Southern Regional Model United Nations, Atlanta 2013
Beyond 2015: Reshaping the Millennium Development Goals for an Empowered Future Sustainability
November 21-23, 2013 - Atlanta, GA
Email: who_atlanta@srmun.org

Dear Delegates:

It is my pleasure to welcome you to the Southern Regional Model United Nations (SRMUN) Atlanta 2013 Conference. My goal is to bring you a balance of academia and real life application to international issues while maintaining the unique SRMUN learning experience. My name is Daniel Leyva Jr., and it is my pleasure to serve as your Director of the World Health Organization (WHO). I have been involved with Model United Nations for nine years, seven of which have been served as a staff member at collegiate level conferences. I graduated from the University of California, Los Angeles and am currently the Director of Communications for a non-profit organization based in Southern California. Your Assistant Directors for this year are Jessica DeJesus and Alexandra Silver. Jessica graduated from Pace University and works as a paralegal with emphasis on civil litigation. Alexandra is a graduate from Pace University at Westchester and has a decorated MUN history with many awards for being a chair and a delegate. I am thrilled to have such a strong dais with a wealth of experience.

The WHO is the authority in health issues within the United Nations system. The WHO oversees efforts in dealing with natural disasters, public health, and health research (to name a few). The WHO, however, is in a unique position to not only offer research, guidance, and information to the United Nations, but they are also able to work on the ground to help victims during natural disasters or offer immunization to prevent children from killer diseases. The WHO's ability to work directly with people as well as offer coordinate policy puts them in a unique situation where they are able to see how their policies work out in a real world context.

We have chosen the following topics to discuss at this year's conference:

I. Advancement and Implementation of HIV/AIDS Prevention and Treatment Strategies; and
II. Managing Health Crises after Natural Disasters

Each delegation is required to submit a position paper which covers both of the topics mentioned above. The papers should be no longer than two pages, singled spaced, as outlined on the SRMUN website. The purpose of the position paper is to discuss your countries position on the two topics and persuade your fellow delegates to follow the course of action laid out in your paper while in committee. These position papers are incredibly important to your success in committee and should provide insight into your countries position on violence against women and refugee women and girls.

Delegates are encouraged to use the paper as a means of stating what your country hopes to achieve in committee, and outline the best course of action for all Member States. Having a clear position outlined in the paper will serve as the foundation for your success in committee, and should thus portray accurate positions relating to our country. More information about position papers can be found on the SRMUN website (www.srmun.org). **All position papers MUST be submitted by November 1st, 11:59pm EST via the on-line submission system at http://www.srmun.org.**

I look forward to serving as your Director for this conference. I speak for the Assistants when I say that we are all excited to work with you. Model United Nations is a unique opportunity afforded to students that allows them to engage real world issues that affect millions of people around the world. SRMUN offers a quality conference that will satisfy your academic indulgence for international issues. We wish you luck, and thank you for your participation.

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History of the World Health Organization

Prior to the establishment of the United Nations, regional agencies, such as Europe's L'Office International d'Hygiene Publique and America's Pan American Health Organization (PAHO), worked with little or no cohesion to address the issue of disease prevention and control.[1] Upon the dissolution of the League of Nations and with the establishment of the United Nations (UN) in 1945, select Member States recognized the dire need for a single, cohesive, international health organization.[2] The creation of such a world health organization was further discussed at the International Health Conference in 1946 but it was through General Assembly (GA) Resolution 61 on December 14, 1946, when the World Health Organization (WHO) became a specialized agency of the UN.[3] As a specialized agency, the WHO has special rights in the General Assembly as described in the Convention on Privileges and Immunities of Specialized Agencies.[4] The WHO's Constitution came into full force on April 7, 1948, (a date we now celebrate every year as World Health Day), when the required number of at least 26 governments ratified the resolution.[5] The WHO was afforded a budget of $5 million US Dollars and the initial focal points determined at the First World Health Assembly in 1948 consisted of malaria, tuberculosis, venereal diseases, maternal and child health, sanitary engineering and nutrition.[6] Additionally, the WHO's Constitution mandated functions "to promote and conduct research in the field of health."[7]

Membership in WHO is open to any UN Member State that accepts the Constitution and is currently composed of 194 Member States.[8] The organization holds an extensive mandate stemming from its foundational beliefs that health is a state of holistic well-being, not merely the absence of disease, and that "the health of all peoples is fundamental to the attainment of peace and security."[9] To address their mandate, the organization has defined a six point plan for dealing with health issues: promoting development; fostering health security; strengthening health systems; harnessing research, information and evidence to set priorities and define strategies; enhancing partnerships with other UN agencies as well as other international organizations; and improving performance, efficiency, and effectiveness.[10] The six point plan is evidence of the increasing influence international public health has on other sectors such as trade, development and security while at the same time considering the development of new leaders in international health such as non-governmental organizations and multinational corporations.[11] In order to achieve all of these goals, the World Health Assembly (WHA) was established as the governing body of the WHO and is composed of delegations from all Member States of the United Nations.[12] The WHA, which meets each May in Geneva, determines policies of the organization as well as its budget, and, when necessary, elects the Director-General who supervises the budget and approves proposed budget programs.[13] The Governing Council of the WHO is elected by the WHA and its primary function is to "give effect to the decisions and policies of the Health Assembly, to advise it and generally to facilitate its

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[1] Michael McCarthy, "A brief history of the World Health Organization," The Lancet, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(02)11244-X/fulltext (Accessed March 30, 2013).
[2] "History of WHO," World Health Organization, http://www.who.int/about/history/en/ (Accessed March 30, 2013).
[3] A-Res-61(1). *Establishment of The World Health Organization*. United Nations General Assembly. December 14, 1946.
[4] *Agreements with other International Organizations*. World Health Organization. June 30 1949.
[5] *Constitution of the World Health Organization*. International Health Conference. July 22, 1946.
[6] Michael McCarthy, "A brief history of the World Health Organization," The Lancet, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(02)11244-X/fulltext (Accessed March 30, 2013).
[7] *Research and the World Health Organization: a history of the Advisory Committee on Health Research, 1959–1999.* WHO Library Cataloguing-in-Publication Data. 2010 http://whqlibdoc.who.int/publications/2010/9789241564113_eng.pdf
[8] "World Health Organization: Countries," World Health Organization, http://www.who.int/countries/en/
[9] http://www.who.int/about/agenda/en/index.html (Accessed March 30, 2013).
[10] "The WHO Agenda," World Health Organization, http://www.who.int/about/agenda/en/index.html (Accessed March 30, 2013).
[11] Srimathy Vijayan, "A World Health Organization Primer" Medscape General Medicine. (2007), http://www.medscape.com/viewarticle/564948_5 (Accessed March 30, 2013).
[12] "World Health Organization: Governance of WHO," World Health Organization, http://www.who.int/about/governance/en/index.html
[13] "The WHO Agenda," World Health Organization, http://www.who.int/about/agenda/en/index.html (Accessed March 30, 2013).

work," and to determine the agenda for the WHA. The Governing Council is a 34 seat body elected by the WHA and appointments are generally for a term of three years.[14] The Director-General is nominated by the Governing Council and then appointed by the WHA for a term of five years. Currently, Dr Margaret Chan is serving her second term as Director-General and will serve in this role until June 30, 2017.[15]

With its headquarters based in Geneva, the WHO is comprised of six regional and 147 country offices around the world; this extensive infrastructure ensures that the scope of its work can be achieved.[16] Dispersed among the infrastructure are upwards of 8,000 public health experts including but not limited to doctors, epidemiologists, scientists, managers and administrators, the work of which allows WHO to achieve its mandate.[17] The organization places a particular emphasis on partnering with other organizations such as the United Nations Development Program (UNDP), United Nations Population Fund (UNFPA), and the United Nations Children's Fund (UNICEF).[18]

The WHO, like most other UN bodies, drafts decisions in the form of resolutions and votes on them depending on their content. Important Questions of the General Assembly must be passed by two thirds majority of the Members present. Associate members of the WHA and UN members may participate in discussions of the WHA; however they cannot participate in substantial voting; there are two associate members of the WHO.[19] Matters of public health concerns may only be added to the agenda of the WHA after the relevant team from either a regional office or headquarters submits a provisional agenda to the executive board, after which the board will discuss the agenda before the next meeting to determine if it should be considered for further discussion at that meeting.[20] Should the answer be yes, the board then submits it to the delegates for discussion regarding whether further investigation, research, action or a report may be necessary.[21] Agendas, once adopted, will be voted on as resolutions and those resolutions form the working agenda and are consequently reviewed in future meetings.[22]

Being that the WHO is a member-led organization a percentage of its funding comes from its Member States. The WHA approves the budget and separates it into four symbiotic categories: essential health interventions; health systems, policies, and products; determinants of health; and effective support for Member States. From that point it is divided up among the regional offices to best suit the needs of each region as determined by aid needed in each, the more aid needed, the greater proportion of the budget the region receives.[23] Traditionally, Member States contribute approximately 30% of the WHO's budget with the remaining 70% funded through UN partners, civil society, and the private sector.[24] Recently the budget included a six year plan, known as the "medium-term strategic plan 2008-2013" which has been implemented with the goal of focusing on thirteen main objectives that are seen to reflect the emerging health problems Member States have stated as major concerns.[25] They include, but are not limited to, the following: reducing child and maternal mortality by universal access to healthcare; combating chronic non-communicable diseases by eliminating lifestyle choices that engender them, (i.e. Tobacco use, poor diet, and lack of exercise); further implementing the International Health Regulations (2005) of rapid response

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[14] "Governance," World Health Organization, http://www.who.int/governance/en/index.html (Accessed March 30, 2013).
[15] "Election of Director-General 2012," World Health Organization, http://www.who.int/mediacentre/events/governance/dgelection/2012/en/index.html (Accessed March 30, 2013).
[16] Srimathy Vijayan, "A World Health Organization Primer" Medscape General Medicine. (2007), http://www.medscape.com/viewarticle/564948_5 (Accessed March 30, 2013).
[17] Ibid.
[18] Ibid.
[19] Ibid.
[20] Ibid.
[21] Ibid.
[22] Ibid.
[23] "Proposed programme budget 2006 – 2007," World Health Organization, http://www.who.int/gb/ebwha/pdf_files/PPB2006/e%20part%20I (Accessed March 30, 2013).
[24] Ibid.
[25] EBPBAC4/4. *World Health Organization. Programme, Budget and Administration, Committee of the Executive Board. 4th meeting*. *Provisional agenda item 3.2*. World Health Organization. May 11, 2006.

to outbreaks of disease and emergencies; improving health systems; and to improving the WHO's efficiency and partnering capabilities.[26]

The WHO communicates the breadth of its work through its published World Health Report. This publication provides the WHO with a measure of accountability while also serving to develop, promote and maintain international adherence to its mandate. Member States can also use the Report as an informative tool to help them make policy and funding decisions relating to a specific issue.[27] The WHO is recognized as the leading specialized agency to deal with health and participates extensively with conferences ranging from the Group of Eight on health, and High Level Meetings dealing with the Health Millennium Development Goals (MDGs).[28]

[26] *Proposed program budget 2008 – 2009*. World Health Organization. http://www.who.int/gb/ebwha/pdf_files/AMTSP-PPB/a-mtsp_4en
[27] 15MTSP/2008-2013. *Draft Medium-Term Strategic plan 2008–2013*. World Health Organization.
[28] A/RES/63/33. *Foreign Policy and Global Health*. United Nations General Assembly. 27 January 2009.

I: Advancement and Implementation of HIV/AIDS Prevention and Treatment Strategies

"The vision for a new generation free from HIV/AIDS is within our reach. We must work together to enhance our response to HIV and achieve universal access to HIV services for all who need them."[29]

Introduction

One of the world's most significant pandemics to date, the Human Immunodeficiency Virus (HIV) and its more progressive counterpart, Acquired Immunodeficiency Syndrome (AIDS), has extensive humanitarian, social and political ramifications,[30] disregards regional and national borders, affects both the undeveloped and developed world, and, as a result, remains at the forefront of international debate. Simply put, the HIV/AIDS epidemic can no longer be regarded solely as a health issue. Since the first reported clinical evidence in 1981, progress towards reduction and sustenance of the virus has changed dramatically. In its infancy, a positive diagnosis was once considered to be an automatic death sentence, but over the last two decades, with the assistance of research, discovery and introduction of new medicines, ones chance at survival has greatly improved.[31]

Benchmark declarations such as the United Nations Millennium Declaration, established at the General Assembly's Millennium Summit in 2000, has helped to highlight AIDS as a pressing, global issue.[32] More specifically, A/RES/55/2 set forth the goal to halve, halt and reverse the spread of HIV/AIDS by year 2015; this goal ultimately laid the foundation for the creation of what is now known as Millennium Development Goal (MDG) number six.[33] One year later, national targets and timelines to meet this goal were established through the Declaration of Commitment on HIV/AIDS, similarly referred to as "Global Crisis – Global Action."[34] Five years passed before the Political Declaration on HIV/AIDS called for countries to intensify their efforts to eliminate HIV/AIDS. A/RES/60/262 urged member states to seek accountability by requesting countries to submit comprehensive reviews in years 2008 and 2011, with their details of individual progress. [35] As promised by A/RES/60/262, world leaders gathered once again in June 2011 to attend the General Assembly High Level Meeting on AIDS and to determine what progress has been made.[36] The byproduct of this meeting was the 2011 UN Political Declaration on HIV/AIDS which further challenged countries to commit to new, accelerated expectations, more specifically, to ensure that by year 2015, there are "zero new HIV infections, zero discrimination and zero AIDS- related deaths."[37]As of 2011, 186 out of 193 United Nations Member States (the highest response rate for any international health and development mechanism) have participated in reporting their individual progress toward intervention and prevention of the disease.[38]

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[29] *A New Health Sector Agenda for HIV/AIDS.* The World Health Organization. 2011. http://whqlibdoc.who.int/hq/2011/WHO_HIV_11.03_eng.pdf

[30] UN/POP/MORT/2003/12. *The HIV/AIDS Epidemic and its Social and Economic Implications.* Department of Economic and Social Affairs. August 11, 2003.

[31] "HIV/AIDS Research: 30 Years of Progress," Innovation.org, http://www.innovation.org/index.cfm/impactofinnovation/Progress_in_HIV-AIDS_Research (accessed June 11, 2013).

[32] "2000 Millennium Development Goals," Joint United Nations Programme on HIV/AIDS (UNAIDS), http://www.unaids.org/en/AboutUNAIDS/unitednationsdeclarationsandgoals/2000millenniumdevelopmentgoals/ (accessed June 11, 2013).

[33] A/RES/55/2. *United Nations Millennium Declaration*. United Nations General Assembly. September 8, 2000.

[34] A/RES/S-26/2. *Declaration of Commitment on HIV/AIDS.* United Nations General Assembly. August 2, 2001.

[35]A/RES/60/262. *Political Declaration on HIV/AIDS.* General Assembly. June 15, 2006.

[36] "2011 United Nations High-Level Meeting on AIDS," World Health Organization, http://www.who.int/hiv/events/un/en/ (accessed June 12, 2013).

[37] "On World AIDS Day, UN officials say end to epidemic is within reach," UN News Centre, http://www.un.org/apps/news/story.asp?NewsID=40581&Cr=HIV&Cr1=AIDS (accessed June 12, 2013).

[38] *Global AIDS Response Progress Reporting 2013, Construction of Core Indicators for Monitoring the 2011 UN Political Declaration on HIV/AIDS.* Joint United Nations Programmedon HIV/AIDS (UNAIDS). January

It has now been more than thirty years since the inception of the HIV/AIDS virus. With this said, "the response to HIV has become perhaps the most compelling example of the power of international solidarity, evidence-informed action and political commitment." [39] Thus far, "countries are making historic gains toward ending the AIDS epidemic: 700,000 fewer new HIV infections across the world in 2011 than 2001 and a record eight million people were receiving antiretroviral therapy [ARTs]."[40] Since 1995 alone, antiretroviral therapy has saved more than 14 million infected with the disease.[41] Moreover, antiretroviral therapy, amongst other preventative and treatment services for pregnant woman, has been detrimental to the decrease of new HIV infections: causing a 43 percent reduction of new infections within children from year 2003 to 2011.[42]

Although HIV/AIDS related deaths and overall global HIV incidence has declined, and furthermore, despite increased access to antiretroviral therapy, "getting to zero" by year 2015 will require much more effort and greater resources.[43] The epidemic's current status is still fragile and continues to have devastating consequences for virtually every sector of society. The role of civil society has become increasingly important and plays a pivotal role in the elimination of gender inequalities, stigma and discrimination.[44]

Equally problematic is the link between HIV/AIDS, human security and international security. For the first time in 2000, the HIV/AIDS virus was acknowledged by the Security Council through Resolution 1308 as a threat to international peace and security efforts.[45] In summary, "a decade ago, the notion that an epidemic could be a security threat - of concern to superpowers and the United Nations Security Council – was a striking innovation. Today, the integration of human security issues, such as hunger, disease and the environment, into the international security agenda is part of commonplace and mainstream discussing in foreign ministries and international agencies."[46] This point is evident when considering the various populations affected by the disease. HIV/AIDS no longer only pertains to men who have sex with men. Today, those at risk include migrant populations, such as military personnel, recruits, and clients of sex workers, as well as persons who inject drugs or mothers who transmit the disease through childbirth.[47]

2013.http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf

[39] A/657/797.Uniting for universal access: towards zero new HIV infections, zero discrimination and zero AIDS-related deaths, Report of the Secretary General. United Nations General Assembly. March 28, 2011.

[40] "Know your Epidemic," Joint United Nations Programme on HIV/AIDS (UNAIDS),http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/JC2434_WorldAIDSday_ results_ en.pdf (accessed June 20, 2013).

[41] *UNAIDS Report on the Global Aids Epidemic2012*. Joint United Nations Programme on HIV/AIDS (UNAIDS). 2012. http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_with_annexes_en.pdf

[42] *UNAIDS World AIDS Day Report 2012.* Joint United Nations Programme on HIV/AIDS (UNAIDS). 2012. http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/JC2434_WorldAIDSday_results_en.pdf

[43] *The Impact of AIDS.* United Nations Department of Economic and Social Affairs/Population Division. http://www.un.org/esa/population/publications/AIDSimpact/92_CHAP_IX.pdf

[44] *Global AIDS Response Progress Reporting 2013, Construction of Core Indicators for Monitoring the 2011 UN Political Declaration on HIV/AIDS.* Joint United Nations Programme on HIV/AIDS (UNAIDS). January 2013.http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf

[45] SC/6890. Adopting 'Historic' Resolution 1308 On HIV/AIDS, Calls for Pre-deployment Testing, Counseling for Peacekeeping Personnel. Security Council. July 17, 2000.

[46] *A More Secure World: Our Shared Responsibility*. Report of the Secretary-General's High-level Panel on Threats, Challenges and Change. December 2004. http://www.un.org/secureworld/report2.pdf

[47] *Guidelines on surveillance among populations most at risk for HIV*. Joint United Nations Programme on HIV/AIDS (UNAIDS). 2011.http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/20110518_Surveillance_among_ most_at_risk.pdf

In hopes to combat the disease, various declarations have attempted to put forth practical strategies consisting of both preventative methods and treatment plans. Epidemiological measures have proven through surveillance data that factors such as political environment, demographics, socio-economics, knowledge or behavior regarding the virus and access to health care are carefully taken into consideration when developing a national strategy. [48] Amongst the numerous strategies implemented today, careful consideration has been given to a new strategy referred to as the "test and treat" method. More specifically, test and treat strategies emphasize that treatment *is* prevention. This shift in thinking might be innovative but its effectiveness is debatable. "This strategy entails regular HIV testing in the entire population and starting antiretroviral treatment immediately in all who are found to be HIV infected."[49] This method is aligned with the current HIV guidelines set forth by the World Health Organization. Theoretically, this approach assumes that taking antiretrovirals will help reduce transmission of the virus.[50] Opponents of the test and treat method claim that there are multiple pitfalls associated with the plan, one being that some refuse to be tested, meanwhile, others simply do not have the same access to antiretrovirals regardless the method's efficiency.[51]

Despite the various methods of prevention and treatment, the statistics surrounding our current HIV/AIDS dilemma is less debatable. As of 2012, more than 34 million people are living with HIV/AIDS. [52] Overall, more than 25 million people have died from AIDS and it is estimated that 1.7 million deaths occurred in 2011 alone.[53] The failure or success of meeting MDG6 by year 2015 will consequently depend on member nations' ability to forge ahead with substantial progress. Likewise, that same vehemence must be put to use when developing the post-2015 development agenda.

History

Very little certainty is known about the HIV/AIDS virus prior to it first being acknowledged in the United States by the Center for Disease Control and Prevention (CDC) in 1981.[54] There have been, however, a plethora of theories regarding the origin and transmission of the disease. Some of the most common theories which still remain questionable today are the Green Monkey theory[55], the Molecular Biology theory[56], the Hunter theory[57], the Manmade theory and the Oral Polio Vaccine (OPV) theory.[58] Whether the AIDS virus has the capability of zoonosis and stems from non-human primates,[59] or whether it was biologically created during the World Health Organization's overhaul of the smallpox virus,[60] still remains a mystery. Whatever the theoretical origin, most modern day scientists will agree that HIV is a descendent

[48] "Epidemiological fact sheets on HIV and AIDS, 2008 update," World Health Organization, http://www.who.int/hiv/pub/epidemiology/pubfacts/en/ (accessed July 1, 2013).
[49] "The Prospect of Elimination of HIV with Test and Treat Strategy," International AIDS Society, http://pag.aids2012.org/Abstracts.aspx?AID=13384 (accessed June 29, 2013).
[50] Alain Lafeuillade, "The 'Test and Treat' Strategy Against HIV," http://ezinearticles.com/?The-Test-And-Treat-Strategy- Against-HIV&id=6240517 (accessed June 24, 2013).
[51] Killian Melloy, "CDC Starts Massive 'Test and Treat' HIV Program in D.C., the Bronx," *Edge* (October 27, 2009), http://www.edgeboston.com/index.php?ch=news&sc=&sc2=news&sc3=&id=98208 (accessed June 24, 2013).
[52] "Statistics World Wide," The Foundation for AIDS Research, November 2012. http://www.amfar.org/About-HIV-and- AIDS/Facts-and-Stats/Statistics--Worldwide/ (accessed June 23, 2013).
[53] "10 Facts on HIV/AIDS," World Health Organization, http://www.who.int/features/factfiles/hiv/facts/en/index3.html (accessed June 23, 2013).
[54] "First Report of AIDS," *Morbidity and Mortality Weekly Report* (June 1, 2001), http://www.cdc.gov/mmwr/PDF/wk/mm5021.pdf (accessed June 22, 2013).
[55] Alan Cantwell, MD., "Debunking the Out of Africa Origin of HIV & Aids," Rense, Januay 1, 2005, http://rense.com/general61/outof.htm (accessed June 22, 2013).
[56] Ibid.
[57] "The Origin of HIV and AIDS," Averting HIV and AIDS, http://www.avert.org/origin-aids-hiv.htm (accessed June 22, 2013).
[58] Ibid.
[59] Ibid.
[60] Alan Cantwell, MD., "Debunking the Out of Africa Origin of HIV & Aids," Rense, Januay 1, 2005, http://rense.com/general61/outof.htm (accessed June 22, 2013).

of the Simian Immunodeficiency Virus (SIV), found in monkeys indigenous to Western Africa.[61] Furthermore, because of its long incubation period, the virus may have gone unnoticed for more than 30 years.[62]

Since the XIII International AIDS Conference in Durban, South Africa, the HIV virus has been commonly accepted as the etiological vehicle for the AIDS infection.[63] A human's CD4 count (cluster of differentiation 4) or the counting of white blood cells,[64] helps to determine three major variables: a positive or negative reading, the current state of the virus and treatment options. [65] A normal CD4 count in a healthy, HIV-negative adult varies between 600-1200 CD4cells,[66] however, when the CD4 count is around 350, HIV treatments are then highly recommended.[67] Further, it is understood that if the CD4 count of a human falls below 200 cells, they can then be clinically diagnosed as having the AIDs virus.[68]
As previously noted, the first cases of the immune suppressed virus were reported to the American public in June of 1981by the CDC.[69] Five young, homosexual men were treated for what was thought to be Pneumocystis carini pneumonia in Los Angeles, California and as a result, two died from the disease.[70] Soon thereafter, an uncommon cancer called Kaposi's Sarcoma (KS) was reported in 26 homosexual men from the California and New York areas.[71] These events, along with the publishing of a news article by the highly famed New York Times newspaper, helped foster the misconception that the virus derived from homo/bisexual lifestyle;[72] the disorder was unequivocally referred to as gay related immunodeficiency (GRID), which inevitably casted a reasonable amount of responsibility on the gay community.[73] Nevertheless, it became apparent throughout the U.S. once population groups such as injecting drug users (IDU) were amongst the most affected that transmission of the virus was not strictly amongst homo/bisexual men only.[74]

It is reported that throughout the industrialized western world, Latin America and in the Caribbean, the populace most commonly affected with the AIDS virus were men who had sex with other men (homosexuals) and injecting drug users (IDU).[75]South and South East Asia discovered an increased HIV prevalence in the late 1980's, mostly caused by the sex worker industry, which specifically impacted Thailand.[76] It was not until the mid to late 1990's when Eastern Europe and Central Asia began to

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[61] Sharp PM, "Origins of HIV and the AIDS pandemic," *Institute of Evolutionary Biology and Centre for Immunity, Infection and Evolution* (September 1, 2011), http://www.ncbi.nlm.nih.gov/pubmed/22229120 (accessed June 22, 2013).
[62] "WHO Report on Global Surveillance of Epidemic-prone Infectious Diseases," World Health Organization, http://www.who.int/csr/resources/CSR_ISR_2000_1hiv/en/ (accessed June 23, 2013).
[63] "The Durban Declaration," AIDS Truth, http://www.aidstruth.org/sites/aidstruth.org/files/documents/the-durban-declaration.pdf (accessed June 22, 2013).
[64] "Difference Between HIV and AIDS," Health Science, http://healthnscience.blogspot.com/2010/12/difference-between-hiv- and-aids.html (accessed June 23, 2013).
[65] Michael Carter, "CD4 Cell Counts," nam (February 17, 2012), http://www.aidsmap.com/CD4-cell-counts/page/1044596/ (accessed June 12, 2013).
[66] "CD4 Count," AIDS gov, October 11, 2010. http://aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/understand-your-test- results/cd4-count/ (accessed June 20, 2013).
[67] Ibid.
[68] Ibid.
[69] "Epidemiology of HIV/AIDS – United States, 1981-2005," Centers for Disease Control and Prevention, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5521a2.htm (accessed June 26, 2013).
[70] "Pneumocystis," Centers for Disease Control and Prevention, http://www.cdc.gov/mmwr/preview/mmwrhtml/june_5.htm (accessed June 26, 2013).
[71] "Thirty Years of HIV/AIDS: Snapshots of an Epidemic," Averting HIV and AIDS, 2013. http://www.amfar.org/thirty-years- of-hiv/aids-snapshots-of-an-epidemic/ (accessed June 26, 2013).
[72] Ibid.
[73] Lawrence K. Altman,"New Homosexual Disorder Worries Health Officials," *The New York Times*, May 11, 1982. http://www.nytimes.com/1982/05/11/science/new-homosexual-disorder-worries-health-officials.html (accessed June 28, 2013).
[74] UN/POP/MORT/2003/2. *Workshop on HIV/AIDS and Adult Mortality in Developing Countries.* Department of Economic and Social Affairs, Population Division. September 5, 2003.
[75] Ibid.
[76] Ibid.

experience a rapid increase of infections, particularly within Ukraine, stemming from the IDU population.[77] However, it is in the African continent where we see the highest prevalence of the virus. More specifically, "South Africa has the highest number of people living with HIV/AIDS in the world"[78] with approximately 5.3 million suffering from the epidemic.[79] Like other regions, there are multiple culprits to blame for the AIDS crisis in Africa, but notably, 90 percent of accounts reported are through heterosexual transmission.[80]Another major concern for Africa is mother to child transmission in which the infant can be infected not only during the pregnancy phase but also through childbirth and breastfeeding. [81] Although consequences and trends vary region to region, and historical accounts pertaining to the virus are fairly inconsistent, one can now arguably conclude through statistical data that the virus affects al l ages, races, religions, genders and sexual orientations. To this point, in his attempt to summarize the history of the virus, researcher and senior member of the WHO Global Programme on AIDS and the United Nations Joint Programme for the Fight Against AIDS (UNAIDS) Michel Carael identifies three specific periods of time and their attitude regarding the epidemic:

> *"The first which he calls denial (1984-1988), the second characterized by a belated and vertical global response (1989-1994) and the third, still in operation (1995-) marked by a broadened reaction at international level. This last period is distinguished by a massive injection of funding from the Global Fund for the fight against AIDS and by the American agency Pepfar as well as by patient access to anti-retroviral treatment which is certainly slow and administered erratically."*[82]

More than thirty years after the first cases were diagnosed, a scientific solution to the AIDS epidemic remains elusive. Despite funding efforts, medical achievements and international awareness, a breakthrough vaccine against HIV is merely just a hope for the future.

Present State of the Epidemic

Current Statistics

As the world's leading infectious killer, an overall 25 million people have died from the disease thus far. **[83]** However, it is estimated that as of 2011, 34 million people were living with HIV worldwide.**[84]** Of this figure, 2.5 million individuals were estimated to have contracted the disease within 2011.**[85]** A contributing factor is the fact that treatment has yet to reach approximately 7 million people.[86] On the contrary, according to the 2012UNAIDS World Aids Day Report:

> *"there were more than 700,000 fewer new HIV infections globally in 2011 than in 2001. Africa has cut AIDS-related deaths by one third in the past six years. And as services*

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[77] Ibid.
[78] Ibid.
[79] "HIV/AIDS Pandemic Affects Development in Africa," Develop Africa, http://www.developafrica.org/hiv-aids-Africa (accessed June 28, 2013).
[80] "WHO Report on Global Surveillance of Epidemic-prone Infectious Diseases," World Health Organization, http://www.who.int/csr/resources/CSR_ISR_2000_1hiv/en/ (accessed June 23, 2013).
[81] "The Origin of HIV and AIDS," Averting HIV and AIDS, http://www.avert.org/origin-aids-hiv.htm (accessed June 22, 2013).
[82] Philippe Denis, "The HIV/AIDS Epidemic in Sub-Saharan Africa in a Historical Perspective," *Senegalese Network* (October 2006), http://rds.refer.sn/IMG/pdf/AIDSHISTORYALL.pdf (accessed July 1, 2013).
[83] "10 Facts on HIV/AIDS," World Health Organization, http://www.who.int/features/factfiles/hiv/facts/en/index3.html (accessed June 23, 2013).
[84] "Difference Between HIV and AIDS," Health Science, http://healthnscience.blogspot.com/2010/12/difference-between-hiv- and-aids.html (accessed June 23, 2013).
[85] "10 Facts on HIV/AIDS," World Health Organization, http://www.who.int/features/factfiles/hiv/facts/en/index3.html (accessed June 23, 2013).
[86] U*NAIDS World AIDS Day Report 2012.* Joint United Nations Programme on HIV/AIDS (UNAIDS). 2012. http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/JC2434_WorldAIDSday_ results_en.pdf

> *have been scaled up, uptake has followed. In fact, what had taken a decade before is now being achieved in 24 months. In the past two years there has been a 60% increase in the number of people accessing lifesaving treatment – 8 million people are on antiretroviral."*[87]

Overall worldwide figures based on statistics from 2011, indicate that the Caribbean has the least affected population with about 230,000, followed closely by the Middle East and North Africa with a total of 300,000; Eastern Europe and Latin America are tied with about 1.4 million victims; North America, Western and Central Europe have approximately 2.3 affected, doubled by Asia with 4.8 million and lastly, the most devastated region is Sub Saharan Africa with a disproportionate amount of 23.5 million affected people.[88] While HIV incidence continues to decline in most regions, the African continent remains fragile as Sub Saharan Africa, particularly South Africa, continues to be the most heavily affected region in the world.[89]

Economic Impact

The HIV/AIDS virus presents a serious challenge to economic development. Present day economists have contradictory theories pertaining to the epidemic's actual effects to national economies and find it difficult to provide direct correlations to the virus.[90] For the purposes of illustrating the fiscal consequence on a macroeconomic level, one can categorize the epidemic's economic impact as either indirect or direct.[91] Some examples of indirect costs are the loss of current wages or decline in production due to sick workers, costs of hiring and training staff members and inevitably, the decay of national savings.[92]Moreover, according to the International Labour Office (ILO), "increasing mortality and morbidity reduce living standards directly and have repercussions that affect all areas of the economy."[93] In contrast, economic losses seen by direct costs, such as medical and treatment expenses, rate increases of medical death related benefits and the impact on health care budgets, are easier to calculate.[94] A case study conducted by the International Monetary Fund (IMF) surveyed the impact of HIV/AIDS on the South African economy and reported the following seven "key impact channels:

> 1. *Lower labor force; 2. Lower productivity through absenteeism and illness; 3. Cost pressures for companies through benefit payments and replacement costs; 4. Lower labour income (employees bear some of the AIDS related costs); 5. Lower population translating into lower expenditure; 6. Increased private sector demand for health services; and 7. Higher government expenditure on health services."*[95]

Ultimately, the HIV/AIDS virus offers a major blow to the economy through its loss of human capital[96] which can produce short term and/or long term effects for a country. A common, short term scenario is the worker who falls ill from the virus. They become less productive and eventually are forced to exit the

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[87] Ibid.
[88] Ibid.
[89] *Global HIV/AIDS Response, Epidemic Update and Health Sector Progress Towards Universal Access,* The United Nations Children's Fund. 2011. http://www.unicefusa.org/assets/pdf/2011HIVreport_opt.pdf
[90] *The Impact of AIDS.* United Nations Department of Economic and Social Affairs/Population Division. http://www.un.org/esa/population/publications/AIDSimpact/92_CHAP_IX.pdf
[91] Ibid.
[92] *Socio-Economic Impact of HIV/AIDS on People Living With HIV/AIDS and Their Families.* International Labour Organization. 2003. http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_121236.pdf
[93] Ibid.
[94] *The Impact of AIDS.* United Nations Department of Economic and Social Affairs/Population Division. http://www.un.org/esa/population/publications/AIDSimpact/92_CHAP_IX.pdf
[95] "The Economic Impact of HIV/AIDS," Economic and Social Development Department, http://www.fao.org/wairdocs/ad696e/ad696e05.htm (accessed July 12, 2013).
[96] *The Impact of AIDS.* United Nations Department of Economic and Social Affairs/Population Division. http://www.un.org/esa/population/publications/AIDSimpact/92_CHAP_IX.pdf

workplace and retire home to a family that is now burdened with the financial responsibility of caring for the family. Many times, when a parent falls ill, the child is left with the financial encumbrance;[97] this particular scenario causes long term effects on a Member State's human capital and economy specifically because that child's "education, nutrition and health" will suffer.[98] In households such as these, children must leave school to earn an income or to assume the role of caregiver.[99] In extreme situations, children are sent to live with relatives or become homeless when a parent dies as a result of the illness.[100] "The effects of lowered investment in the human capital of the younger generation will affect economic performance over future decades."[101]

The HIV/AIDS epidemic affects all areas of the public and private sectors but as showcased above, has a significant impact on human capital, health services and education. It remains difficult to quantitatively gauge both the short term and long term impacts of HIV/AIDS on a particular sector.

Social Impact and the Issue of Human Rights

Much like the economical impact caused by the HIV/AIDS virus, the social impact is also quite difficult to quantify. After one is diagnosed with the virus, socioeconomic status might likely change due to the individual's inability to work or earn income. However, developing countries that lack typical socioeconomic resources to begin with, face major issues due to the absence of women's rights and gender equality, educational and awareness programs and equal access to healthcare and medicines. Furthermore, there is severe social stigmatization and /or discrimination toward effected populations, particularly, woman and children.[102] According to UNAIDS, there are ten major areas of social life in which distinctions, exclusions or restrictions against persons with HIV/AIDS may occur. These areas include health care, employment, justice/legal process, administration, social welfare, housing, education, reproductive and family life, insurance and other financial services and access to other public accommodations or services (e.g. funeral services)."[103]
Mandates such as the *International Guidelines on HIV/AIDS and Human Rights* have been established to ensure that Governments comply with international human rights standards in the context of the HIV epidemic.[104] Furthermore, doctrines such as, the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS, have called on Member States to establish programs that will empower vulnerable populations. [105] The UN High Commissioner for Human Rights, Louise Arbour, explains:

> *"The international human rights system explicitly recognized HIV status as a prohibited ground of discrimination. At the same time, the impact of HIV highlight the inequities and vulnerabilities leading to increased rates of infection among women, children, the poor and marginalized groups and thereby contributed to a renewed focus on economic, social and cultural rights. In this regard, the content of the right to health has been increasingly defined and now explicitly includes the availability and accessibility*

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[97] Channing Arndt, "HIV/AIDS, Human Capital, and Economic Growth Prospects for Mozambique," *World Bank* (February 2003), http://www.worldbank.org/afr/wps/wp48.pdf (accessed July 13, 2013).
[98] *The Impact of AIDS.* United Nations Department of Economic and Social Affairs/Population Division. http://www.un.org/esa/population/publications/AIDSimpact/92_CHAP_IX.pdf
[99] "New UN Report Cites Devastating Effects of HIV/AIDS," Department of Economic and Social Affairs, September 16, 2004. http://www.un.org/News/Press/docs/2004/aids82.doc.htm (accessed July 13, 2013).
[100] Ibid.
[101] *The Impact of AIDS.* United Nations Department of Economic and Social Affairs/Population Division. http://www.un.org/esa/population/publications/AIDSimpact/92_CHAP_IX.pdf
[102] Ann May, "Social and Economic Impacts of HIV/AIDS in Sub-Saharan Africa, with Specific Reference to Aging," *Institute of Behavioral Science* (October 2003), http://www.colorado.edu/ibs/pubs/pac/pac2003-0005.pdf (accessed July 10, 2013).
[103] *Protocol for the Identification of Discrimination Against People Living with HIV.* Joint United Nations Programmed on HIV/AIDS (UNAIDS). May 2000. http://www.unaids.org/en/media/unaids/contentassets/dataimport/publications/irc-pub01/jc295-protocol_en.pdf
[104] *International Guidelines on HIV/AIDS and Human Rights.* Office of the United Nations High Commissioner for Human Rights. 2006. http://www2.ohchr.org/english/issues/hiv/docs/consolidated_guidelines.pdf
[105] A/RES/S-26/2. *Declaration of Commitment on HIV/AIDS.* United Nations General Assembly. August 2, 2001.

of HIV prevention, treatment, care and support for children and adults. Either through legislation or litigation, many countries have recognized that their people have the right to HIV treatment as a part of their human rights."[106]

As Abour mentions, legislation has been a key component in the fight against unfair practices. National law is one tool frequently used for the protection and fulfillment of human rights. However, legislative formulation regarding HIV/AIDS can be complicated because as history has shown, the law can either protect or hinder one's human rights. Some legislative measures have been viewed as controversial, such as that suggested in the Guidelines on HIV/AIDS and Human Rights, which called for the prosecution of individuals who intentionally or knowingly spread the virus.[107] At the 1st Global Parliamentary Meeting on HIV/AIDS in 2007, Member States were asked to carefully weigh all options before passing HIV-related legislation that imposed criminal punishment.[108] This particular piece of legislation becomes problematic when attempting to define "intentional" exposure; can an individual's refusal of HIV/AIDS testing be considered as "intentional" transmission?

Another contentious policy which threatens human rights standards is mandatory HIV testing. Greek Health Minister, Adonis Georgiadis, for example, has come under intense international scrutiny for advocating mandatory testing legislation throughout his country.[109] In late 2012, a joint statement issued by WHO and UNAIDS stated, "people being tested for HIV must give informed consent to be tested. Mandatory or compulsory (coerced) testing is never appropriate, regardless of where that coercion comes from: health-care providers, partners, family members, employers or others."[110] Furthermore, mandatory testing has been used by the few remaining Member States which still employ travel restrictions based on one's HIV status. [111] Entry restriction laws fuel discriminatory practices and lend credibility to myths that suggest HIV is transmitted through casual contact. [112] The International Guidelines on HIV/AIDS and Human Rights state "any restriction on liberty of movement or choice of residence based on suspected or real HIV status alone, including HIV screening of international travelers, is discriminatory." [113] Rather than mandatory testing, voluntary examinations are encouraged by WHO because evidence shows that "early knowledge of one's positive HIV status maximizes opportunities for the people living with HIV to access treatment, thereby greatly reducing HIV-related morbidity and mortality, and/or preventing mother-to-child transmission of HIV."[114]

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[106] *International Guidelines on HIV/AIDS and Human Rights.* Office of the United Nations High Commissioner for Human Rights. 2006. http://www2.ohchr.org/english/issues/hiv/docs/consolidated_guidelines.pdf

[107] A/HRC/16/69. *The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).* Human Rights Council. December 20, 2010.

[108] *Criminalization of HIV Transmission,* Joint United Nations Programme on HIV/AIDS (UNAIDS). August 2008. http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/basedocument/2008/20080731_jc1513_policy_criminalization_en.pdf

[109] "The Battle of Civil Society Against Reinstatement of Mandatory HIV Testing Legislation in Greece," Aids Action Europe, http://www.aidsactioneurope.org/news/announcements/battle-civil-society-against-reinstatement-mandatory-hiv (accessed July 20, 2013).

[110] "Statement on HIV Testing and Counseling: WHO, UNAIDS re-affirm opposition to mandatory HIV testing," World Health Organization, http://www.who.int/hiv/events/2012/world_aids_day/hiv_testing_counselling/en/index.html (accessed August 2, 2013).

[111] *Legal Aspects of HIV/AIDS: A Guide for Policy and Law Reform.* The World Bank. 2007. http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/LegalAspectsOfHIVAIDS.pdf

[112] Ibid.

[113] "HIV-related travel restrictions," Joint United Nations Programme on HIV/AIDS (UNAIDS), March 04, 2008. http://www.unaids.org/en/Resources/PressCentre/Featurestories/2008/March/20080304HIVrelatedtravelrestrictions/ (accessed August 12, 2013).

[114] "Statement on HIV Testing and Counseling: WHO, UNAIDS re-affirm opposition to mandatory HIV testing," World Health Organization, http://www.who.int/hiv/events/2012/world_aids_day/hiv_testing_counselling/en/index.html (accessed August 2, 2013).

Social stigma and acts of discrimination have multiple adverse effects, some psychological in nature, and ultimately, are detrimental to the HIV/AIDS preventative process. UNAIDS defines HIV-related stigma and discrimination as "a process of devaluation of people either living with or associated with HIV and AIDS…Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status."[115]

According to the UNAIDS sponsored *HIV-related Stigma, Discrimination and Human Rights Violations, Case studies of successful programmes,* stigma is described as Social stigma and acts of discrimination have multiple adverse effects, some psychological in nature, and ultimately, are detrimental to the HIV/AIDS preventative process. The stigmatization of this disease has led to an epidemic within an epidemic as it hinders prevention efforts and impedes treatment possibilities. "Abandonment by spouse and/or family, social ostracism, job and property loss, school expulsion, denial of medical services, lack of care and support, and violence. These consequences, or fear of them, mean that people are less likely to come in for HIV testing, disclose their HIV status to others, adopt HIV preventive behaviour, or access treatment, care and support."[116] While overcoming stigma and discrimination has been an important part of international development agendas, reduction efforts are oftentimes put on the back burner. Former Under Secretary-General of the United Nations and former Executive Director of the UNAIDS, Peter Piot, admits in his strategic response that such efforts have been "relegated to the bottom of AIDS programmes, together with human rights, and often with no funding attached to them."[117]

Getting to Zero

The World Health Organization, along with numerous agencies within the United Nations, has taken a major stance in the fight against HIV/AIDS by developing several cohesive strategies to achieve universal access to HIV prevention, diagnosis, treatment, care and support. In support of the former plan, Global Health Sector Strategy on HIV/AIDS (GHSS), WHO has developed the 2013-2013 HIV Operational Plan which highlights four strategies geared towards prevention and treatment.[118] The Plan places significant emphasis on at risk populations, the advancement of human rights and gender equality, education and access to pharmaceuticals.[119] Similar in nature to WHO's 2012-2013 HIV Operational Plan, the World Health Organization aligned with UNICEF and other various UN agencies in the approval of The UNAIDS Strategy 2011-2015 *Getting to Zero*. Ultimately, the strategy has two main global commitments: achieve universal access to HIV prevention, treatment, care and support and halt/reverse the spread of HIV to achieve the Millennium Development Goals.[120] The vision is multifaceted and the strategy is broken down into three parts: zero AIDS-related deaths, zero discrimination and zero new infections. As of World AIDS Day, December 1, 2012, there was a decrease in more than 50 percent of new HIV infections,[121] which indicated that achieving the 2015 goal is possible.

Conclusion

The HIV/AIDS epidemic is one that has been heavily discussed and debated in the various forums and agencies at the United Nations. Global response to the HIV/AIDS epidemic is imperative and could not come at a more pivotal moment than here and now when we continue to see an unprecedented acceleration

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[115] *Reducing HIV Stigma and Discrimination: a critical part of national AIDS programmes.* Joint United Nations Programme on HIV/AIDS (UNAIDS). December 2007. http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/report/2008/jc1521_stigmatisation_en.pdf

[116] Ibid.

[117] Ibid.

[118] *HIV Operational Plan 2012-2013.* World Health Organization. 2012. http://whqlibdoc.who.int/publications/2012/9789241503709_eng.pdf

[119] Ibid.

[120] *Getting to Zero.* Joint United Nations Programme on HIV/AIDS (UNAIDS). 2010. http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/jc2034_unaids_strategy_en.p df

[121] "World AIDS Day: Getting to Zero," United Nations, http://www.un.org/en/events/aidsday/ (accessed August 12, 2013).

in the AIDS response which has resulted in the reduction of HIV/AIDS related deaths across the globe. As we continue to see technological advances in medicine and breakdowns in stigmatic social barriers, it is essential that the World Health Organization along with other agencies, continues to advance its efforts to identify social, legal and economic conditions that increase the risk of HIV transmission. Moreover, "the course of the HIV/AIDS epidemic is by no means pre-determined. The eventual course of the disease depends on how individuals, communities, nations and the world respond to the HIV/AIDS threat today and tomorrow."[122] We cannot forget that much progress has been achieved and sustainable development is feasible if we invest in approaches that combine global targets with community mobilization.

Committee Directive

The World Health Organization acknowledges the UNAIDS Strategy 2011-2015 and recalls the fundamental commitments to Millennium Development Goals, as well as, the 2001 Declaration of Commitment on HIV/AIDS. With that in mind: what structure of accountability can regional bodies and their constituencies develop to ensure that Member States are meeting targets for 2015? How can we ensure that the process towards eradication remains at the forefront of international agendas once 2015 has surpassed? How can Member States further promote their constituents to be HIV tested? What best practices can be adapted to assist those living with the virus but not currently receiving antiretroviral therapy? What are the implications of HIV/AIDS for public policy, and what are the fiscal consequences?

[122] "New UN Report Cites Devastating Effects of HIV/AIDS," Department of Economic and Social Affairs, September 16, 2004. http://www.un.org/News/Press/docs/2004/aids82.doc.htm (accessed July 13, 2013).

II. Managing Health Crises after Natural Disasters

"A natural disaster is an act of nature of such magnitude as to create a catastrophic situation in which the day-to-day patterns of life are suddenly disrupted and people are plunged into helplessness and suffering, and as a result, need food, clothing, shelter, medical and nursing care and other necessities of life, and protection against unfavorable environmental factors and conditions."[123]

Introduction

"Global demographic trends suggest that more people are living in areas vulnerable to sudden-onset natural disasters even as scientists predict that the frequency and intensity of these disasters are likely to increase as a result of the effects of climate change."[124] Given this knowledge, now more than ever international organizations are imperative in the responding to disasters and managing the after effects. Natural disasters are catastrophic events with atmospheric, geologic, and hydrologic origins.[125] Any region of the world is susceptible to a natural disaster; a natural disaster can be a volcano eruption, a landslide, earthquake, tsunami, flood, or hurricane (to name a few). The past two decades alone have seen millions of deaths caused by natural disasters.[126] All natural disasters are not, however, created equal.

In the event of an earthquake, high mortality can be caused by trauma, asphyxia, dust inhalation, or exposure to the environment (i.e. hypothermia).[127] In the wake of a flood, health infrastructure can be indirectly impacted and disrupt basic public health services.[128] In the event of a tropical cyclone, the risk of water borne diseases, while not always observed, presents a potential risk.[129] Every natural disaster poses a different threat to health and human safety, and international responses do not always act hastily enough to handle the mass.

The goal of this guide is to present an array of ways the World Health Organization addresses natural disasters, and also how their strategies to be prepared are in place. It will also evaluate the role of the WHO with other entities (namely the United Nations) in relation to crisis management. To add, real world examples, in the form of case studies, will highlight how the WHO has responded in the wake of disasters. It is important to note that while this guide will present you with a variety of ways this topic is approached, the complexity of this topic means there is a lot that can be done in terms of research. Make sure

Disaster Risk Reduction & Disaster Risk Management

"The more governments, United Nations agencies, organizations, businesses and civil society understand risk and vulnerability, the better equipped they will be to mitigate disasters when they strike and save more lives."[130] Disaster Risk Reduction (DRR) refers to reducing the damage caused by natural hazards (floods, cyclones, earthquakes etc.) through an ethic of prevention.[131] The United Nations International Strategy for Disaster Reduction (UNISDR) was established due to an increase of civilians affected by natural disasters in recent decades.[132] Natural disasters are one of many emergencies that can impact a person's health.[133]

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[123]"Guide to Sanitation in Natural Disasters." World Health Organization,1971. http://www.who.int/environmental_health_emergencies/natural_events/en/ (accessed July 8, 2013)
[124]Ferris, In the Neighborhood: The Growing Role of Regional Organizations in Disaster Risk Management, http://www.brookings.edu/events/2013/04/22-natural-disaster-trends, (2013)
[125]"Communicable Diseases in the Wake of Natural Disasters" http://www.who.int/diseasecontrol_emergencies/guidelines/CD_Disasters_26_06.pdf (accessed August 2, 2013)
[126] *Ibid*
[127] "Floods: Technical Hazard Sheet – Natural Disaster Profile" http://www.who.int/hac/techguidance/ems/earthquakes/en/index.html (accessed August 2, 2013)
[128] "Earthquakes: Technical Hazard Sheet – Natural Disaster Profile" http://www.who.int/hac/techguidance/ems/floods/en/index.html (accessed August 2, 2013)
[129]"Tropical Storms: Technical Hazard Sheet – Natural Disaster Profile" http://www.who.int/hac/techguidance/ems/tropical_cyclones/en/index.html (accessed August 2, 2013)
[130] "What is Disaster Risk Reduction?" http://www.unisdr.org/who-we-are/what-is-drr (accessed August 2, 2013)
[131]"Disaster Risk Reduction" http://www.unisdr.org/who-we-are/what-is-drr (accessed July 13, 2013)
[132] *Ibid.*

Disaster Risk Management (DRM), specifically for health, is an analysis of health risks attained by disasters through a combination of "hazard and vulnerability reduction to prevent and mitigate risks, preparedness, response and recovery measures".[134]

Under GA Resolution A/RES/60/195 the UNISDR implemented the Hyogo Framework for Action 2005-2015outlining five priorities for action and guidelines toward DRR and DRM [135] Stakeholders from sectors expressed their desire for a system in which they could share their experiences in DRR while accessing how other Member States dealt with the same or similar issue.[136] The Global Platform for Risk Reduction was designed to bring together stakeholders, NGOs, international organizations, UN agencies, and the private sector that are committed to DRR.[137] The first session of the Global Platform met from June 5-7, 2007 in Geneva, Switzerland to discuss expanding political space devoted to the issue of DRR and further working toward achieving the Millennium Development Goals (MDGs).[138] More recently, the Fourth Session of the biennial meeting of the Global Platform was held in Geneva, Switzerland from May 19-23, 2013, during which WHO co-organized events addressing health as a component to disaster risk management.[139] Members of the conference discussed proposals for the agenda of the Post-2015 Framework for Disaster Risk Reduction while also considering a successor to the Hyogo Framework.[140]

Evaluating Methods of Health Crises Management

According to the WHO, a shift occurred in how to respond to crises and emergencies in the last 30 years.[141] The organization places emphasis on how focus has transitioned to humanitarian and relief activities in lieu of implementing strategies that were already set in place.[142]

Member States encounter a broad range of health emergencies and its complexities may end with mixed results.[143] Therefore, it is essential to evaluate the methods orchestrated before, during, and after responding to crises.[144] A core commitment with the WHO in a crisis is accountability.[145] For all emergencies, ranging from food insecurity, environmental factors, natural disasters, or political crises, the WHO has underscored a five-step process. The process includes: 1) develop an evidence centered on health sector response strategy, plan, and appeal; 2) ensure that adapted disease observation and early warning response systems are established; 3) deliver up-to-date information on the crisis situation and health sector performance; 4) promote and monitor the application of standards and best practices; and 5) offer appropriate technical expertise to affected Member States and all relevant stakeholders.[146]

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[133] Disaster Risk Management for Health Overview
http://www.who.int/hac/techguidance/preparedness/en/ (accessed July 13, 2013)
[134] *Ibid.*
[135] Hyogo Framework for Action
http://www.unisdr.org/we/coordinate/hfa (accessed July 13, 2013)
[136] First Session of the Global Platform for Disaster Risk Reduction
http://www.unisdr.org/we/coordinate/hfa (accessed July 13, 2013)
[137] Global Platform for Risk Reduction – 2013
http://www.who.int/hac/techguidance/preparedness/globalplatform2013/en/index.html (accessed July 13, 2013)
[138] First Session of the Global Platform for Disaster Risk Reduction
http://www.unisdr.org/we/coordinate/hfa (accessed July 13, 2013)
[139] Global Platform for Risk Reduction – 2013
http://www.who.int/hac/techguidance/preparedness/globalplatform2013/en/index.html (accessed July 13, 2013)
[140] Chairman's Summary; Fourth Session of the Global Platform for Disaster Risk Reduction: Geneva, Switzerland May 19-23, 2013
www.preventionweb.net/globalplatform/2013/news/view/33306 (accessed July 13, 2013)
[141] "Risk reduction and emergency preparedness," The World Health Organization, 2007.www.who.int/hac/techguidance/preparedness/emergency_preparedness_eng.pdf (accessed July 22, 2013)
[142] *Ibid.*
[143] World Health Organization Emergency Response Framework
http://www.who.int/hac/crises/en/ (accessed July 22, 2013)
[144] *Ibid.*
[145] *Ibid.*
[146] *Ibid.*

The WHO Emergency Risk Management and Humanitarian Response department, which has worked closely with Member States along with institutions from international and national levels, has committed to managing health crises in a number of methods.[147] For one, the department focuses on "building efficient partnerships" for the purpose of emergency management and proper coordination.[148]

The WHO, however, understands and noted that managing health crises are both expensive and a large investment.[149] The training of WHO staff members and external health professionals is an important element in enhancing not only the individual but the organization.[150] Response times during crises are a criteria WHO evaluates; the organization evaluates if a trainer's performance was ineffective during the crises, if a specific performance was ineffective or effective compared to previous times, the ability to rise above the occasion, and emerge as a leader.[151]

The management of a health crisis includes the emergency health kit, which includes essentials for up to ten thousand people for approximately three months.[152] Within the emergency health kit, materials include medicine and disposables; however, it is not a resort for immunization programs and specific epidemics, such as cholera and meningitis.[153]

The WHO's Regional Office for Europe, for example, organized a toolkit with the purpose of easing the impact of future health crises in Member States by assessing the capabilities of their health systems and response to crises.[154] Although not meant to replace pre-existing efforts, the toolkit is recommended to serve as an instrument in understanding the complexity in the crisis-preparedness process.[155] The toolkit's intention was to provide ministries of health and relevant organizations a guide on evaluating systems during crisis management and address any gaps that were identified in the process.[156] The toolkit features a glossary of technical terms, how to implement the toolkit, instructions on how to complete assessments, and how to develop a plan of action.[157]

The WHO is aware that if a sole Member State attempted to manage a major emergency, being overwhelmed by the emergencies is probable.[158] In a recommendation set forth by the WHO Executive Board to the 64th World Health Assembly, it is highlighted that lack of coordination, communication, and logistics are often exposed as the route of weak health emergency management.[159]

The evaluation of Member States' methods in emergency preparedness is a subject the WHO monitors carefully.[160] WHO has stressed the role of synergy in evaluating methods during a health crisis at local,

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[147] "Humanitarian Health Action." World Health Organization. http://www.who.int/hac/about/en/ (accessed July 22, 2013)
[148] *Ibid.*
[149] "Evaluating Training in WHO," World Health Organization, 2010.http://whqlibdoc.who.int/hq/2010/WHO_HSE_GIP_ITP_2011.2_eng.pdf (accessed July 22, 2013)
[150] *Ibid.*
[151] *Ibid.*
[152] "What is an emergency health kit?," The World Health Organization.www.who.int/hac/techguidance/ems/healthkit/en/ (accessed July 22, 2013)
[153] *Ibid.*
[154] "Toolkit for Assessing Health-System Capacity for Crisis Management." The World Health Organization, 2012. www.euro.who.int/__data/assets/pdf_file/0008/157886/e96187.pdf (accessed July 22, 2013)
[155] *Ibid.*
[156] *Ibid.*
[157] *Ibid.*
[158] EB128.R10. Strengthening National Health Emergency and Disaster Management Capacities and Resilience of Health Systems. The World Health Assembly. January 21, 2011. http://apps.who.int/gb/ebwha/pdf_files/EB128/B128_R10-en.pdf (accessed July 22, 2013)
[159] *Ibid.*
[160] "Risk Reduction and Emergency Preparedness," The World Health Organization, 2007.www.who.int/hac/techguidance/preparedness/emergency_preparedness_eng.pdf (accessed July 22, 2013)

regional, and global levels.[161] The synergy is emphasized between Member States' preparedness and response in real time and after-action evaluations.[162]

Crisis Management Beyond the first 72 Hours

The WHO and its partners executed humanitarian responses in 43 Member States in 2012; throughout 2013 the world is expecting various natural disasters and rapid onset emergencies.[163]The most crucial key to maintain peace and deliver emergency aid to the most affected area is to steadily manage the onset crisis and beyond, especially as the natural disaster passes an area, which will be vulnerable to diseases and chaos.[164]

Immediate Responses

The Red Cross and Red Crescent is one of the most successful programs that help bring immediate assistance to affected areas by mobilizing people, money and assets.[165] The objectives for immediate response teams aim to rescue survivors from onset danger; however, the most immediate response to emergency assistance focusses heavily on food, shelter and medical care.[166] It usually takes one to six months to rescue an area after a natural disaster, which unfortunately leaves enough time for diseases to form and spread.[167]

When disasters such as floods and earthquakes hit Member States with an already poor infrastructure, the potential for development is halted.[168] In January 2012, for example, Haiti encountered an earthquake which killed thousands and hospitalized thousands of people.[169] This disaster, because of its magnitude, sought help from the international community. To add, the International Red Cross and Red Crescent Societies (IFRC) aided Zimbabwe when the Member State underwent a cholera outbreak in 2008, bringing in over 800,000 liters of clean water.[170] Several groups within the affected area of a natural disaster become vulnerable when the community attempts to return to their daily routines.

To better approach this, the United Nations High Commissioner for Refugees (UNHCR) believes it is important to implement contingency planning and early recovery initiatives for future disasters.[171] The UNHCR plans to further develop its Global Protection Cluster to spread awareness of disaster response through the establishment of responsive protection programs.[172]

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[161] *Ibid.*
[162] *Ibid.*
[163] "Humanitarian Response." World Health Organization, 2013. http://www.who.int/hac/cap_2013_Feb.pdf (accessed July 23, 2013)
[164] *Ibid.*
[165] "Responding to Disasters." http://www.ifrc.org/en/what-we-do/disaster-management/responding/ (accessed July 23, 2013)
[166] "The World Turned Upside Down. A Review of Protection Risks and UNHCR's Role in Natural Disasters." http://www.unhcr.org/cgibin/texis/vtx/home/opendocPDFViewer.html?docid=51408d589&query=natural%20disasters (accessed July 23, 2013)
[167] *Ibid.*
[168] "Health in Emergencies" http://www.ifrc.org/en/what-we-do/health/health-in-emergencies/ (accessed July 23, 2013)
[169] *Ibid.*
[170] *Ibid.*
[171] "The World Turned Upside Down. A Review of Protection Risks and UNHCR's Role in Natural Disasters." http://www.unhcr.org/cgibin/texis/vtx/home/opendocPDFViewer.html?docid=51408d589&query=natural%20disasters (accessed July 23, 2013)
[172] *Ibid.*

Case Study - South-East Asia Earthquake and Tsunami (December 26, 2004)

Disaster struck Southeast Asia when a 9.0 magnitude earthquake erupted in the Indian Ocean on December 26, 2004.[173] The resulting tsunami swept through the coastal regions of India, Indonesia, Malaysia, Maldives, Myanmar, Seychelles, Somalia, Sri Lanka, Tanzania and Thailand, impacting citizen health and infrastructure.[174] It is estimated the tsunami claimed 200,000 lives and displaced over one million people.[175]

The large scale of this crisis called for immediate action by the WHO, UN, non-governmental organizations (NGOs), local governments ,and authorities.[176] Further assistance was given by agencies such as the IFRC, the International Organization for Migration (IOM), and the private sector. [177]As laid out in the WHO Emergency Response Framework, it is the responsibility of the WHO to monitor Member States when disaster strikes.[178] The day following the tsunami the WHO established operation rooms in its Regional Office in Delhi, India and in offices of those Member States affected.[179] Daily reports were fed to these offices through the Strategic Operations Center in Geneva, international partners and the humanitarian community.[180]

Promptly, the WHO established early warning systems for detection of disease outbreak within days of the disaster.[181] In some places sewage treatment centers were damaged, resulting in contaminated drinking water and a potential for diseases.[182] Many healthcare centers and hospitals were damaged by the tsunami, leaving people in fear of lack of treatment in the case of a sudden outbreak of salmonellosis, cholera, hepatitis or measles.[183] The WHO recognized these threats, were able to detain those with early signs of exposure, and stop those before an outbreak occurred by assisting in the rehabilitation of Member State's health systems and disposing dead bodies.[184] Furthermore, the WHO activated the Global Outbreak Alert and Response Network (GOARN), a collaboration of networks and institutions whose people confirm and respond to international outbreaks, to strengthen disease surveillance systems.[185] To date the WHO has established the Tsunami Recovery Impact Assessment and Monitoring System (TRIAMS), a sub-regional system to monitor and assist the governments of Indonesia, Maldives, Sri Lanka and Thailand, the four most affected Member States, in recovery.[186]

Case Study – Haiti January 12, 2010

The Member State of Haiti is no stranger to natural disasters making landfall in their nation, having undergone a series of hurricanes in 2008.[187] However, a new level of devastation occurred when a 7.0

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[173] "A year after the Tsunami of 26 December 2004."
http://www.who.int/hac/crises/international/asia_tsunami/one_year_story/en/index.html (accessed July 23, 2013)
[174] *Ibid.*

[175] "South Asia Earthquake and Tsunamis"
http://www.who.int/tsunami/en/ (accessed July 23, 2013)

[176] *Ibid.*
[177] "Conference on the Health aspects of the Tsunami Disaster." Phuket, Thailand 4 May 2005.
http://www.who.int/dg/lee/speeches/2005/phuket_tsunamiconference/en/index.html (accessed July 23, 2013)
[178] World Health Organization Emergency Response Framework
http://www.who.int/hac/crises/en/ (accessed July 23, 2013)
[179] "Conference on the Health aspects of the Tsunami Disaster." Phuket, Thailand 4 May 2005.
http://www.who.int/dg/lee/speeches/2005/phuket_tsunamiconference/en/index.html (accessed July 23, 2013)
[180] *Ibid.*
[181] *Ibid.*
[182] "Three months after the Indian Ocean earthquake-tsunami report." Health consequences and WHO's response.
http://www.who.int/hac/crises/international/asia_tsunami/3months/report/en/ (accessed July 23, 2013)
[183] *Ibid.*
[184] *Ibid.*
[185] *Ibid.*
[186] Tsunami Recovery Impact Assessment and Monitoring System
http://www.who.int/hac/crises/international/asia_tsunami/triams/en/index.html (accessed July 25, 2013)
[187] "WHO Spearheads Health Response to Earthquake in Haiti."

magnitude earthquake struck right outside its capital of Port-au-Prince.[188] According to a survey done by the Post-Disaster Needs Assessment (PDNA), there were over 100,000 deaths, 200,000 injuries, over 100 homes were destroyed, over two-thousand were damaged, and over one-thousand educational buildings and 50 hospitals collapsed.[189] Government buldings such as the Presidential Palace and Parliament were also destroyed in the earthquake along with the United Nations Stabilization Mission in Haiti (MINUSTAH).[190]

Early response teams were delayed assisting Haiti due to the high extent of damage done to the airport guidance system, leaving the local government to delegate its airspace monitoring to the United States' military.[191] Days following the disaster the American Red Cross made its way into Haiti, providing shelter for displaced families and, with assistance from the World Food Programme, distributing millions of pre-packaged food, enough to feed 1.3 million people for a month.[192] Due to the sudden lack of hospitals, the American Red Cross arranged for 70 Creole speaking volunteers to assist its medical staff as translators when treating patients for surgeries and support families for emotional counseling.[193]

Not only did the earthquake have a quick and sudden impact, but overtime its aftermath proved to be a health hazard. The disaster destroyed the already limited access to clean water and sanitation infrastructure, combined with displaced people living in camps of hundreds, resulted in a cholera outbreak.[194] In efforts to control the outbreak, the American Red Cross distributed chlorine tablets and oral rehydration salts.[195] The WHO, in collaboration with the Pan American Health Organization (PAHO), a specialized health agency of the Inter-American System, established an updated alert and response system to strengthen the pre-existing surveillance unit.[196] The new system was meant to identify hot spots with increasing deaths and send in mobilized response units.[197]

Two years post disaster, the global Red Cross placed 36,000 people in new homes, ensuring access to clean water to prevent another cholera epidemic.[198] Furthermore, the American Red Cross has worked to prevent and educate communities on communicable diseases by conducting campaigns and training local disaster response organizations.[199]

Conclusion

A key focus point in this topic is determining what Member States and other organizations have done to mitigate health crisis in times of natural disasters. Although much progress has been made in implementing early warning systems to detect both natural disasters and disease outbreaks, it is important to bear in mind

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http://www.who.int/mediacentre/news/releases/2010/haiti_earthquake_20100113/en/ (accessed July 25, 2013)

[188] *Ibid.*

[189] "Health Response to the Earthquake in Haiti." The Pan American Health Organization. January 2010. http://new.paho.org/disasters/dmdocuments/HealthResponseHaitiEarthq.pdf (accessed July 25, 2013)

[190] United Nations Environment Programme (UNEP; UNEP in Haiti: 2010 Year in Review. http://postconflict.unep.ch/publications/UNEP_Haiti_2010.pdf (accessed July 25, 2013)

[191] "Health Response to the Earthquake in Haiti." The Pan American Health Organization. January 2010. http://new.paho.org/disasters/dmdocuments/HealthResponseHaitiEarthq.pdf (accessed July 25, 2013)

[192] "Haiti Earthquake Relief, One Year Report." American Red Cross. http://www.redcross.org/images/MEDIA_CustomProductCatalog/m3140113_HaitiEarthquake_OneYearReport.pdf (accessed July 25, 2013)

[193] *Ibid.*

[194] Cholera Outbreak in Haiti – Press Briefing by Dr. Jon Andrus, PAHO Deputy Director 23 November 2010 http://www.paho.org/hq/index.php?option=com_content&view=article&id=4487&Itemid=1926 (accessed July 25, 2013)

[195] *Ibid.*

[196] *Ibid.*

[197] *Ibid.*

[198] "Haiti Earthquake Response – Two Year Update." January 2012. http://www.redcross.org/images/MEDIA_CustomProductCatalog/m6340449_HaitiEarthquake_TwoYearReport.pdf (accessed July 25, 2013)

[199] *Ibid.*

pre-existing methods. Looking forward, there is still relief and rebuilding needed post the South-East Asia earthquake and tsunami and the earthquake in Haiti. Humanitarian relief agencies, including the Red Cross, are known for successful programs and aid in time of disaster, but more financial assistance is needed.

Committee Directives

In their research delegates should explore other natural disasters, including Hurricane Sandy one year later. Could anything have been done to prevent such destruction? What steps were taken in the days after? Furthermore, there are topics and queestions that are essential to the committee and should be taken into consideration while writing position papers as well as draft resolutions:

Is the Global Health Cluster effective? Do new thresholds need to be established to trigger its involvement? When determining whether current protocols are effective or outdated, what should be the norm for handling crises after a disaster strikes? How is basic infrastructure important to recovery? How should current steps be modified to better handle such health crises?

Attention should be made to mobile units' arrival time and set up on disaster sites, preventative measures to be placed on existing infrastructure to alleviate heightened risks of failure, and emergency protocol systems and kits.

Technical Appendix Guidance

I. Advancement and Implementation of HIV/AIDS Prevention and Treatment Strategies

Peter Chappel, "The Origin of AIDS," (2004), http://www.aidsorigins.com/sections/documentary (Accessed August 1, 2013).

This award winning documentary explores the controversial theory that HIV virus derives from the creation of the polio vaccination. The documentary addresses various theories and hypothesis which explain how HIV was spread to humans. It also offers an extensive overview of the virus itself through its creative depiction of the divergent scientific arguments behind the HIV/AIDS epidemiology.

Guidelines for Addressing HIV in Humanitarian Settings. Inter-Agency Standing Committee. UNAIDS. 2010. http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/jc1767_iasc_doc_en.pdf

These guidelines emphasize HIV prevention, care and support in emergency settings and for those affected by humanitarian crises. These guidelines provide tactics to address human rights violations in conflict zones and how to offer treatment despite a shortage of resources. With recent Security Council resolutions passed in 2011 and a new understanding for the major consequences of gender inequality amongst other human rights violations, these guidelines offer the framework for response in nine different humanitarian settings (most which are consistent with the ten major areas of social life impacted by HIV/AIDS discrimination).

State of the Art: Aids and Economics. International AIDS-Economics Network. 2002. http://pdf.usaid.gov/pdf_docs/PNACP969.pdf

This document attempts to measure the global economic consequences of the HIV/AIDs epidemic. It evaluates the cost effectiveness of policies currently in place and explains the various ways we can measure the impact of HIV/AIDS, for example, through trade and commerce. Moreover, the report concentrates on resource allocation and gives particular attention to Africa's private sector. Overall, there are 12 chapters, written by 12 different economists, so the varying perspectives offer a solid representation of the current economic impact.

Jessica Ogden and Laura Nyblade, "Common at Its Core: HIV-Related Stigma Across Contexts," International Center for Research on Woman, 2005, http://www.icrw.org/files/publications/Common-at-its-Core-HIV-Related-Stigma-Across-Contexts.pdf (Accessed August 1, 2013).

This handbook details the stigma associated with HIV and sites the root causes of stigma as ones knowledge and morality. It discusses the various expressions and forms of stigma as well as its consequences. Furthermore, it offers recommendations based on research and case studies conducted in Ethiopia, Tanzania, Zambia and Vietnam.

Ann E Kurth, "Combination HIV Prevention: Significance, Challenges, and Opportunities," *Current HIV/AIDS Reports (*March 2011*):* 62-72, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3036787/ (Accessed August 1, 2013).

This article examines the various HIV/AIDS treatment strategies which are currently utilized today and suggests that a combination of these methods, or a prevention package as it is referred to, be implemented to address the various epidemiological profiles. The article focuses on various strategies such as male circumcision, behavioral risk reduction and antiretroviral use.

UNAIDS 2011-2015 Strategy: Getting to Zero. UNAIDS. 2010.
http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/jc2034_unaids_strategy_en.pdf (Accessed August 1, 2013).

This is the key document behind the United Nations Millennium Development Goal number 6: Combat HIV/AIDS, malaria and other diseases. This text examines current global efforts to achieve MDG6 and provides further recommendation to ensure reversal of the HIV/AIDS virus is achieved. It is also highlighted numerous times in the Background guide due to the utilization and adherence from other United Nations agencies and programs. The strategy provides a roadmap to achieving the vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths.

UNAIDS. Global Fact Sheet: World AIDS Day 2012. UNAIDS. 2010
http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_FactSheet_Global_en.pdf (Accessed August 1, 2013).

This handy fact sheet offers the latest statistics and data reporting regarding the HIV/AIDS virus. This can be used as a quick go-to guide as it offers an overview of figures relating to the virus from years 2001-2011. This fact sheet can also serve as a good comparative tool for global and regional statistics.

"The Quest for an HIV Vaccine," UNAIDS,
http://www.unaids.org/en/resources/presscentre/featurestories/2012/may/20120518vaccinesday/ (Accessed August 1, 2013).

This feature story discusses the recent development in HIV vaccine discovery and relies on the results from a trial in Thailand to support its position that finding an HIV vaccine is possible, and, potentially nearer than expected.

Global Health Sector Strategy on HIV/AIDS 2011 – 2015. World Health Organization. 2011.
http://whqlibdoc.who.int/publications/2011/9789241501651_eng.pdf (Accessed August 1, 2013).

This report was established to outline the strategies specific to the global health sector. Reminiscent of the "Getting to Zero" UNAIDS Strategy for 2011-2015, this report details the four strategic directions for 2011-2015 but also provides recommended actions for countries to implement and achieve each strategic goal. Further, this report will assist in understanding how and why the health sector has a central role in attaining goals set for 2015.

Chen Reis et al. "Discriminatory Attitudes and Practices by Health Workers toward Patients with HIV/AIDS in Nigeria." *PLoS Medicine*.:1-10.
http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0020246.
(Accessed August 1, 2013).

This study done in the African state of Nigeria looks at discrimination based on HIV/AIDS factors. Member States will learn what contributed specifically towards such discrimination, as well as possible intervention strategies in combating it. Among its results, the study finds that health clinics refused care to patients based on mere appearance, believing they held the HIV/AIDS virus. Moreover, health care professionals were also found to believe that those with the disease deserved it and should not be provided assistance. Therefore, Member States will be better able to understand this perspective into HIV/AIDS discrimination and formulate appropriate policies aimed at eliminating such practices towards the betterment of those carrying HIV/AIDS.

Daniel R. Hogan et al. "Cost Effectiveness Analysis of Strategies to Combat HIV/AIDS in Developing Countries." *BMJ*. 2005. http://www.bmj.com/content/331/7530/1431. (Accessed August 1, 2013).

This study assesses how certain cost effective measures have provided a better response to those affected with HIV/AIDS in correlation to the Millennium Development Goal 6. By seeing the costs of methods used to increase awareness of HIV/AIDS, Member States will be able to analyze which cost effective strategies are truly effective and in-line to meet MDG 6 by 2015.

Edward M. Gardner et al. "The Spectrum of Engagement in HIV Care and its Relevance to Test-and-Treat Strategies for Prevention of HIV Infection." *Clinical Infectious Diseases*. 1-8. http://cid.oxfordjournals.org/content/52/6/793.full.pdf+html. (Accessed August 1, 2013).

This paper provides better insight into test-and-treat strategies for combating HIV/AIDS. Its argument that early detection would substantially reduce HIV/AIDS cases can serve as a policy alternative for Member States. Furthermore, this article provides insight into the possible implications of test-and-treat strategies, and its new positive outlook on it. It also discusses financial limitations for effective HIV/AIDS treatment within the United States as its case study. Member States will be better able to understand limitations for an effective and successful HIV/AIDS treatment strategy, including test-and-treat, and what is best at the international realm.

Robert Hecht et al. "Putting It Together: AIDS and the Millennium Development Goals." *PLoS Medicine*. 1-7. http://www.plosmedicine.org/article/fetchObject.action?uri=info%3Adoi%2F10.1371%2Fjournal.pmed.0030455&representation=PDF. (Accessed August 1, 2013).

This paper provides further insight into the impact HIV/AIDS has on the United Nations Millennium Development Goals. By incorporating numerical models, the impact HIV/AIDS has on poverty alleviation has the possibility of better guiding Member States in instituting appropriate policies that will better serve their populace. Moreover, by delving deeper into the impact on Children, as well as the effect HIV/AIDS can have on attaining other diseases because of a lower immune system. The authors of this article conclude that if the MDGs are to be reached, then HIV/AIDS is a prerequisite for doing so.

Vinod Mishra et al. "HIV Infection does not disproportionately Affect the Poorer in Sub-Saharan Africa." *AIDS (International AIDS Society)*. 1-12. http://journals.lww.com/aidsonline/Abstract/2007/11007/HIV_infection_does_not_disproportionately_affect.3.aspx. (Accessed August 1, 2013).

This article discusses the relationship between wealth and the possibility of attaining the HIV/AIDS virus. Using data from several Sub-Saharan African states, including Kenya, Ghana, and others, Member States can analyze the prevalence of those with HIV/AIDS increases with wealth. By incorporating this research into their policymaking, Member States of the World Health Organization can be better prepared for any past policy inefficiencies and implement successful ones for the future.

II. Managing Health Crises after Natural Disasters

"Disasters and Conflicts," United Nations Environment Programme, http://www.unep.org/disastersandconflicts/ (Accessed August 21, 2013).

The United Nations Environment Programme has outlined the science and the policy of the UNEP for natural disasters. Delegates should always bear in mind how its sister organizations respond to crises, as well as policy that is already in place. It also includes recovery efforts that are being made for those crises, as well as outlines further crises that could emerge as a result of things such as climate change.

"Emergency Response Framework," World Health Organization, http://www.who.int/hac/about/erf_.pdf (Accessed August 21, 2013).

This document is essential to understanding the role the WHO has in responding to emergency crises. It not only outlines the responsibilities the WHO has, but how the organization approaches them. Within the document, delegates will find information on trigger signs and procedures taken by the WHO to handle natural disasters and disease outbreaks. The Emergency Response Framework will give delegates an idea of measures already in place, and can give delegates an idea as to how effective this legislation has been in managing those crises.

"Humanitarian Health Action: Crises," The World Health Organization. http://www.who.int/hac/crises/en/ (Accessed August 21, 2013).

This page indexes crises from the recent past by Member States. It links to various pages for those Member States, and from there, links regarding those specific crises, including updates and situation reports. This index of crises will be useful to delegates in drawing from the handling of previous crises, and how those were handled from both a governmental and humanitarian organization perspective.

"The Interagency Emergency Health Kit 2011," World Health Organization, http://whqlibdoc.who.int/publications/2011/9789241502115_eng.pdf (Accessed August 21, 2013).

This publication discusses the contents of emergency health kits and how they can be utilized in times of crises. The document contains further information on medicines, immunization emergencies, and post-exposure measures to be taken. Delegates can use this publication as a guideline, again, to draw from in terms of what is already in place. It also indexes various issues, and useful partners that delegates can use as further resources.

"International Federation of Red Cross and Red Crescent Societies," http://www.ifrc.org/ (Accessed August 21, 2013).

The IFRC can be a crucial resource in the event of a natural emergency. The official website of the organizations gives a in depth view of what these organizations do, and the parameters of their work. In terms of natural disasters and their aftermath, it is imperative that delegates understand how those organization function.

"Pan American Health Organization," Pan American Health Organization, http://www.paho.org/hq/index.php?lang=en, (Accessed August 21, 2013).

The PAHO is a subsidiary of the World Health Organization, focusing on both North and South America and the Caribbean. The website outlines the projects currently in place. Delegates can use this as a model for regional actions, allowing for more immediate responses to natural disasters and crises.

"Private sector," United Nations Office for Disaster Risk Reduction, http://www.unisdr.org/partners/private-sector (Accessed August 21, 2013).

Delegates should bear in mind that private sector investors can be as crucial as those in the public sector. Those private sector partners could also be a more immediate relief than public partners. The UNSIDR has these partners as a resource, and explains why they use private sector partners, and other benefits. These are things that delegates should bear in mind when creating resolutions that require large funding or immediate reactions.

"What we do," United Nations Office for Disaster Risk Reduction, http://www.unisdr.org/we (Accessed August 21, 2013).

The UNSIDR is a program for preparing for and avoiding disasters and minimizing damages when they occur. This could be a useful partner for the World Health Organization. Delegates could also use the UNSIDR as an example of ways to take pre-emptive measures for those disaster and crises. UNSIDR also advocates for sustainable development and adaptation for climate change, putting its priorities in line with the overall theme of SRMUN 24.