HIV stands for human immunodeficiency virus. It is the virus that can lead to acquired immunodeficiency syndrome, or AIDS.

No safe and effective cure currently exists, but scientists are working hard to find one, and remain hopeful. With proper medical care, HIV can be controlled.

Treatment for HIV is often called antiretroviral therapy or ART. ART can dramatically prolong the lives of many people infected with HIV and lower their

⁵http://apps.who.int/iris/bitstream/10665/94334/1/9789241506168_eng.pdf?ua=1

chance of infecting others. Before the introduction of ART in the mid-1990s, people with HIV could progress to AIDS in just a few years. Today, someone diagnosed with HIV and treated before the disease is advanced can have a nearly normal life expectancy.

HIV affects specific cells of the immune system, called CD4 cells, or T cells. Over time, HIV can destroy so many of these cells that the body cannot fight off infection and disease. When this happens, HIV infection leads to AIDS.⁷

Transmission

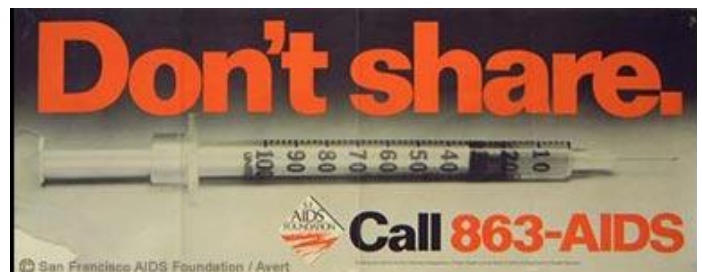
HIV has many known routes of transmission which are detailed below.⁸

Sexual intercourse

HIV is found in the sexual fluids of an infected person, and sexual intercourse without a condom carries a high risk of transmission. This risk is higher for men who have sex with men. Globally, men who have sex with men are 19 times more likely to be living with HIV than the general population

Injecting drugs

Blood transfer, through the sharing of drug taking equipment, particularly unsterilized needles, carries a high risk of HIV transmission. Around 30 percent of global HIV infections outside of sub-Saharan Africa are caused by injecting drugs.⁹



The most commonly injected drugs are heroin and other opiates, cocaine and amphetamines; the prevalence of each varies according to location and population group. In Western European nations, heroin is the most commonly injected drug amongst older users, and amphetamine-type stimulants (ATS) amongst younger people. ATS are also the most commonly injected drugs in

⁷ <http://www.cdc.gov/hiv/basics/whatishiv.html>

⁸ <http://www.avert.org/can-you-get-hiv.htm>

⁹ http://www.ihra.net/files/2012/07/24/GlobalState2012_Web.pdf

Thailand, Laos, South Korea, Cambodia and Japan, whilst across Latin America, cocaine is the most commonly injected drug.

Disinfecting equipment between each use can reduce the chance of transmission, but does not eliminate it entirely.

Mother-to-child transmission (MTCT)

MTCT is when an HIV-positive mother passes the virus to her child during pregnancy, labor, delivery, or breastfeeding. Each year around 1.5 million women living with HIV become pregnant, and without antiretroviral drugs (ARVs), there is a 15 to 45 percent chance that their child will become infected. However, among mothers that take a regimen of ARVs for the prevention of mother-to-child transmission (PMTCT), the risk of HIV transmission can be reduced to less than 5 percent.

Blood in medical settings

These days, all the blood used for transfusions in high-income countries is tested for HIV, therefore HIV infection through blood transfusions is now extremely rare. Yet, this is not the case in some middle- and low-income countries, where a lack of adequate blood safety procedures means HIV transmission through blood transfusions continues to occur .



Blood can be separated into its different components: red blood cells, white blood cells, platelets, plasma, and immunoglobulin. These are known as blood products. Whilst whole blood can be placed through a rigorous screening process and infected donations discarded, some blood products, such as those used by people with hemophilia, can be heat-treated to make them safe.

Prevention

Taking measures to actively prevent HIV is especially important for high-risk groups such as gay men, people who inject drugs (PWID), sex workers, internally displaced people, etc.

Same-sex sexual acts are criminalized in 78 countries and are punishable by death in seven countries. Sex work is illegal and criminalized in 116 countries. People who inject drugs are almost universally criminalized. Criminalization leads to unsafe practices and prevents these groups of people from getting necessary help. For example, the HIV prevalence among sex workers is 12 times greater than among the general population.

Access to HIV testing facilities and condoms for prevention is also a priority. Many young people do not know their HIV status. In sub-Saharan Africa, for example, it is estimated that only 10% of young men and 15% of young women (15-24 years) know their HIV status. These numbers are consistently low in other places as well. In that same region, only eight male condoms were available per year for each sexually active individual. Among young people, condom access was even less.

An increasing number of people living with HIV are being prosecuted for transmitting the virus to their sexual partners. Stories of people 'deliberately' or 'recklessly' transmitting HIV to others have appeared in the media since the epidemic first began, and some of the individuals concerned have even been criminally charged and imprisoned. Forty-two countries have laws specifically criminalizing HIV non-disclosure, exposure, and transmission¹⁰. This may have a negative impact on prevention efforts.

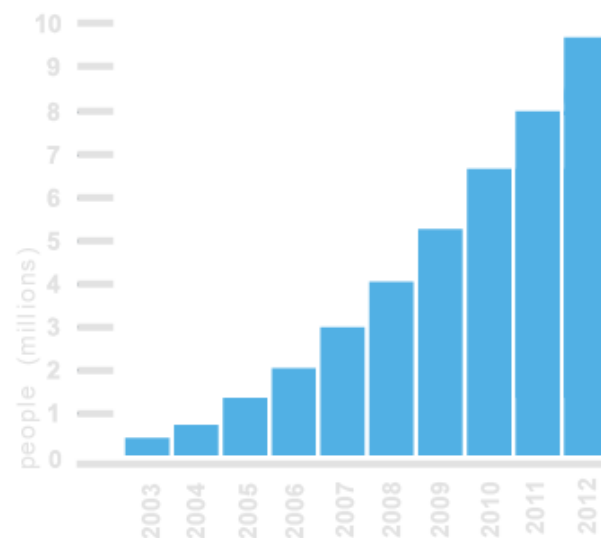
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www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf

Treatment

NUMBER OF PEOPLE RECEIVING ANTIRETROVIRAL THERAPY

(end of year, lower- and
middle-income countries)



“In recent years, considerable energy and money have been spent trying to achieve universal access to treatment for HIV. This is part of a wider objective to provide universal access (15 million people on treatment) by 2015, as agreed on in 2010. Most countries aspiring to expand treatment access set themselves a goal of providing antiretroviral treatment (ART) to around 80 percent of those in need.”¹¹

There were 12.9 million people receiving antiretroviral therapy globally at the end of 2013. The percentage of people living with HIV who are not receiving antiretroviral therapy has been reduced from 90% in 2006 to 63% in 2013.

Pre-exposure prophylaxis (PrEP) is a special course of HIV treatment that aims to prevent people from becoming infected with HIV. PrEP is intended for people at-risk of exposure, for example in the case of couples where one partner is HIV-positive and the other is HIV-negative.

AIDS weakens the body’s immune system, making it vulnerable to many other diseases. Tuberculosis remains the leading cause of death among people living with HIV. In 2012, people living with HIV accounted for 1.1 million (13%) of the

¹¹ <http://www.avert.org/universal-access-hiv-treatment.htm>

estimated 8.7 million people who developed tuberculosis globally. People living with HIV who are coinfecting with either hepatitis B or C virus need to be given priority attention. Coinfection accelerates the progression of liver disease among these people. Access to treatment for these diseases should be kept in mind when making AIDS policies.

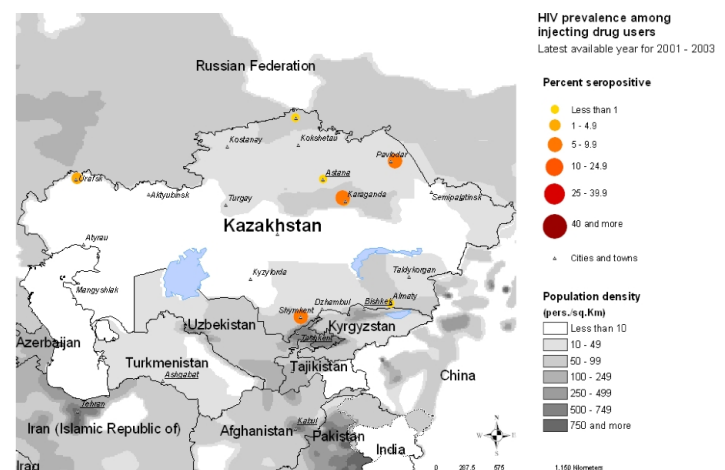
Case study: Kazakhstan



Kazakhstan¹² registered its first HIV Case in 1987 and today has 12,500 people living with HIV and 850 with AIDS. It has spent 56 million US Dollars on adoption of HIV/AIDS prevention and treatment strategies.

In Kazakhstan, citizens who are infected with HIV have the right to supplies, medications, and care in state health establishments. Although the Law on HIV/AIDS Prevention provides for free treatment for people living with HIV/AIDS, in practice, state and local budgets do not usually allow such costly medicines to be procured. As a result, most people do not have access to antiretroviral therapy due to its high cost.

Kazakhstan has invested in needle and syringe exchange programs since 1997, resulting in very low levels of HIV infection among PWID. This has continued to drop year on year, from 3.8 percent in 2012, to 2.8 percent in 2013. The AIDS centers and nongovernmental organizations have established 98 trust points which provide injecting drug users with syringes, condoms, brochures, and pretest and posttest counseling.



¹² http://www.who.int/hiv/HIVCP_KAZ.pdf

Hospitals, tuberculosis centers and oncological dispensaries are expected to provide treatment for HIV/AIDS opportunistic diseases and palliative care for terminal patients.

A number of issue still need to be dealt with, such as the concurrent epidemics of injecting drug use and sexually transmitted infections, lack of social and legal tolerance for activities directed towards vulnerable populations, and insufficient money. The existing legal framework does not facilitate HIV/AIDS prevention or treatment among most groups with high-risk behavior and discourages their contact with government institutions.

Questions to consider

- Is it right to criminalize AIDS transmission?
- Is there a way to further protect infants from the disease?
- How should children orphaned by AIDS be raised?
- Are young people getting the information they need to protect themselves from HIV?
- Why are certain groups at higher risk? How can we better care for these groups? Can this be done just by changing legislation or do social perceptions need to be changed as well?
- Why is AIDS more prevalent in certain regions than others? What actions should be taken to remedy this?
- How do we provide equitable access to treatment?

Topic B: Combatting the Ebola outbreak

Introduction

Previously known as Ebola hemorrhagic fever, Ebola virus disease (EVD) has caused what the Emergency Committee deems an extraordinary event with possible health risk to other existing states, with its largest and most complex outbreak having started in March of 2014. This infection has an incubation period ranging from 2 to 21 days and causes symptoms like fever, severe headache, hemorrhaging, and diarrhea. Once symptoms appear, Ebola has a case fatality rate of 50% to 90%, is transmittable through direct contact with blood, bodily fluids or tissues of infected persons or animals, and requires increase in health safety measures as well as patient care as the patient grows increasingly ill.

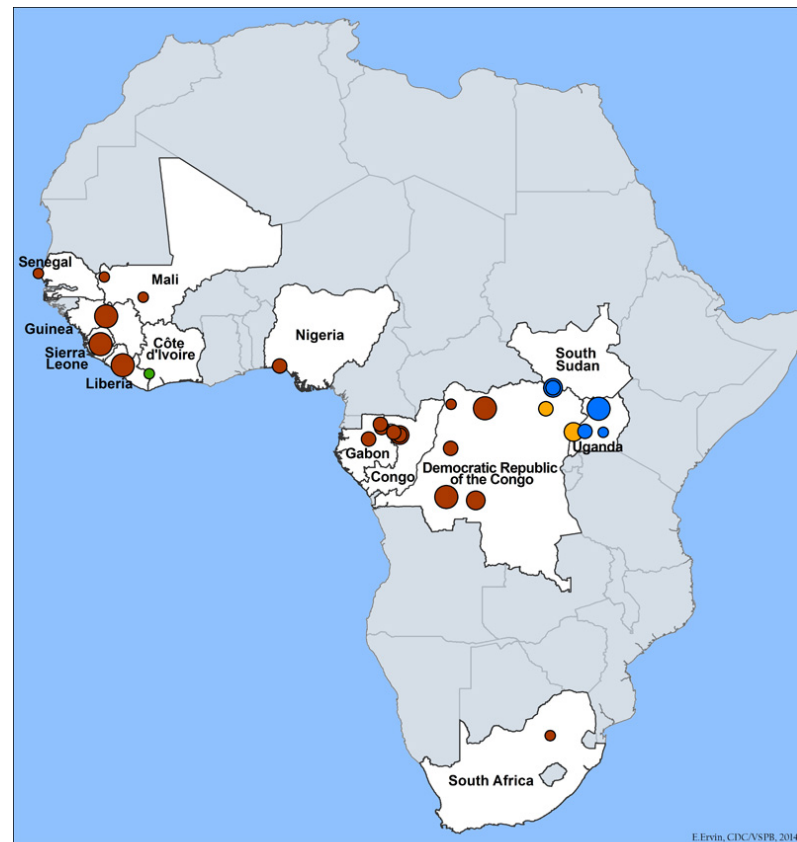
This virus was first documented in 1976 at two separate but simultaneous outbreaks: at Nzara, Sudan and Yambuku, Democratic Republic of Congo, and in both instances the outbreak spread to around 300 reported cases because of close contact transmission within hospitals. Since then there have been over 20 distinct outbreaks of the four strains of ebola across specific African countries, with a frequency in the Central Africa region, including the Democratic Republic of Congo, Sudan, Gabon, Ivory Coast, South Africa, Uganda, Nigeria, Republic of Congo, Guinea, Sierra Leone, Liberia, Mali, and Senegal.

Past Ebola Outbreaks and Progresses in Containing the Infection

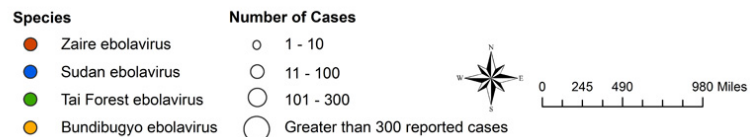
In each of the Ebola outbreaks prior to 2014, the affected country's Ministry of Health established a task force dedicated to managing the epidemic and worked alongside the WHO to coordinate and implement an international response

geared toward supplying protective equipment, creating procedures, boundaries, and other control measures to prevent further local spread of the infection. Over time, local and international officials have worked to educate the public about Ebola, its spread, and how citizens can protect their loved ones through a variety of means.

In the October 2000 Uganda outbreak, WHO epidemiologists collaborated with the Ugandan authorities to provide clinical management and containment of the outbreak, and were initially funded by Germany, Ireland, Italy, and Japan. However, these containment measures were limited to a local and direct community scale, as in Update 19 on the 2000 Ebola hemorrhagic fever in Uganda, the WHO advisory note did not recommend special procedures to be put in place regarding the spread of disease within Uganda or beyond Uganda's borders.



EBOLAVIRUS OUTBREAKS BY SPECIES AND SIZE, 1976 - 2014



In the December 2001 Gabon outbreak, WHO and the Global Outbreak Alert and Response Network collaborated with the Gabon Ministry of Health to accomplish the same goals set during the Uganda outbreak: containment through supplying protective gear, creating boundaries, and other methods of controlling local spread.

Similar cases followed in the February 2003 outbreak in the Republic of Congo and in the May 2004 outbreak in South Sudan, though in Sudan the WHO South

Sudan Early Warning and Response Network, in junction with other local organizations and international organizations including UNICEF, formed a crisis committee to establish a follow-up procedure with the patients. This South Sudan outbreak was the fifth Ebola incident, and was marked a success due to the rapid and concentrated social mobilization effort to inform the citizens and family members of patients on how to protect themselves and the community. Usage of low fenced isolation wards provided an efficient method of both protecting the community and reassuring family members by granting them visibility of their loved ones. From this incident in the Yambio Hospital authorities gained insight into the importance of rapid action, local cooperation and involvement, and active socialization with the native culture and community.

The outbreaks following the 2004 South Sudan incident all focused on educating the native community about Ebola and measures of protection. In the May 2005 Republic of Congo incident, the WHO, Médecins Sans Frontières-Holland, and Ministry of Health all worked together to spread awareness among the public, as well as following up on patients. In the December 2007 Uganda outbreak isolation wards and other control measures, such as clean burials, social support, radio broadcasts, distributed flyers, posters and mobilized vans were all used to effectively educate and stabilize the local community to stop the further spread of Ebola. In the 2009 Democratic Republic of Congo outbreak, once again, social mobilization and other efforts to educate the public remained a crucial method of stopping the transmission of disease. In the 2012 Uganda outbreak, isolation facilities, and social mobilization teams were sent with Information, Education, and Communication (IEC) materials designed to increase public awareness of Ebola and how to prevent its spread.

Current Outbreak

The first outbreak began in March of 2014 in the West Africa region and has continued to spread from Guinea to Sierra Leone, Liberia, Nigeria, and Senegal. The three countries most severely impacted are Guinea, Sierra Leone, and Liberia. Currently, they are still fighting the spread of Ebola as all three countries lack a stable and strong government structure that would be able to respond in crisis.

Regarding the Ebola outbreak in West Africa, since August 6, 2014, when the first meeting of the Emergency Committee convened, the infection has been deemed a public risk to other states, and State Parties are taking measures to control the current outbreak response. In unanimity, the Committee has deemed that all conditions for a Public Health Emergency of International Concern have been fulfilled. With over 1000 reported cases, this outbreak is the largest ever recorded, and only exacerbated by the weak health systems in the largely affected countries and weak infrastructure ill equipped to handle the outbreak, control, and surveillance and containment of the area. With a region vulnerable to high travel frequency and denser populations, there is a higher rate of transmission than before. Generally ill equipped facilities have caused a lot of health-care workers to become patients themselves, and international bodies are looking to control the situation as treatments are being sought out.

As of October 22, 2014, cases have only increased to 9,936, with the situation remaining the worse in Guinea, Liberia, and Sierra Leone. In comparison to the outbreaks in Nigeria and Senegal, which were both managed with stronger leadership and more planning, Guinea, Liberia, and Sierra Leone continued to

as well.



Case Study: Senegal



Senegal's first official case began on August 29th when a young man had direct contact with an Ebola patient. Following this, the government of Senegal and WHO followed through with procedures of a public health emergency. In light of the epidemic in neighboring countries, Senegal has been maintaining active case finding in double the maximum incubation period for Ebola in order to track down any possible cases.

The success of Senegal, as stated by the WHO, depended on planning, in regards to strengthening surveillance to fortify a country vulnerable to imported cases due to its location within the African region; speed, in regards to mobilizing resources, support services, and educating the public about the infection; and leadership, both from within the Senegal government and from international groups like WHO, in regards to allocating and effectively using resources. Two other key points about Senegal's plan was to instate a nation-wide case tracking and public health emergency code despite only one small imported case, as well as creating a National Crisis Committee which could serve as the functional meeting point to mobilize action.

Questions to Consider:

- Increased travel and transportation methods indicate industrialization, improved infrastructure and higher economic health for a country, but at what cost to the containment of future outbreaks?
- How will the network of countries currently focused on creating vaccines work together to deliver vaccines to the areas of outbreaks?
- Who has precedence over delivery and how do the affected nations work together to distribute resources amongst themselves?
- What is your country's current stance on providing aid to affected nations and where is your country's stance headed in the future?
- What technological advancements could supporting countries provide in an effort to aid control of Ebola transmission? What are the possible consequences and benefits?
- What policy in regards to social mobilization will better help educate the public effectively, and at what social and political cost?

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