GENERAL ASSEMBLY

PACMUN 2019

DIRECTOR

Jasmine Yang

CHAIR

Jieyan Wang

AD

Autumn Rhee

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DIRECTOR'S LETTER

Dear Delegates,

Welcome to Pacific Model United Nations 2019 and the General Assembly (GA). My name is Jasmine Yang, I am currently a junior as part of the Cambridge program at Juanita High School, and I will be serving as your Director this year. Joining me on the dais this year is my Chair, Jieyan Wang, a senior attending Moscow High School, and my Assistant Director Autumn Rhee, currently a junior at the International Community School.

The GA is one of the six main organs of the United Nations and the only committee where every member state is represented and holds equal power. The GA is the main policy-making body of the UN dealing with a multitude of issues and duties. This year, as a dais, we have selected Global Accessibility to Healthcare and Addressing Criminal Rights as the topics for the conference. These two topics are highly relevant to society today are key indicators of the development and status of a nation.

Access to adequate healthcare is a pressing issue affecting every person but has yet to be comprehensively addressed. In less developed countries, it's less of a priority and NGOs typically lead the charge in providing it. In more developed countries, the biggest debate is whether healthcare should be privatized and costly or free. Access to healthcare is integral in improving the quality of life as well as saving it and as such needs to be tackled.

Every country in the world, has in some essence, a criminal justice system. Though some are more developed and reliable while others are rooted in aged beliefs, one commonality is that the rights of these criminals are neglected as they are no longer viewed as people. However, they are still citizens and as such, it is imperative that solutions are presented to ensure that they are never stripped of their rights.

Detailed information is available to delegates in this guide which will aid and direct their research in order to engage in ardent and productive debate that will lead to collaborative efforts on potential resolutions.

Feel free to contact us via email, at ga@pacificmun.com, at any time if you have any questions or concerns. I am excited for this year's conference and look forward to committee with all of you.

Sincerely,

Jasmine Yang
Director | General Assembly
Pacific Model United Nations 2019

COMMITTEE OVERVIEW

Welcome to the General Assembly (GA) at PACMUN 2019! The GA is the primary deliberative, representative, and policy making body of the UN where all 193 member states have a voice, equal power, and may vote. Every year, a new president of the GA is elected at the start of the September to December session. The president presides over the general debate, a weeklong forum for all representatives and world leaders to speak and bring up issues. All other work is delegated to its subsidiary organs: DISEC, ECOFIN, SOCHUM, SPECPOL, the Fifth Committee, and the Sixth Committee.

All actions and work of the GA must be in accordance with Charter IV of the UN. As outlined in the Charter, the Assembly may approve the UN budget, elect non-permanent members of the UN Security Council, and appoint the Secretary General, among other things. Simply stated, the mandate of the GA is “promoting international co-operation in the economic, social, cultural, educational, and health fields, and assisting in the realization of human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion”.

The GA receives its funding from three main sources, the International Monetary Fund (IMF), the World Bank, and mandatory payments from member states. The IMF and the World Bank are both institutions of the UN system with complementary goals. The IMF provides short and medium-term loans to member countries through bond issuances. The World Bank provides long-term economic help via technical and financial support. In addition to the IMF and World Bank, all member states of the UN must make mandatory payments each year, which vary based on their socioeconomic status that also help fund the GA and UN as a whole.

It is important for delegates to note, that while the GA is the main deliberative and policy making body of the UN, it can only discuss issues and make recommendations. The GA does not possess the power to enforce its resolutions or compel its member states to adhere to them. Moreover, the GA does not have the capacity to call upon other UN committees to take actions and can only, once again,

make recommendations. Despite these limitations, the GA is still the central and largest body of the UN where majority of the policies are made.

At this year's conference, delegates will represent a member state of the UN and will communicate and collaborate with other delegates to come up with resolutions for our topics of criminal rights and global accessibility to healthcare. Majority of the debate will be focused on the aforementioned topics, but delegates must also come prepared with knowledge on the economic capabilities, policies, political structure, and cultural attitudes held by their assigned countries in order to have a productive and sensitive discussion on the topics at hand. Additionally, delegates should be properly informed on current and past GA actions regarding the topics, rules of procedure, and the jurisdiction and abilities of the GA.

In preparation for the conference, each delegate must submit a position paper per topic if they wish eligible for awards. Each position paper will be one page in length and should address the background of the issue while considering past UN and country actions, its relevance to the GA and global community, the significance in the delegate's assigned country, and possible solutions. At the end of the position paper, delegates should include a bibliography of the sources they have used.

Position papers should be turned in to the committee email address, ga@pacificmun.com, no later than the time listed on the website, unless an extension has been granted by the dais.

TOPIC A

Global Accessibility to Healthcare

TOPIC INTRODUCTION

Over the course of the 21st century, there has been a general positive trend in the accessibility of healthcare across the globe. More and more people can obtain key health services, such as immunization and HIV treatment, than ever before. However, global accessibility to healthcare is still far from satisfactory. Over 50% of the world's population cannot obtain essential services. Additionally, each year, a large number of households are pushed into poverty due to healthcare costs. A complex and widespread issue, this problem requires the comprehensive consideration of a host of factors, including nations' incomes, government policy, and the growing concern for sustainable development, among others.

Furthermore, progress in global healthcare has been uneven and largely inconsistent. Low- and middle-income countries (LMICs) are the most affected by lack of access to healthcare; although LMICs account for 90% of the global burden for disease, they only account for 12% of global spending on health. In LMICs, the most prominent cause of this deficiency in health care is typically the lack of funds, sufficient infrastructure, and political support for health care programs. Even in higher income countries (HICs), where health service availability is often abundant, a growing number of people spend at least 10% of their household budgets on out-of-pocket health expenses. For HICs, the absence of political support and efficient structures for health care programs is the most common root cause for this upward trend in health care expenses. As such, lack of accessibility to health care not only threatens the quality of life worldwide, but it also threatens to create massive inequality between higher income and lower income nations. So, it is imperative that UN bodies such as the General Assembly (GA) come together to address this issue. With its resources and diversity of voices, the GA can work to resolve this inequality and address challenges with preexisting healthcare infrastructure, accessibility, and funding across the globe.

HISTORY

Although health has always been a fundamental component of human life, several movements during the 18th, 19th, and early 20th centuries first raised global awareness of healthcare in the form of disease eradication. Perhaps most directly, the trends of urbanization, industrialization, and increased global trade led to challenges in urban sanitation and disease spread. As a result, a series of pandemics swept through the world, including three cholera plagues and one bubonic plague that resulted in over 12 million deaths. This, combined with the development of a better understanding of biology and epidemiology, motivated the development of the first large-scale domestic eradication and control programs such as the discovery of the smallpox vaccine in 1796. This vaccine eventually enabled the systematic reduction of smallpox in the United States, Britain, and northern Europe. However, due to a lack of financial resources and socioeconomic instability, developing countries had neither the capacity nor the proper knowledge to synthesize and distribute a smallpox vaccine. This was most evident in India and Africa, which suffered approximately 60% of all smallpox cases worldwide. As such, even in the early disease eradication stages of healthcare, inequality between nations was prominent.

Eventually, these eradication efforts evolved into international efforts. By the time World War II began, preliminary global health conferences had already formed, including the International Sanitary Conferences and the League of Nations Health Committee. Simultaneously, private organizations relating to health began to rise. The most salient of these was the International Committee of the Red Cross (ICRC). The ICRC was one of the first organizations to focus on health as a humanitarian issue aimed at protecting human life, not just disease eradication. This foreshadowed the principles that the United Nations would adopt in the second half of the 20th century.

Following the end of World War II in 1945, there was a huge push for global health initiatives using the newly formed UN. Through the United Nations Children's

Fund (UNICEF), the United Nations Relief and Rehabilitation Administration (UNRRA), and the World Health Organization (WHO), the UN implemented programs that provided loans, disease prevention programs, and health education. Domestically, many of the developed countries began bolstering their own health programs with new regulatory agencies, especially in Europe; it is in this time period that many European countries' high spending in healthcare originate from. Lower income countries, however, continued to suffer from insufficient access to healthcare and only accounted for 6% of worldwide health spending.

Moreover, in more developed nations, healthcare bundled with health insurance transitioned into a trillion-dollar industry. Prices of insurance, medical treatments, and medication skyrocket, leaving many with crippling amounts of debt. Recently, many developed countries have begun to shift from privatized health care to free healthcare, regulated by the government, in an attempt to provide all citizens with easy access to cheap healthcare.

Although the focus of healthcare had already begun to change from disease treatment and eradication to a more humanitarian sentiment aimed at improving the quality of life globally, the complete eradication of smallpox in 1979 and the immense reduction of cases of polio and measles allowed for a sharp shift to the latter view. Consequently, this shift was accompanied by the rise of nongovernmental organizations (NGOs) that strove to reduce inequalities in healthcare across nations. Throughout the 20th and 21st centuries, NGOs proved to be effective in their mission. For example, Sudan has been working with Doctors Without Borders (MSF) since 1979 to lower its malnutrition rates, an effort that is estimated to have saved over 30,000 lives. As evidenced by the efforts of both NGOs and the UN, the viewpoint of health as a human rights issue encompassing all aspects of care from infectious disease treatment to maternal-infant care still holds today, and inequality in access to healthcare has become a forefront issue.

PAST UN ACTION

Improving access to healthcare has long been a major goal of the General Assembly and other UN bodies such as the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). Perhaps most saliently, the establishment of the Millennium Development Goals (MDGs) at the 2000 UN Millennium has largely set the tone for the UN's attitude towards healthcare. With four of the eight MDGs directly pertaining to health, the UN has expressed a great and urgent need for international action to improve healthcare worldwide. These four MDGs also outline the forms of healthcare that the UN currently prioritizes: disease prevention, maternal health, hunger reduction, and child mortality reduction. Following the MDGs, in 2015, the GA passed the Sustainable Development Goals (SDGs). In addition to the four forms of healthcare mentioned in the MDGs, the SDGs state clean water, sanitation, and general well-being as crucial factors in improving global health. Hence, both the MDGs and the SDGs have been instrumental in shaping modern-day UN Action towards healthcare.

A few years before the creation of the SDGs, the GA passed resolution A/67/81 in 2012. Supported with a unanimous vote, the resolution urges all of the GA's member states to accelerate progress towards universal health coverage as an essential priority for international development. In the same vein of thought, the resolution also emphasizes the need for access to affordable, quality health-care services worldwide. It reaffirms health as a humanitarian issue and stresses the importance of taking a comprehensive, multi-sectoral approach to reduce inequalities in healthcare and enable sustainable development.

To continually raise awareness of the need to improve global health, the GA has proclaimed numerous UN observances relating to health. These include: World Health Day, World Water Day, World Autism Awareness Day, World No-Tobacco Day, International Day against Drug Abuse and Illicit Trafficking, World Mental Health Day, World Diabetes Day, and World AIDs Day. Each of these observance days aim to reach out to the public and policy makers through social media campaigns and events such as the Solidarity Chain, which asks people to join hands to show support for universal health coverage.

The two most recent GA resolution focusing on healthcare are A/73/131 and A/73/132, which were both passed in December 2018. Resolution A/73/131 calls for a special, one-day meeting on universal health coverage that will be hosted by the GA in September 2019. A/73/132, on the other hand, focuses on improving nutritional access and living standards around the world as a key component in the development of healthcare. While they are different in size and scope, both resolutions reflect the UN's current comprehensive goal of promoting general wellbeing among the world's populace, not just providing access to medical services. Although the GA resolutions in the past decades have not directly launched any programs aimed at increasing accessibility to healthcare, they have been influential in guiding the efforts of other UN bodies. This is particularly true in the case of the World Health Organization. In response to the passage of the MDGs, WHO and UNDP started in 2010 the first global project centered around the adoption of healthcare in the face of climate change. Still running today, this project works with the health ministries of Barbados, Bhutan, China, Fiji, Kenya, Jordan, and Uzbekistan to lower health risks associated with climate change in these countries. For example, in Jordan, the project has helped establish a safe wastewater reuse system in response to growing water scarcity. Following the project's success, WHO created several other related projects, including Water, Sanitation, Hygiene (WASH) and the Global Framework for Climate Services (GFCS), both of which help developing countries fight health risks imposed by climate change. Over the course of the years, WASH and GFCS have aided five low-income countries in developing clear frameworks to reduce the spread of climate-related diseases. Through extensive and dedicated efforts such as these, the UN is able to greatly improve the living standards of the world's population and move one step closer towards fulfilling the MDGs and the SDGs.

CURRENT SITUATION

Since the 20th century, global accessibility to healthcare has been steadily improving worldwide. However, insufficient access to healthcare remains an issue in many developing countries across the globe. For example, the countries of Bangladesh, Ethiopia, Cambodia, Democratic Republic of the Congo, and Nigeria have all scored below 3.0 on the Global Access to Healthcare Index, where a score of 7.5 is considered to be "adequate". This indicates that these countries not only suffer from a lack of availability in health services, but also great inequity in access to those services. When measuring equity, several factors are considered, including availability of health services across different regions and income levels within a nation. Hence, currently, one of the greatest challenges in global health is ensuring that every citizen of each nation has equal access to quality healthcare.

Often times, the cause behind inadequate accessibility to healthcare in developing nations is the absence of proper infrastructure to provide health services. In order to ensure equal healthcare access, a nation needs to have a sufficient amount of hospitals, medication, trained clinical workers, and medical equipment. At the same time, nations must also create policies that guarantee access to healthcare for its citizens in order to make access more equal. Unfortunately, right now, the majority of Low- and Middle-Income Countries (LMICs) still struggle to meet these guidelines.

Frequently, the primary reason of developing countries' difficulty in making healthcare more available is simply the lack of financial resources to do so. For some LMICs, there is also an added issue of weak political support for increasing funding for public healthcare. For example, even though WHO recommends that all nations spend at least 5% of their GDP on healthcare, the countries of India, Pakistan, and Nigeria consistently spend less than 1% on it. As a result, funding, infrastructure, policies, and political support have all been long-standing obstacles for developing countries aiming to improve healthcare accessibility.

Unsurprisingly, high-income countries score the highest when it comes to both access to healthcare and healthcare quality. Even so, their healthcare systems

are not flawless, and developed countries still deal with issues regarding accessibility. One of these problems is the amount of time a sick patient must wait before they can see a doctor. For example, even though Sweden's law stipulates that patients should wait no more than 90 days to undergo surgery or see a specialist, approximately one-third of Sweden's patients end up waiting longer than that. Long wait times such as these can be costly to a patient's health as they must endure long periods of time without receiving care. Additionally, for some nations like the U.S. and Canada, affordability in healthcare has been a consistent issue. For instance, in Canada, around 11% of the population is not adequately covered by a private or public insurance plan for prescription drugs. In the U.S., a recent study found that 25% of privately insured American adults have unaffordable healthcare costs, which include premiums, deductibles, and co-payments. So, affordability and waiting times remain two prevalent obstacles in improving access to healthcare in developed countries.

Although developing and developed nations face unique challenges in healthcare, they are interconnected with one another; as a developing nation continues to grow its healthcare system, it will have to face the issues that the developed nations are facing right now. Consequently, it is crucial that the GA take into account all aspects of healthcare when devising a resolution to increase accessibility. To this day, the UN has maintained all of the goals relating to healthcare in the MDGs and the SDGs, both of which state that progress in global health can be accelerated greatly over the next few decades. This is supported by a recent study that projects that the global expenditure in healthcare to rise to $18 trillion by 2040, with the current expenditure being approximately $8 trillion. For these goals to be achieved, the UN must display a firm commitment to this issue as well as a willingness to revolutionize and reestablish current institutions working in health worldwide.

CASE STUDIES

CASE STUDY 1: UNITED STATES

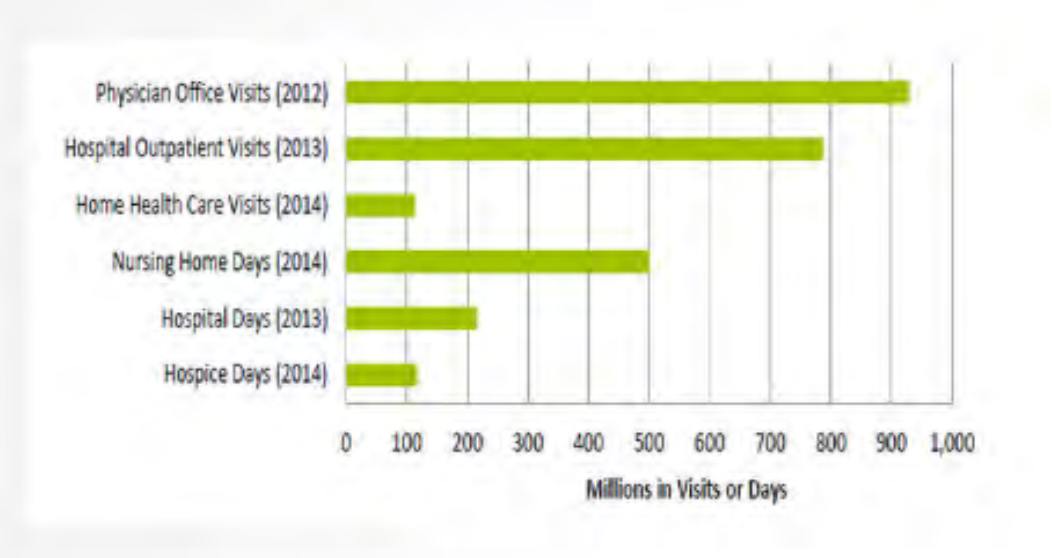
As the world's third most populous country, with over 327 million people, the United States has the world's largest economy by nominal GDP and second-largest economy in terms of purchasing power parity (PPP). While the manufacturing sector of the United States is the second largest in the world, the economy of the United States can be described as post-industrial, meaning its dominated by services and knowledge-based activities. The United States holds 31% of the total wealth in the world, despite its population being 4.3% of the world. Despite large disparities in income and wealth within its population, the United States continues to rank highly in socioeconomic performance, human development, per capita GDP, and worker productivity.

Due to its open market and capitalist nature, the United States is one of the few developed nations in the world that doesn't have publicly funded universal and basic healthcare for its citizens. Primarily, the United States relies on employers to voluntarily provide health insurance coverage for their employees and dependents. There are government programs such as Medicaid and Medicare, but they are limited to the elderly, the disabled, and the poor. However, even if someone is uninsured, they can still receive health care services at public clinics and hospitals which are financed by shifting the costs to other payers such as the public or private providers who finance them as charity which can be used as a tax deductible.

In the United States, 91.2% of the population has health insurance with 67.2% of that coming from private health insurance coverage and 37.7% from government coverage. Of that, 56% is provided by employers, 19.3% by Medicaid, 17.2 percent by Medicare, 16% from direct purchase coverage, and 4.8% from military coverage. The range and depth of services covered varies based on cost of private health insurance, but the majority of those with private insurance have coverage for inpatient hospital and physician services. The amount of co-payment also varies depending on the insurance policy. Despite the fact that the vast majority of the population has health insurance coverage, 28% or 41 million adults are underinsured. These people are left

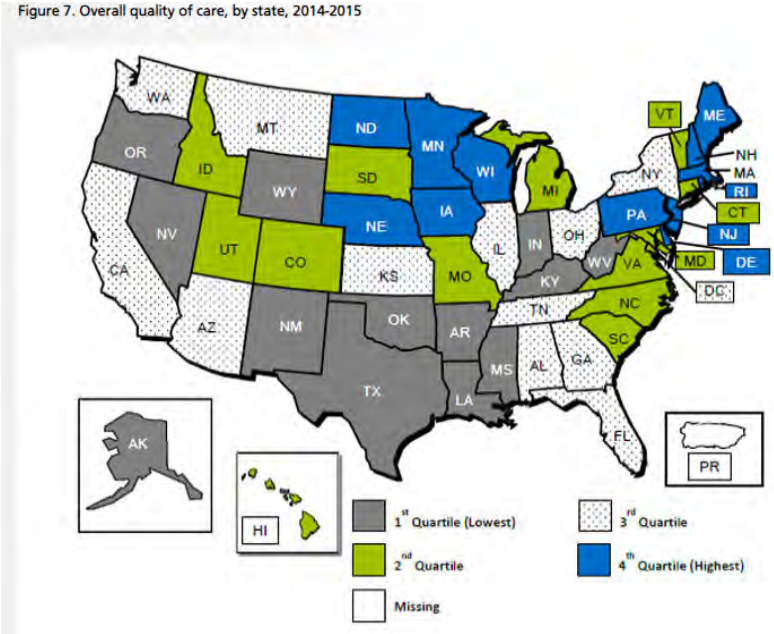
financially vulnerable and are at risk of becoming impoverished in the face of a costly and major illness. A breakdown of the various health care service encounters is as follows:

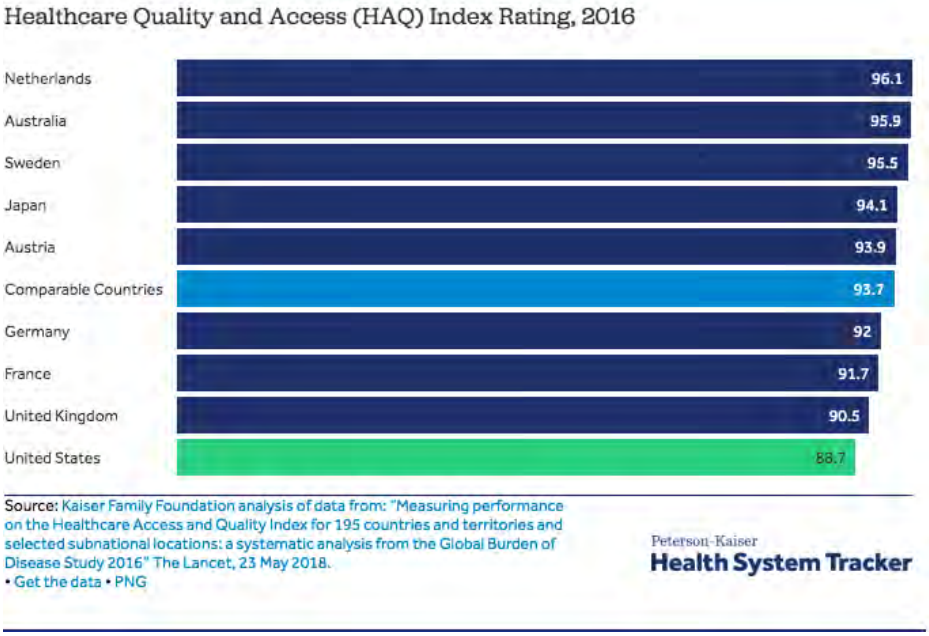
The federal government spends roughly $1.1 trillion on healthcare each year. Majority of that goes to government programs aimed at ensuring all citizens have access to some form of healthcare. Medicare accounted for around $538 billion, Medicaid and the Children's Health Insurance Program (CHIP) made up about $399 billion, and the Veterans Health Administration (VHA) required $70 billion. The remaining $146 billion of that figure was due to the exclusion from taxable income of the employers' contributions to healthcare insurance. In total, U.S. healthcare spending reached $3.5 trillion last year which is roughly $10,739 per person and accounted for 17.9% of the country's GDP.



Virtually everybody in the United States has access to some form of healthcare or health related service. However, the quality of those services vastly differs based on a person's ability to pay. The rich can afford better healthcare coverage which provides them an array of services and treatments while the poor and disabled are often left underinsured or with the minimum. Furthermore, states choose to spend different amounts on healthcare. Some states have far better-quality healthcare than others. In general, however, the U.S. ranks the worst in the

Healthcare Quality and Access (HAQ) Index rating compared to other highly developed nations. In the world, the U.S. only ranks 27th in terms of healthcare.





The next step is guaranteeing that all citizens have access to quality healthcare. However, various economic, cultural, and political reasons hinder such progress. Healthcare companies in the U.S. continues to make profits that far exceed the expectations of Wall Street. As of August 2nd, 85 of the publicly traded

healthcare companies have accumulated $47 billion of global profits and $545 billion of the global revenue in the second quarter of the fiscal year. Given that the private healthcare industry generates so much money every year, many lawmakers are reluctant to switch to publicly funded universal health care or enact policies that would drastically reduce the costs of health insurance. A key reason as to why there isn't quality universal healthcare in the United States is the political culture. The U.S. is a nation with entrepreneurial spirit without a rigid social structure which means Americans are more individualistic. As such, there is a strong belief in classical liberalism which means that the government should play a limited role in society. Universal healthcare is regarded as socialist and as such, clashes with that ideal. Often, those in favor of liberalism will point to the fact that throughout history, socialism has only brought people into poverty, not out of it, and often the large amount of government control leads to authoritarianism. As such, most Americans are reluctant or unwilling to try out a socialist form of healthcare. Economic and cultural reasons aren't the only challenges. Another factor is the role of interest groups which influences the political process. The insurance spent over $100 million to keep private insurers as the main component in American health care and spend $1.2 billion lobbying over the content of the Affordable Care Act (ACA). If the U.S. government would be keen to introduce universal health coverage, which is hard in it of itself to pass through Congress and legislation, then interest groups would surely spend billions more lobbying against it.

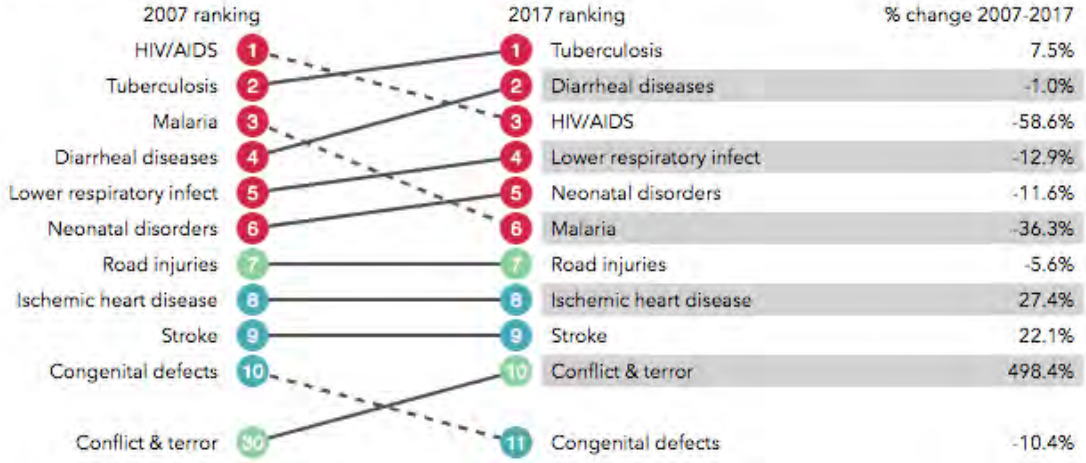
Healthcare is currently at the forefront of the political agenda with 2020 presidential candidates all presenting their own plans to tackle it. Liberals lean towards comprehensive universal health care whereas conservatives prefer to stick to largely private health insurance. The U.S. is a prime example of a country who is successful in guaranteeing there is access to healthcare for all its citizens but has more work to be done because it is undeniable that far too many Americans lack access to quality health care, especially considering that the U.S. is such a developed nation.

CASE STUDY 2: CENTRAL AFRICAN REPUBLIC

The Central African Republic (CAR) is a landlocked nation bordered by Chad in the North, South Sudan in the East, the Democratic Republic of the Congo to the south, and Cameroon in the west. The CAR is one of the world's least-developed countries with a poor transportation system, a largely unskilled workforce, and a string of failed macroeconomic policies. The CAR is ranked 143rd in economic quality, 148th in education, 148th overall on the prosperity index, and 188th out of 189 on the Human Development Index. Despite an abundance of mineral deposits and other resources such as uranium reserves, crude oil, gold, diamonds, cobalt, lumber, and hydropower, the CAR is poorest country in the world and has the lowest GDP per capita and PPP. This is largely due to corruption, violence, human rights violations, and poverty that has been present since it gained independence from France in 1960. This is only exacerbated by the fact that CAR has been embroiled in a civil war that has been ongoing since 2012.

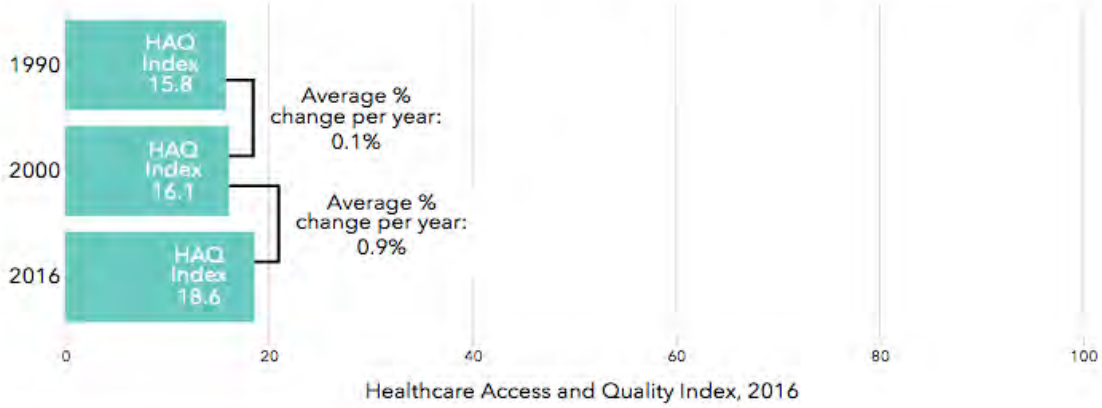
The CAR is considered one of the unhealthiest countries in the world and is ranked by the WHO as 189th out of 190th in terms of health systems. The mortality rate of those under five is 81.5 and the average life expectancy is 55 for females and 49.2 for males. The CAR is also an endemic zone for yellow fever and is plagued with diseases such as tuberculosis, diarrheal diseases, HIV/AIDS, malaria, ischemic heart disease, and various neonatal disorders. Moreover, 2.2 million people are in dire need basic health care, 50% of the population are victims of chronic malnutrition, and the maternal mortality rate is the third highest in the world. On average, only a total of $22 USD is spent on healthcare per person, $11 of which from international assistance, $3 from government health spending, and $8 from out of pocket spending. The Healthcare Access and Quality (HAQ) index gives the CAR a rating of 18.6 out of 100.

What causes the most deaths?



Top 10 causes of death in 2017 and percent change, 2007-2017, all ages, number

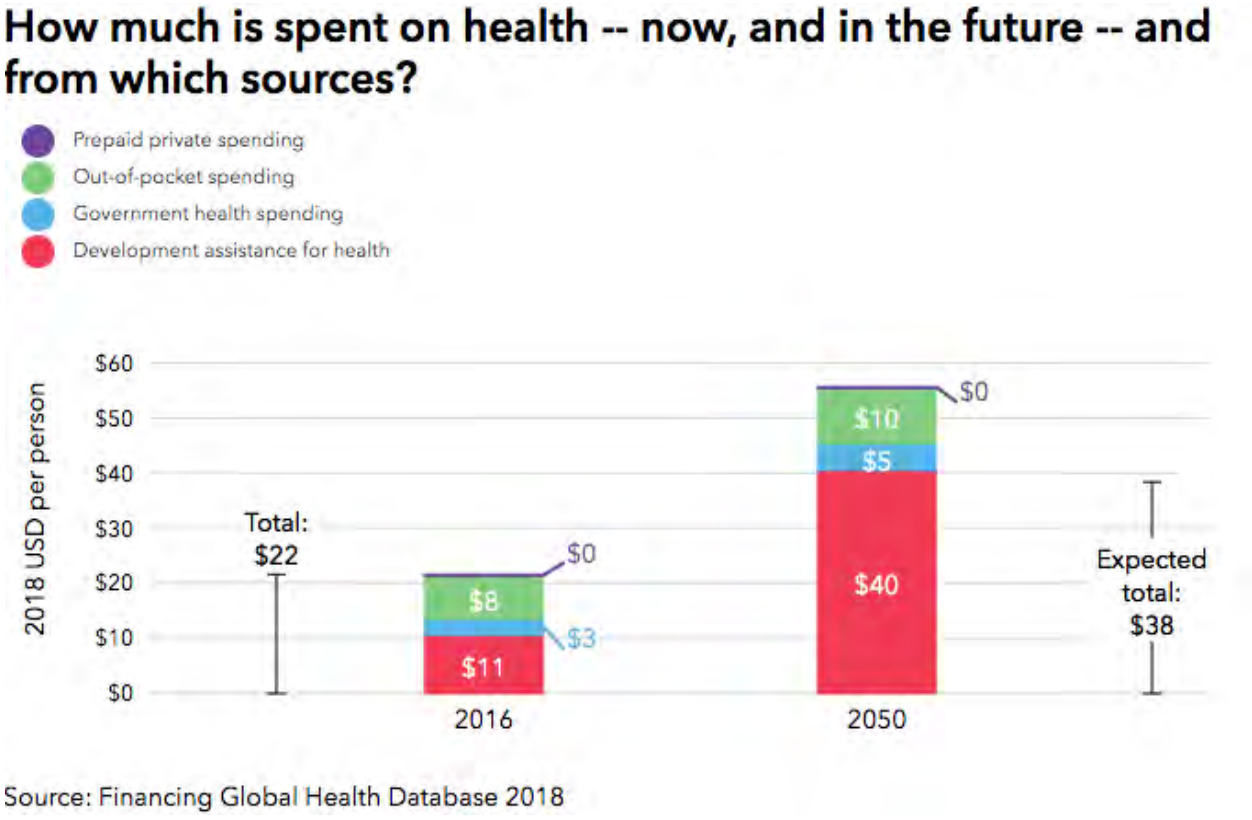
How does personal healthcare access and quality measure up?



Stars indicate the average rate of change was statistically significant for that time period.

Source: bit.ly/HAQ-GBD2016

The Healthcare Access and Quality (HAQ) Index provides a summary measure of healthcare access and quality for a given location. This measure is based on risk-standardized mortality rates or mortality-to-incidence ratios from causes that, in the presence of quality healthcare, should not result in death – also known as amenable mortality.



Source: Financing Global Health Database 2018

No modern health care facilities exist outside of the capital, Bangui, which only has one major hospital itself. 34% of health structures have been damaged or destroyed in the civil war with 18% of those still standing being non-functional. Prior to the civil war that began in 2012, there were numerous hospitals and clinics operated by missionaries, but they have since left the country. For the vast majority of Central Africans, there is little offered to them by the few poorly equipped and insufficiently staffed maternity clinics, dispensaries, and first aid posts in the countryside. Furthermore, the distribution of medicine is highly difficult due to the poor transportation systems in the CAR.

Given that the government is involved in an ongoing civil war with rebel militia groups, it doesn't have much funding or resources to be devoted towards healthcare. However, efforts are being made. In 2018, the CAR partnered with Global Financing Facility to create on plan to "help strengthen the country's capacity to make much greater progress towards universal health coverage; recruit doctors, nurses and professionally trained health workers; and improve access to and the

quality of essential medicines" (globalfinancingfacility.org). As a result of this partnership, it will help the CAR achieve the Sustainable Development Goals (SDGSs) for health by 2030.

Despite an effort by the government, there are still many challenges to providing healthcare for all in the CAR. One of the biggest factors being that the government is laden with corruption where the officials most often embezzle any funds meant for its citizens. Other challenges include the poor and ineffective education system in the CAR which makes it extremely hard to train and educate the large amounts of doctors and nurses needed. Finally, the most obvious reason is the ongoing civil war where 690,000 people have been internally displaced, and 2.5 million people are in need of humanitarian aid.

Currently, most Central Africans receive health services from international organizations such as the UN and various NGOs, like the Red Cross, the Bill and Melinda Gates Foundation, Doctors Without Borders, Medecins Sans Frontieres (MSF), and the International Rescue Committee (IRC). The CAR is an example of the many challenges a developing nation faces regarding access to healthcare and how various political and economic factors play into it. These issues include lack of education, lack of infrastructure, high rates of poverty, political instability, and a weak economy. Therefore, like most developing nations, the CAR requires the assistance of other nations, NGOs, and international organizations to improve its healthcare. However, until the civil war ends, the CAR and its government cannot effectively provide access to healthcare for all its citizens and outside assistance won't have much effect.

BLOC POSITIONS

Developed Countries: **Australia, Belgium, Canada, Denmark, Finland, France, Germany, Israel, Italy, Japan, Netherlands, Poland, Republic of Korea, Sweden, Turkey, United Kingdom, United States**

Countries in this bloc possess an advanced technological infrastructure and a high standard of living. Healthcare is at the forefront of the political agenda for these

countries and as such they spend billions ensuring that their citizens have access to some form of healthcare. However, these countries utilize different systems of healthcare. Some countries have government controlled universal healthcare, some have privatized healthcare, and some a mix of both. All of these systems provide numerous challenges that still need to be addressed because while these countries boast near total accessibility, it isn't always quality or even adequate healthcare. That being said, these countries all have a high capacity to ensure that all their citizens have access to quality healthcare.

Developing Countries: **Afghanistan, Algeria, Bolivia, Brazil, Cameroon, Central African Republic, People's Republic of China, Colombia, Djibouti, Cuba, Democratic Republic of Korea, Egypt, India, Indonesia, Iran, Iraq, Kenya, Libya, Mexico, Nicaragua, Nigeria, Pakistan, Panama, Peru, Philippines, Russian Federation, Saudi Arabia, Somalia, Syria, Thailand, United Arab Emirates, Venezuela, Vietnam**

These countries are less industrially and economically developed and have a lower human development index (HDI). Typically, these countries have a lower standard of living, higher rates of diseases and deaths from diseases, and a large lower class. There is a substantial range in terms of accessibility to healthcare within this bloc, however in all these countries, adequate hospitals and treatment centers are all centered in urban areas. Furthermore, most of the governments in this bloc are unable to provide healthcare for all its citizens due to a lack of funding and they don't have a developed private healthcare sector either. Nations in this bloc predominantly deal with epidemics and preventable diseases that aren't seen in the countries in the other bloc. Furthermore, countries in this bloc are often dealing with challenges such as war, religious barriers, and low education levels. As such, while some countries are more able and equipped than others, these countries have a low capacity when it comes to providing healthcare for all its citizens, in large part due to the difference in medical crises these countries face.

GUIDING QUESTIONS

1. To what extent should the government be responsible or held accountable for access to healthcare? Should private healthcare be incorporated?

2. What should the quality of the healthcare be? Adequate? Advanced?

3. How would total accessibility to healthcare affect the economy? How much exactly would it cost? How do we offset the costs?

4. Should developing countries be held to the same standards as developed nations in terms of how accessible healthcare is?

5. Should healthcare in urban areas be addressed differently than in rural ones?

6. How will we ensure that the systems in place are equipped to handle growing population sizes?

FURTHER RESEARCH

HTTPS://WWW.NCBI.NLM.NIH.GOV/PMC/ARTICLES/PMC509351/

An article about how to achieve the Millenium Development Goals, whose main focus is on health and healthcare

HTTPS://IJ-HEALTHGEOGRAPHICS.BIOMEDCENTRAL.COM/ARTICLES/10.1186/1476-072X-3-3

A basic overview of the issue, potential hindrances and challenges regarding accessibility to healthcare, and how to address them

HTTP://WWW.PNHP.ORG/SINGLE_PAYER_RESOURCES/HEALTH_CARE_SYSTEMS_FOUR_BASIC_MODELS.PHP

Descriptions of the four main systems of healthcare currently being used in the world

HTTPS://SUSTAINABLEDEVELOPMENT.UN.ORG/SDG3
Sustainable Development Goal 3 which addresses universal healthcare

HTTPS://UNFOUNDATION.ORG/WHAT-WE-DO/ISSUES/GLOBAL-HEALTH/
A UN foundation dedicated to bringing medical care to those who can't access it

TOPIC B

Addressing Criminal Rights

TOPIC INTRODUCTION

The general purpose of a prison is to confine those who have convicted a crime, according to their sentence and the degree of their felony. However, many have started to re-examine the prison's purpose, the prisoner's basic rights and the criminals' impacts upon society. Evidence of these controversial discussions are shown in the establishment of The Standard Minimum Rules for the Treatment of Prisoners, adopted in 1957, but recently changed to the Nelson Mandela Rules in 2015 with more specification and amendments. Throughout the duration of the past century, prison reform has become a highly disputed matter and politically divisive.

With overcrowding in jails in over 115 countries as of 2016, local governments have struggled to manage so many people, especially regarding the authority:prisoner ratio, and the country's overall economy. Extreme overcrowding can lead to the rapid spread of disease--prisoners are 5 times more likely to have HIV compared to the general population, and the number of notifications for tuberculosis of prisoners in Europe are 11 to 81 times higher than the general community. Moreover, parole, defined as the temporary or permanent release of a prisoner before the completion of their sentence, has also led to controversial discussions. Some believe that the stiff regulations imposed when on parole limit the criminal's opportunity for improved behavior, while others believe that even offering parole shows enough leniency from the authorities. Finally, another challenge lies when offenders are released. In 2018, studies show that over 27% of former prisoners

are unemployed. Due to the struggle to re-integrate themselves into society, many push for education programs within the prison to combat against this issue, diminishing the risk for recidivism. All these critical aspects of prison reform should be analyzed with an understanding of past events and an understanding of their impact for the future justice system.

Three prominent reasons as to the lack of rights afforded to criminals are economic capacity, cultural beliefs, and social perceptions. There is a direct correlation between the socioeconomic status of a country and the quality of their prisons. Countries who are less developed both industrially and economically tend to have prisons characterized by inhumane conditions and are poorly regulated. . Furthermore, there is more likely to be overcrowding in developing nations due to greater rates of crime and an inability to build and maintain more prisons. The prison and criminal justice system in every country is different, often based on their cultural norms and beliefs. For example, many countries that abide by Sharia law will treat their criminals as dictated by the Quran as opposed to the United States where criminals treatment is based almost entirely off of federal or state law. Lastly, social perceptions and stereotypes play an immense role in the treatment of criminals. Criminals are largely perceived as inferior or second-rate citizens who aren't entitled to basic human rights, evidenced by their depiction in the media and treatment as ex-convicts. This discrimination and judgement against criminals plays a large part as to why the push to guarantee humane conditions, fair treatment, and protection of legal rights is often met with substantial backlash.

HISTORY

Originating from the rise of a justice system, the concept of a prison only came after the thought of using punishment to actually improve the behavior of criminals. Initially, law offenders were given death penalties in early years, later simply being fined for their felonies, but people began to look at the system from a different perspective of retribution versus reformation. The International Covenant on Civil and Political Rights Act adopted by the UN in 1966, elaborates on this topic

by reaffirming the fact that criminals still maintain their basic human rights. By the 16th century, the purpose of a prison was to detain criminals for punishment and rehabilitation reasons, known as a penitentiary. Few regulations and legislation regarding sanitation management led to wide outbreaks of disease, emphasizing the need for prison reform.

Initiating the spark, John Howard's persistence pushed the Parliament to pass the Gaol Act of 1774 which revoked the concept of jailer fees and introduced sanitation proposals. Later, Howard also introduced the Penitentiary Act of 1779, the first piece of legislation advocating for reformation systems over retribution.

Some prison systems that have been utilized involved the "separate system", the "silent system", and the "mark system". First used in 1829, the separate system aimed for seclusion that would result in rehabilitation. Much of Europe had eventually come to adopt this system. By 1850, much of the US had adopted the silent system, which allowed for visible contact among the prisoners during the day but also constant silence. The mark system created by Captain Alexander Maconochie around the 1840s focused on a point system to show consistently good conduct, allowing for the prisoner's release. From these initial systems, advancements and adjustments were made to allow for the variety of methods modern prison systems use today.

Although there has been a recent push towards criminal justice reform, during a similar phase of liberal prison reforms from the 1960s - 70s, the United States experienced an approximate 300% increase in crime rates. This period involved more relaxed parole to show the government's leniency and less supervision. Soon after, more strict regulations were put in place to form the current prison system.

Over the past century, incarceration rates have rose and declined repeatedly due to different prison methods suggested, or large political events that have occurred. One such instance was in England when prison population rates rounded to about 32,000 individuals in 1988 but decreased to about 10,000 after World War I ended in 1918. From then on, the prison population continued to increase exponentially to the point where occupancy levels are now at 463.6% in the Philippines, 312.3% in Uganda, and 232.2% in Peru, just to name a few. Select

countries have managed to diminish their incarceration rates by promoting parole and shortened sentences, such as Finland, dropping their number by about 2/5 of the original prison populations. However, currently many developing countries still struggle with overcrowding and poor conditions due to a lower prison capacity while developed countries disregard the gross mistreatment of inmates and prolific bribing of prison officials. For example, the rise of private prisons is simply one example of the prison officials who exploit their power. They charge prisoners unreasonably high fees to make simple phone calls, while abusing them for essentially free labor. No health benefits, strikes, or unemployment insurances need to be accounted for.

PAST UN ACTION

Over the course of the past few decades, the General Assembly and other associated UN bodies have increasingly addressed the pressing issues of criminal justice around the world, predominantly by creating standards to promote the rights of prisoners. In 1955, the subject of criminal justice was first internationally discussed at the First UN Congress on the Prevention of Crime and the Treatment of Offenders Solutions regarding how to create a more effective prison structure while still using humane practices, sparking the need for more crime congresses. Further crime congresses were held in Vienna and Bangkok in 2000 and 2005 respectively. Matters brought up in these events helped to shape future international standards in relation to prison reform.

For example, the “United Nations Standard Minimum Rules for the Treatment of Prisoners” provide internationally accepted guidance on the critical aspects of a prison system. Some of these elements include prison management, staffing, prison conditions, health services, prison activities, and preparation for release and post-release support. This piece of legislation, also known as the Nelson Mandela Rules, changed the whole perspective of the purpose for a prison. Instead of focusing on punishment of prisoners, the president of South Africa emphasized their proper rights given by the government, shown through this quote: “*It is said that no one*

truly knows a nation until one has been inside its jails. A nation should not be judged by how it treats its highest citizens, but its lowest ones."

The "Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment", adopted by the GA in 1988, defines key imprisonment terms, outlines guidelines to protect the rights of all detained and imprisoned persons, including the following: their right to be informed of charges, right to contact their families, to have immediate access to lawyers, and to be brought promptly before a judicial authority. Due to grey areas that the Nelson Mandela Rules didn't specify, "The Body of Principles" was meant to ensure that no prison official or government official could find a loophole around the given standards.

The "Basic Principles for the Treatment of Prisoners" also centers around 11 principles, discussing respect for different cultures and religions, as well as prisoners' right of access to education, cultural activities, along with employment and health services. Due to high levels of discrimination and social hierarchy in the prison environment, the GA released these 11 principles to address the discriminatory issues ignored by the government.

Finally, adopted by the GA in 1990, the "United Nations Standard Minimum Rules for Non-custodial Measures" (Tokyo Rules) encourage the development and implementation of alternatives to imprisonment and provide guidance on non-custodial measures, including at pre-trial, sentencing and post-sentencing stage. Finally, after recognizing matters within the prison, the UN decided to address problems for inmates after being released and trying to become reintegrated into society.

Especially for countries struggling to establish a well-functioning penal system, these standards can assist them with developing sub-regional or regional strategies. Additionally, they provide guidance to help countries improve their prison systems, so they stay in line with internationally recommended standards.

CURRENT SITUATION

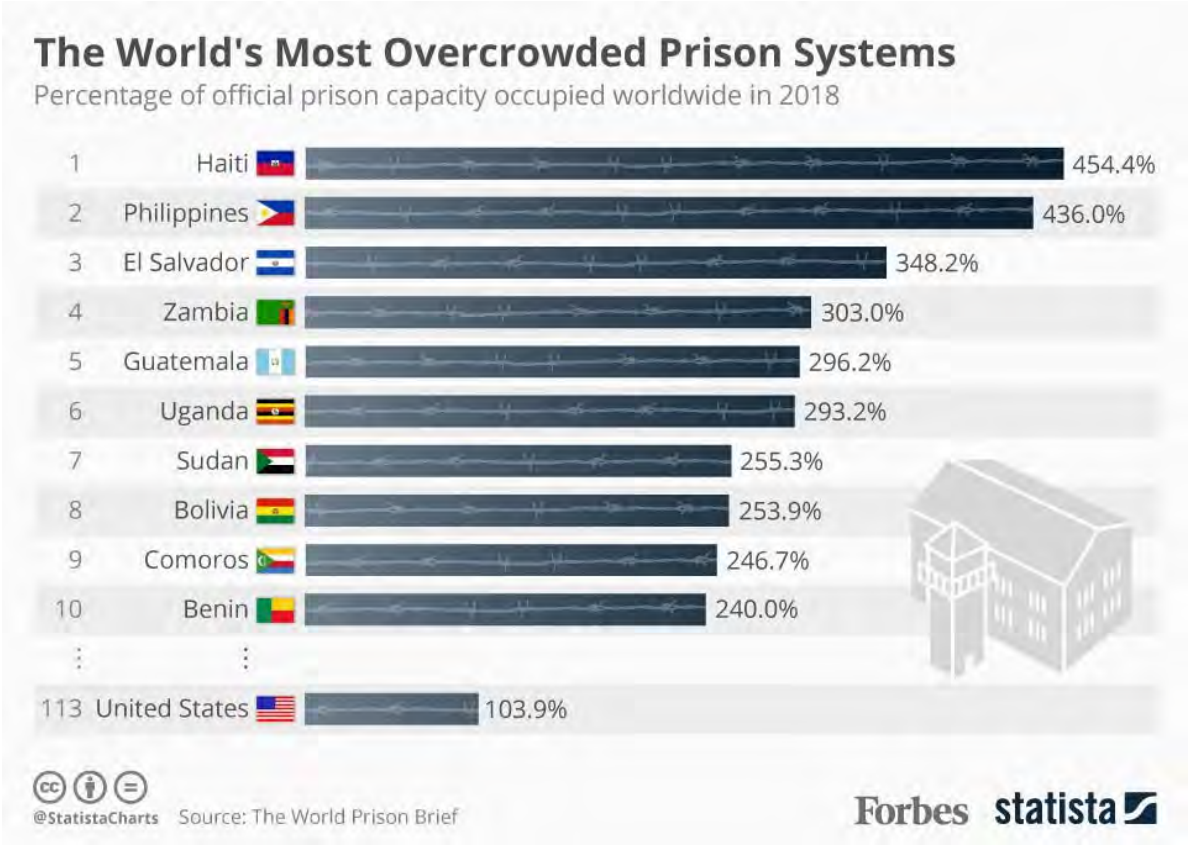
Today, topics of criminal rights are receiving a great deal of attention around the globe due to the easy access to news programs through the internet and television. Situations ranging from shootings to domestic abuse are all given high attention because of the severity of the crime and curiosity about the events' direct impacts as well as how the criminals are brought to justice. In order to ensure internationally consistent legal system guidelines, the United Nations dedicates multiple groups for the purpose of working together towards the goal of a fair society. Some of these groups include the General Assembly, the Legal (Sixth) Committee, the International Law Commission, the International Court of Justice, and the International Criminal Court. In fact, based on the recommendation of the Commission on Crime Prevention & Criminal Justice, another sub UN body, the GA adopted a foundational resolution (70/175), the "United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) (2015)". This resolution focuses on prisoners as individuals, encapsulating racial, sexual, or religious discrimination and primarily helped to bring about awareness of these issues in prison institutions.

Rob Allen, director of the International Centre for Prison Studies in London, estimated that currently, there are an estimated 10 million people in prison, while each year 30 million enter prison establishments. To put those numbers into context, as of 2017, the estimated global population was 7.53 billion people. Each inmate becomes a heavy burden on the government's economy costing an average of $31,000 per year, which accounts for housing, food, and security. With such high concentrations of people in prison buildings, overcrowding has been very common. To clarify, overcrowding where there is not enough room for prisoners results in the inability to provide sufficient food, health care, or constructive activities. There also results a weak staff to prisoner ratio causing uncontrollable violent outbreaks among prisoners who should be kept apart in ideal conditions.

The UN Standard Minimum Rules say that all cells and dormitories must have adequate heating, lighting, and ventilation and that every detainee or prisoner should have his own bed or mattress with clean bedding. This piece of legislation

helps to provide guidelines for countries without much structure, but for some (even developed countries), meeting these standards can be a challenge. Countries have attempted to take measures counteracting these negative impacts but not with much success. In the UK, emergency measures in 2007 released prisoners 18 days early in order to free up space. However, simply releasing prisoners broke legal procedures, arising vocal concerns from the citizens. In France during 2010, violent protests arose due to differing perspectives on how staff should treat criminal detainees. Belgium has needed to rent prison space from the Netherlands. In some of the poorest countries, particularly Africa, overcrowding can lead to suffocation and death. Moreover, if ordinary citizens in developing countries can't afford health services, those in overcrowded incarceration will certainly not be given a chance for a health check-up. Numerous events have confirmed the negative impacts of overcrowding, leading to riots and mutinies, violence and corruption, and damage to the physical and mental health of everyone related.

Aside from overcrowding, discrimination is also very present in the criminal system. Especially without separation of people based on their backgrounds or danger, social hierarchy immediately forms, becoming intensified by racial and socioeconomic differences. Although this shouldn't impact life in the prison very much, with a low number of staff members, it's difficult to put a stop to the discrimination. In addition, depending on country values, some officials don't even attempt to cease this biased unfairness. During late 2018, the World Justice Project Rule of Index surveyed people of each country around the globe to gather data as to how closely they believe their government aims to follow international criminal law policies. Unfortunately, data shows that in 65 of 113 countries, citizens believe that compared to the previous year, their government has shown a weaker adherence to the law regarding criminal rights.



Beyond just the prison system, solutions need to be created to help reintegrate former prisoners into society. Because of the social stigma and permanent impact on their record, many struggle to find employment opportunities. After becoming discouraged or low on money, ex-convicts return to breaking the law once more, falling into an endless cycle that becomes more and more difficult to escape. With so many problems regarding the criminal justice system, many multi-step, comprehensive solutions must be developed.

Although legislation has been created to bring about awareness, concrete action needs to be taken. Regarding overpopulation, alternatives to prison could be suggested, or standards might need to be revised for establishing sentence lengths for prisoners. Additionally, there still needs to be nuanced, thoughtful global discussion on reintegration of released inmates into family life, society, the workforce and more. The complexity and severity of this issue today proves that changes need

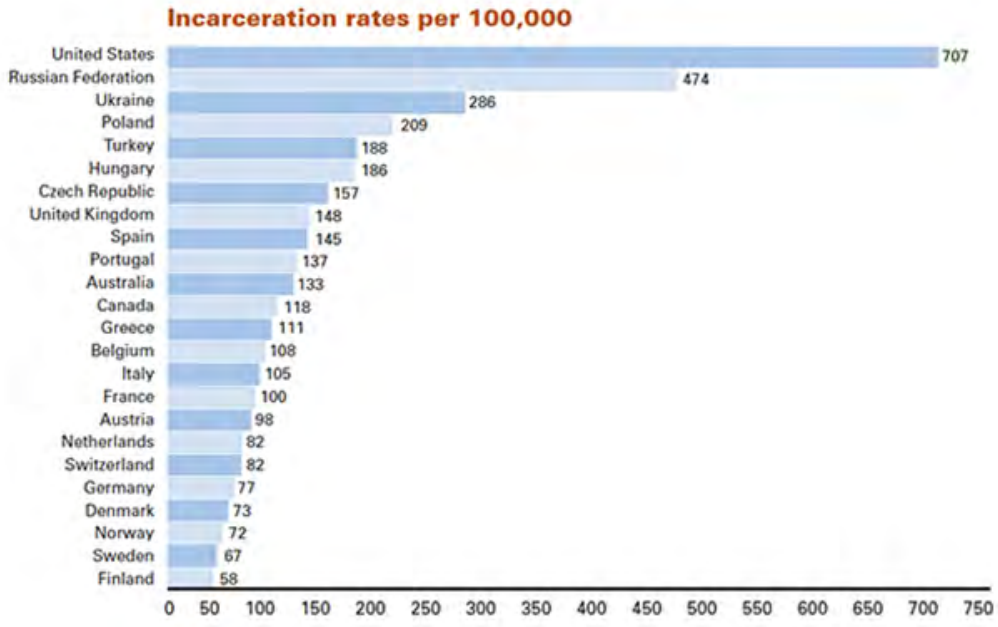
to be made and enforced now to provide a global system that will ensure peace and fairness.

CASE STUDIES

CASE STUDY 1: RUSSIAN FEDERATION

In 1919, under the leadership of Vladimir Lenin, the Soviet Union set up a forced-labor camp system known as the Gulag. From the 1930s to the 1950s, the Gulag system reached its peak under Joseph Stalin's regime and incarcerated a total of 18 million people in overcrowded prisons with meager food rations, poor hygiene, and harsh physical labor. Although the Gulag ended in 1960, it has deeply impacted the modern-day Russian prison system, which primarily consists of penal colonies that combine imprisonment and compulsory work. To this day, much of Russia's penitentiary system displays a resemblance to the repressive nature, poor conditions, and human rights violations of the Gulag.

Over the past five years, most of the amendments to the Russian penal code have toughened penalties. Additionally, although Russia's criminal code officially assumes an "innocent unless proven guilty" mindset, only 0.4% of court rulings result in an acquittal. As a result, Russia's penal colonies suffer from heavy overcrowding, and 375 out of 100,000 people in the Russia Federation are incarcerated, the highest prison population rate of any European country. Consequently, even though the European Convention on Human Rights states that prisons should afford each inmate at least four-square meters of space, Russia's guidelines only require each of its inmates to have 2 square meters of space. The spread of tuberculosis (TB) within penal colonies has been a major issue in Russia due to this consistent overcrowding. Although the rate of TB in Russian penal colonies has been falling, the proportion still sits high at 1,308 cases per 100,000 inmates.



To address the issue of overcrowding, in the past decade, Russia has begun to allow courts to pronounce more non-prison sentences for minor crimes. This policy has managed to help reduce Russia's prison population from 893,000 inmates in 2008 to 559,000 in 2019. However, because this reduction in prison population has also been accompanied by the closure of numerous penal colonies in Russia, overcrowding is still a serious issue. Russia has also attempted to create specialized

TB treatment facilities in its prisons to prevent TB spread. However, these facilities, like Russia's penal colonies, also suffer from overcrowding and cannot sufficiently protect inmates from TB. In both cases, the effectiveness of Russia's policies is hindered by Russia's consistent disproportion in the number of inmates that are sentenced to prison in comparison to the number of prison facilities available.

Physical abuse is also common in Russia's penal colonies. In 2018, the Russian press reported over 100 cases of torture by prison staff and officials in the penal colonies. The Russian Federal Penitentiary Service (FSIM), the agency that administers the prisons, reports that there are around 15 riots per year across the Russian prison system as a result of physical abuse and harsh conditions. Since most of these instances of physical coercion occur in rooms with no video surveillance, the perpetrators are often never held accountable for their actions. Without sufficient consequences for abusers, the cycle of physical abuse in prisons continues to be a persistent issue in Russia.

Russia is an example of how insufficient accountability for prison staff and harsh criminal codes can result in overcrowding in prisons and human rights violations. As Russia still retains many attributes of the Soviet Gulag system, it is also an example of how history impacts modern-day society. Thus, it is crucial that today's nations display a willingness to reform their current institutions in order to improve both efficacy and ethicality of their prison systems.

CASE STUDY 2: FINLAND

Finland, one of the most developed countries in the world, is located beside Norway and Sweden with an estimated population of 5.27 million as of 2013. They're a leading country in areas such as education, boasting a 100% literacy rate in 2008. Although Finland is currently a leading country in levels of happiness, gender equality, and environmental awareness, it only began its route towards decarceration in the 1960s.

Up until 1809, Finland belonged to the Kingdom of Sweden, and as such, their early criminal justice system was based upon the Swedish civil code of 1734, which

promoted severe punishments and the use of capital punishment. After being defeated in the Finnish War, Finland became an autonomous Grand Duchy of Russia. Due to the period of Russian oppression, Finland was only able to initiate its reformative work for the criminal justice system starting from the 1960s.

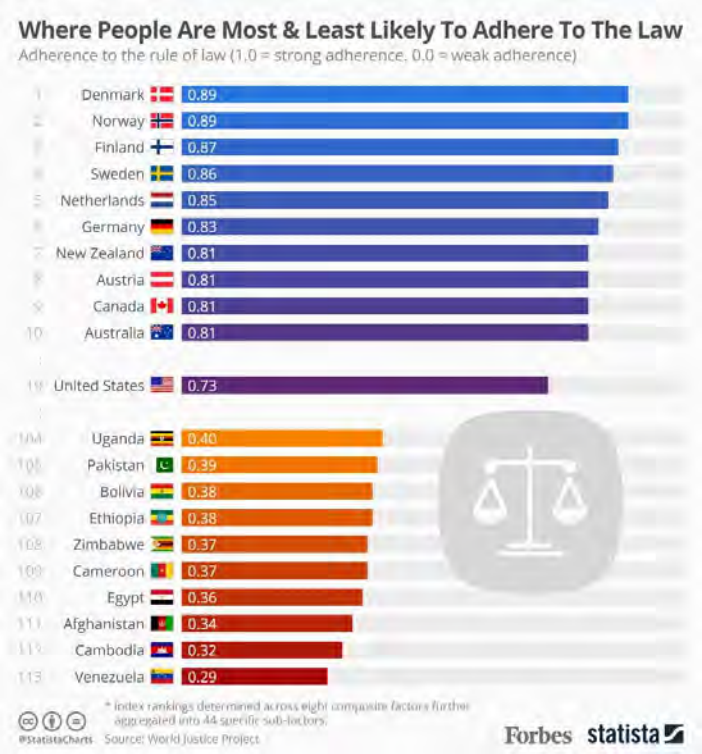
Currently, Finland bases much of its criminal justice system upon the Criminal Code, established in 1894, which provides a set of guidelines regarding criminal rights. Some elements of this code include: the scope of application of criminal law, penalties, the general prerequisite of criminal liability, the grounds for exemption of liability, sentencing, joint punishment, the statute of limitations, crimes against humanity, and so forth. Certainly, with the changing times, amendments have been made by the Ministry of Justice who also works to implement national treaties. According to the written penal code, criminals in Finland today are subject to imprisonment or fines in proportion to their crime, but hard labor is frowned upon because it appears cruel.

In the years between 1970 and 1986, statistics show that offenses known to the police had doubled in rate from 348,859 to 698,762. This corresponds with global rising prison population rates leading to dangers of overpopulation However, from 2006 to 2016, we see the prison population impressively fall from 3778 to 3120. Now what strategies did the country use that others can possibly emulate? One such strategy, radically different from countries such as the US, Finland offers both open and closed institutions.

Open prison locations in Kerava and Suomenlinna are the main reason for Finland's decarceration success. The concept of an open prison first began in the 1930s where it primarily served as an alternative sentencing and labor colony. Gradually, it has been amended to what it is today. Prison cells are made to look much like dorms at a university, and they feature all the necessities as well as pleasurable activities such as a flat screen TV, mini-fridges, and so on. After numerous studies investigating the effectiveness of punishment in relation to crime rates, researchers have found that punishment does not in fact decrease crime. On the other hand, this gradual transition into normal society using the open institution system has dropped incarceration rates by two-thirds and has dropped the reoffending rate by nearly 20%. It also decreases heavy costs for the government by

removing high security implementations and staff. Esa Vesterbacka, head of the country's Criminal Sanctions Agency, says “by eliminating the need for extra security systems and personnel — and by housing people in what are essentially dorms — the cost per prisoner drops almost a third”.

Today, a third of Finland’s prison population serves their time in open prisons. Although some foreign countries may worry about the country’s prison outbreaks, one would be surprised to know that this does not occur often. Why? Because prisoners understand that attempting to escape would only bring them back to jail with less freedom, and they’d struggle to reintegrate themselves into society. Transitioning the whole globe to offer open prisons might obviously be a difficult path, however, Finland serves to represent that radical ideas can be utilized and actually succeed to transform the country for the better.



BLOC POSITIONS

High Income: **Australia, Belgium, Canada, Denmark, Finland, France, Germany, Israel, Italy, Japan, Netherlands, Panama, Poland, Republic of Korea, Saudi Arabia, Sweden, United Arab Emirates, United Kingdom, United States**

The World Bank classifies high income countries as those whose gross national income per capital exceeds $12,376. Countries in this bloc are, for the most part, developed economies who have larger amounts of funding available to be allocated towards their prison systems. As such, given that criminal rights violations often stem from lack of funding and overcrowding, these countries have the greatest capacity to ensure the rights of their criminals are being observed and respected. However, it's important to note that countries in this bloc utilize different prison systems and operate under varying ideals which affects the amount they are willing to spend on prisons and how much they value the rights of their criminals.

Upper Middle Income: **Algeria, Brazil, People's Republic of China, Colombia, Cuba, Iran, Iraq, Libya, Mexico, Peru, Russian Federation, Thailand, Turkey, Venezuela**

Countries in this bloc have a gross national income per capita between $3,956 to $12,235 and are all considered developing economies by the WTO. These countries have enough money to sustain their prison systems, but criminal rights isn't at the forefront of their agendas. These countries allocate most of their funds to building infrastructure and increasing trade in order to help push their countries into the higher income bracket. Countries in this bloc possess the capacity to improve their prisons, though it is more of a challenge.

Lower Middle Income: **Bolivia, Cameroon, Djibouti, Egypt, India, Indonesia, Kenya, Nicaragua, Nigeria, Pakistan, Philippines, Vietnam**

Classified as having a gross national income per capita ranging from $1,026 to $3,955, these countries often have high poverty, unemployment, and crime rates.

Countries in this bloc often only have the bare minimum funding to keep prisons operational and don't have any more to spare. Furthermore, criminal rights isn't of importance to the government or the citizens because there are other pressing issues facing the nation. These countries have a very low capacity to address criminal rights and aren't able to devote significant resources towards it, however it still remains an issue of importance.

Low Income: **Afghanistan, Central African Republic, Democratic Republic of Korea, Somalia, Syria**

These countries are all developing nations with a gross national income per capita of $1,025. These countries suffer from political instability, economic isolation, and immense poverty. Moreover, countries in this bloc are often facing violent conflict or civil war. Given the current situation of countries in this bloc, criminal rights aren't a priority for governments nor does the government have the means to allocate funding to improve their prisons. Furthermore, human rights violations in these countries are often used as a means of war or political control. As such, these countries don't have the capacity or will to address criminal rights at the moment, however ensuring that prison systems work best for their needs is a priority.

GUIDING QUESTIONS

1. What are some of the cultural and political beliefs when it comes to criminal rights and how do those hinder or aid in addressing the issue?

2. What is the extent to which criminals should be afforded rights? Should they get the same amount as a law-abiding citizen? Should some get more than others?

3. Should inhumane or harsh prison conditions be a part of the punishment for committing a crime? If not, what is the ideal prison condition in order for this issue to be resolved?

4. What should be the main goal of a prison?

5. What would be the effects on the economy, society, and standards of living if more funding was dedicated towards prisons and criminal rights?

6. Should a country face punishment if it doesn't respect the rights of its criminals? How so and how would they be held accountable?

FURTHER RESEARCH

HTTPS://WWW.PRISONPOLICY.ORG/RESEARCH/INTERNATIONAL_INCARCERATION_COMPARISONS/

A database that compares prisons and incarceration around the world

HTTPS://WORLDJUSTICEPROJECT.ORG/NEWS/WHAT-DATA-SAYS-ABOUT-CRIMINAL-JUSTICE-SYSTEMS-AROUND-WORLD

An evaluation of the criminal justice systems of numerous countries

HTTPS://WWW.UN.ORG/EN/EVENTS/MANDELADAY/MANDELA_RULES.SHTML

The UN's Nelson Mandela Rules which are basic guidelines to how inmates should be treated

HTTP://RESTORATIVEJUSTICE.ORG/AM-SITE/MEDIA/OVERCROWDING-EN.PDF

Ways to improve and solve the horrible prison conditions that currently exist

HTTPS://WWW.UNODC.ORG/CENTRALASIA/EN/NEWS/DEVELOPING-AN-EFFECTIVE-PRISON-REFORM.HTML

The UNODC's suggestion on how to effectively reform prisons

CITATIONS

Topic A

- https://www.worldbank.org/en/news/press-release/2017/12/13/world-bank-who-half-world-lacks-access-to-essential-health-services-100-million-still-pushed-into-extreme-poverty-because-of-health-expenses
- https://nyaspubs.onlinelibrary.wiley.com/doi/pdf/10.1196/annals.1425.011
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4923068/pdf/fpubh-04-00129.pdf
- http://accesstohealthcare.eiu.com/wp-content/uploads/sites/42/2017/06/Globalaccesstohealthcare-3.pdf
- https://web.archive.org/web/20160418174941/http://s2.medicina.uady.mx/observatorio/docs/ee/ac/EE2014_Ac_Markel.pdf
- http://bioethics.wfu.edu/wp-content/uploads/2015/09/Topic-3-A-Brief-History-of-Global-Health.pdf
- https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)60108-8/fulltext
- https://www.who.int/publications/almaata_declaration_en.pdf
- http://www.undp.org/content/undp/en/home/sustainable-development-goals.html
- https://www.cbc.ca/news/technology/cholera-s-seven-pandemics-1.758504
- https://www.icrc.org/en
- https://www.doctorswithoutborders.org/who-we-are/history
- https://ourworldindata.org/smallpox
- https://news.un.org/en/story/2018/12/1028331
- https://www.who.int/universal_health_coverage/un_resolution/en/
- https://www.un.org/en/sections/issues-depth/health/
- https://www.unicef.org/health/index_action.html
- https://www.un.org/millenniumgoals/
- https://sustainabledevelopment.un.org/sdgs
- https://www.un.org/en/ga/73/resolutions.shtml
- https://research.un.org/en/docs/ga/resolutions
- http://accesstohealthcare.eiu.com/wp-content/uploads/sites/42/2017/06/Globalaccesstohealthcare-3.pdf
- http://accesstohealthcare.eiu.com/region/north-america/
- http://accesstohealthcare.eiu.com/region/europe/
- https://www.who.int/globalchange/projects/en/
- http://worldpopulationreview.com/countries/developed-countries/

- http://worldpopulationreview.com/countries/developing-countries/
- https://www.businessinsider.com/us-ranks-27th-for-healthcare-and-education-2018-9
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193322/
- https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/
- https://www.ahrq.gov/research/findings/nhqrdr/nhqdr16/overview.html
- https://www.census.gov/library/publications/2018/demo/p60-264.html
- https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html
- https://www.usatoday.com/story/money/personalfinance/budget-and-spending/2017/11/23/guess-how-many-adults-are-underinsured/107709988/
- https://www.taxpolicycenter.org/briefing-book/how-much-does-federal-government-spend-health-care
- https://www.axios.com/health-care-industry-on-track-massive-q2-profits-1533226387-dacec8f8-c9f5-406c-a49e-1103e3316c64.html
- https://theconversation.com/three-reasons-the-us-doesnt-have-universal-health-coverage-67292
- http://worldpopulationreview.com/countries/central-african-republic-population/
- https://www.prosperity.com/globe/central-african-republic
- http://thepatientfactor.com/canadian-health-care-information/world-health-organizations-ranking-of-the-worlds-health-systems/
- http://www.healthdata.org/central-african-republic
- https://www.britannica.com/place/Central-African-Republic/Health-and-welfare
- https://www.euronews.com/2018/02/22/the-battle-to-provide-healthcare-in-car
- https://www.ifrc.org/en/news-and-media/news-stories/africa/central-african-republic/access-to-medical-care-in-central-african-republic-a-major-challenge-for-the-internally-displaced-65689/

Topic B

- https://www.criminaljusticedegreeschools.com/criminal-justice-resources/criminal-rights-laws-and-protections/
- https://sks.sirs.com/webapp/leading-issue?subtopic=true&keyno=0000020840&type=sub
- https://www.britannica.com/topic/prison

- https://www.crimemuseum.org/crime-library/famous-prisons-incarceration/history-of-imprisonment/
- http://www.prisonstudies.org/highest-to-lowest/occupancy-level?field_region_taxonomy_tid=All
- https://www.newworldencyclopedia.org/entry/John_Howard_(prison_reformer)
- https://www.penalreform.org/priorities/prison-conditions/
- https://cdn.penalreform.org/wp-content/uploads/2019/05/PRI_Rehabilitation-of-women-prisoners_WEB.pdf
- https://borgenproject.org/prison-systems-in-developing-nations/
- https://www.unodc.org/documents/justice-and-prison-reform/UNODC_Prison_reform_concept_note.pdf
- https://www.prisonstudies.org/country/finland
- https://www.pri.org/stories/2015-04-15/finlands-open-prisons-inmates-have-keys
- http://worldpopulationreview.com/countries/high-income-countries/
- https://data.worldbank.org/income-level/upper-middle-income
- https://data.worldbank.org/income-level/lower-middle-income
- https://data.worldbank.org/income-level/low-income
- https://www.apa.org/monitor/2014/10/incarceration
- https://www.e-reading.club/bookreader.php/142054/Kriminologiya.pdf
- https://prisonstudies.org/country/russian-federation
- https://www.osw.waw.pl/en/publikacje/osw-commentary/2019-02-07/russia-behind-bars-peculiarities-russian-prison-system
- https://www.theatlantic.com/international/archive/2012/10/inside-russias-prison-system/263806/
- https://www.bjs.gov/content/pub/pdf/wfbcjsru.pdf
- https://cdn.penalreform.org/wp-content/uploads/2019/05/PRI-Global-prison-trends-report-2019_WEB.pdf
- https://www.unodc.org/unodc/en/justice-and-prison-reform/prison-reform-and-alternatives-to-imprisonment.html