

SRMUN Atlanta 2015
*Unifying Our Global Community through
Humanitarian Collaboration*
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Atlanta, GA
who_atlanta@srmun.org



Esteemed Delegates,

Welcome to the SRMUN Atlanta 2015 Conference and the United Nations World Health Organization (WHO). My name is Allie Molinari and I have the honor of serving as the director of the WHO which will be my third SRMUN conference on staff. Model UN offers the unique experience to challenge oneself and engaging other delegates in discussion on issues facing not only this committee, but the world at large. The Assistant Directors this year will be Lauren DeLeon and Rachael Rascoe, who are both ecstatic to be serving on the WHO dais. We all hope to learn from your work, speeches, and our discussions during this committee. We encourage all of our delegates to take advantage of this opportunity and to make the most of your SRMUN experience.

The WHO was founded by the United Nations (UN) on 7 April 1948 and is the primary body within the UN tasked with directing and maintaining authority on international health. We have chosen the following topics to discuss at this conference, with consideration of the theme “Unifying Our Global Community Through Humanitarian Collaboration”:

- I. Improving Public Education on Preventive Medicine
- II. Promoting Health Policy Reform for the International Aging Population

Each delegation is required to submit a position paper that covers both topics. Position papers should be single spaced and no longer than 2 pages in length. Please follow the position paper guidelines which can be found on the SRMUN website. Delegates must strive to convince fellow committee members that their solutions and ideas are the best course of action. The position papers are therefore critical in providing insight into not only the policies and position of each Member State, but also set a strong foundation for the direction your Member State will take in approaching each of the topics.

Position papers are an effective way to present the history and policy of your particular Member State. More importantly, however, they should be used as an opportunity to also present and discuss effective, unique solutions to the problems our committee is facing. A strong position paper is the foundation of your conference preparation and should showcase your research and understanding of both topics. More detailed information about how to write position papers can be found at the SRMUN website (www.srmun.org). **All position papers MUST be submitted by Friday, 30 October 2015, by 11:59pm EST using the submission system on the SRMUN website.**

Delegations are reminded that the WHO is a double delegation committee at SRMUN Atlanta 2015. I appreciate the opportunity to serve as the director for the United Nations World Health Organization and I look forward to working with and learning from each of you. I wish all of you the best of luck. Please feel free to contact the Director-General Joel Fitzgerald or myself if you have any questions.

Allie Molinari
Director
who_atlanta@srmun.org

Lauren DeLeon
Assistant Director
who_atlanta@srmun.org

Rachael Rascoe
Assistant Director
who_atlanta@srmun.org

Joel Fitzgerald
Director-General
dg_atlanta@srmun.org

The History of the World Health Organization

The Constitution of the World Health Organization (WHO) was first presented in 1946 during the International Health Conference: the document was ratified on 7 April 1948.¹ Although this date is considered the birth day of World Health Organization (WHO) and is annually celebrated as World Health Day, the WHO was devised many years before its ratification in 1945, when, during a UN conference on International Organization in San Francisco, the delegations from Brazil and China prompted a discussion regarding the proposal of a General Conference in order to create an international health organization.² The United Nations Economic and Social Council (ECOSOC) held its first Technical Preparatory Committee, which was comprised of international health experts from 16 Member States and other health organization observers, which met in Paris in 1946.³ With the assistance of pre-existing international health organizations and the United Nations Relief and Rehabilitation Administration (UNRRA), the International Health Conference prepared a draft of the WHO constitution.⁴ Following the conference, the Interim Commission was endorsed to take over all responsibilities and functions of the pre-existing international public health infrastructure. At the final meeting, the Interim Commission provided an agenda, and suggested work for the World Health Assembly, plenary, and legislative body for the WHO.⁵

After ratification of the constitution, the first World Health Assembly was held in June of 1948 in Geneva.⁶ The WHO continued the Interim Commission's work of international sanitary conventions, epidemiological reporting, and medical relief. Additionally, the WHO has many regional bodies, some of which were created and which stemmed from pre-existing bodies that had been integrated into the organization.⁷ By 1977, the WHO proclaimed that "the main social target of governments and WHO...should be the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life."⁸

The WHO has worked since its inception at creating international programs to help treat and eradicate disease across the globe. One of the first programs was created in 1955, when the WHO began its worldwide malaria campaign, which continued well into the 1990s. The "Roll Back Malaria" initiative created different pillars to focus on, including treatment, net usage, prevention (specifically in pregnant women), and emergency care, and is one example of a widely successful campaign during this timeframe. With the smallpox eradication campaign that stemmed from 1966 to 1980, the WHO successfully eliminated the disease, finding that this universal vaccination had positive effects on economic dividends. The WHO also started an AIDS campaign in 1987 under the WHO Global Programme intended to prevent infection, reduce the impact of HIV, and unify efforts.⁹ In addition to campaigns, the WHO readily resolves new health threats every day, including Ebola, Severe Acute Respiratory Syndrome, and Avian Influenza.¹⁰ In order to keep up with burgeoning diseases and viruses, the WHO has established a Global Outbreak and Alert and Responses Network, which uses technical and operational resources

¹ Elisabetta Minnelli, "World Health Organization: The Mandate of a Specialized Agency of the United Nations," Geneva Foundation for Medical Education and Research, August 1, 2012.

² Charles Clift, "The Role of the World Health Organization in the International System," Working Group on Governance, Paper 1, 2013, (accessed May 21, 2015).

³ Yves Beigbeder, "World Health Organization," Oxford Public International Law: Max Planck Encyclopedia of Public International Law, July 1, 2013, <http://opil.ouplaw.com/view/10.1093/law:epil/9780199231690/law-9780199231690-e575> (accessed May 25, 2015).

⁴ Charles Clift, "The Role of the World Health Organization in the International System," Working Group on Governance, Paper 1, 2013, (accessed May 21, 2015).

⁵ Elisabetta Minnelli, "World Health Organization: The Mandate of a Specialized Agency of the United Nations," Geneva Foundation for Medical Education and Research, August 1, 2012.

⁶ Charles Clift, "The Role of the World Health Organization in the International System," Working Group on Governance, Paper 1, 2013, (accessed May 21, 2015).

⁷ Yves Beigbeder, "World Health Organization," Oxford Public International Law: Max Planck Encyclopedia of Public International Law, July 1, 2013, <http://opil.ouplaw.com/view/10.1093/law:epil/9780199231690/law-9780199231690-e575> (accessed May 25, 2015).

⁸ Ibid.

⁹ Ibid.

¹⁰ Yves Beigbeder, "World Health Organization," Oxford Public International Law: Max Planck Encyclopedia of Public International Law, July 1, 2013, <http://opil.ouplaw.com/view/10.1093/law:epil/9780199231690/law-9780199231690-e575> (accessed May 25, 2015).

through various health institutions and surveillance programs to respond to, and alert, Member States as efficiently as possible for future threats.¹¹

Member States and their respective delegations meet annually as part of the World Health Assembly to discuss the various priorities and agenda items that the WHO Executive Board has decided upon. The World Health Assembly is the decision making body of the WHO.¹² During the Assembly's annual meetings, Member States debate and ultimately vote on whether or not to adopt certain resolutions. The WHO has seven subsections, each with different responsibilities. These subdivisions are: General Management (GMG), Health Security (HSE), Family, Women and Children Health (FWC), HIV/Aids/Tropical Disease (HTM), Noncommunicable Diseases/Mental Health (NMH), Health Systems and Innovation (HIS) and Polio and Emergencies (PEC).¹³ The current 2014/2015 budget of the WHO is USD 3.98 Billion. Approximately USD 0.93 billion is provided by Member States while the remaining USD 3.05 Billion is provided through voluntary contributions.¹⁴ Recent focuses of the organization have been on health emergencies and disease outbreaks throughout the world such as: the Ebola outbreak, the MERS-CoV outbreak, and the Avian Influenza virus outbreak.¹⁵ With the committee's traditional role focusing on the protection of the people, much of the focus of the WHO on these topics has included: response to the situation via patient care, safe postmortem practices, and infection control.¹⁶

The WHO currently has 194 Member States:

AFGHANISTAN, ALBANIA, ALGERIA, ANDORRA, ANGOLA, ANTIGUA AND BARBUDA, ARGENTINA, ARMENIA, AUSTRALIA, AUSTRIA, AZERBAIJAN, BAHAMAS, BAHRAIN, BANGLADESH, BARBADOS, BELARUS, BELGIUM, BELIZE, BENIN, BHUTAN, BOLIVIA, BOSNIA AND HERZEGOVINA, BOTSWANA, BRAZIL, BRUNEI DARUSSALAM, BULGARIA, BURKINA FASO, BURUNDI, CAMBODIA, CAMEROON, CANADA, CAPE VERDE, CENTRAL AFRICAN REPUBLIC, CHAD, CHILE, CHINA, COLOMBIA, COMOROS, CONGO, COOK ISLANDS, COSTA RICA, CÔTE D'IVOIRE, CROATIA, CUBA, CYPRUS, CZECH REPUBLIC, DEMOCRATIC PEOPLES' REPUBLIC OF KOREA, DEMOCRATIC REPUBLIC OF THE CONGO, DENMARK, DJIBOUTI, DOMINICA, DOMINICAN REPUBLIC, ECUADOR, EGYPT, EL SALVADOR, EQUATORIAL GUINEA, ERITREA, ESTONIA, ETHIOPIA, FIJI, FINLAND, FRANCE, GABON, GAMBIA, GEORGIA, GERMANY, GHANA, GREECE, GRENADA, GUATEMALA, GUINEA, GUINEA-BISSAU, GUYANA, HAITI, HONDURAS, HUNGARY, ICELAND, INDIA, INDONESIA, ISLAMIC REPUBLIC OF IRAN, IRAN, IRELAND, ISRAEL, ITALY, JAMAICA, JAPAN, JORDAN, KAZAKHSTAN, KENYA, KIRIBATI, REPUBLIC OF KOREA, KUWAIT, KYRGYZSTAN, LAO PEOPLE'S DEMOCRATIC REPUBLIC, LATVIA, LEBANON, LESOTHO, LIBERIA, LIBYA, LITHUANIA, LUXEMBOURG, THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA, MADAGASCAR, MALAWI, MALDIVES, MALI, MALTA, MARSHALL ISLANDS, MAURITANIA, MAURITIUS, MEXICO, FEDERATED STATES OF MICRONESIA, REPUBLIC OF MOLDOVA, MONACO, MONGOLIA, MONTENEGRO, MOROCCO, MOZAMBIQUE, MYANMAR, NAMIBIA, NAURU, NEPAL, NETHERLANDS, NEW ZEALAND, NICARAGUA, NIGER, NIGERIA, NIUE, NORWAY, OMAN, PAKISTAN, PALAU, PANAMA, PAPUA NEW GUINEA, PARAGUAY, PERU, PHILIPPINES, POLAND, PORTUGAL, ROMANIA, RUSSIAN FEDERATION, RWANDA, SAINT KITTS AND NEVIS, SAINT LUCIA, SAINT VINCENT AND THE GRENADINES, SAMOA, SAN MARINO, SAO TOME AND PRINCIPE, SAUDI ARABIA, SENEGAL, SERBIA, SEYCHELLES, SIERRA LEONE, SINGAPORE, SLOVAKIA, SLOVENIA, SOMALIA, SOLOMON ISLANDS, SOUTH AFRICA, SPAIN, SRI LANKA, SUDAN, SOUTH SUDAN, SURINAME, SWAZILAND, SWEDEN, SWITZERLAND, SYRIAN ARAB REPUBLIC, UNITED REPUBLIC OF TANZANIA, TAJIKISTAN, THAILAND, TIMOR-LESTE, TOGO, TONGA, TRINIDAD, TOBAGO, TUNISIA, TURKEY, TURKMENISTAN, TUVALU, UGANDA, UKRAINE, UNITED ARAB EMIRATES, UNITED KINGDOM, UNITED STATES OF AMERICA, URUGUAY, UZBEKISTAN, VANUATU, VENEZUELA, VIETNAM, YEMEN, ZAMBIA, ZIMBABWE.¹⁷

¹¹ Ibid.

¹² "World Health Assembly," The World Health Organization, <http://www.who.int/entity/mediacentre/events/governance/wha/en/index.html> (accessed June 19, 2015).

¹³ "WHO Headquarters Structure," The World Health Organization, <http://www.who.int/about/structure/organigram/en/> (accessed June 19, 2015).

¹⁴ Ibid.

¹⁵ "Programme Budget 2014-2015," The World Health Organization, October 2014, <http://www.who.int/csr/don/archive/year/en/> (accessed June 19, 2015).

¹⁶ "Ebola," The World Health Organization, <http://apps.who.int/ebola/> (accessed June 19, 2015).

¹⁷ "Alphabetical List of WHO Member States," The World Health Organization, http://www.who.int/choice/demography/by_country/en/ (accessed June 19, 2015).

I. Improving Public Education on Preventive Medicine

Introduction

Preventive medicine is defined as: “A medical practice that focuses on individuals, communities, and populations in order to protect, promote, and maintain health, while also resisting disease, disability, and death.”¹⁸ Key components of preventive care include vaccines, diet, lifestyle and regular access to healthcare clinics. Research has indicated that preventive medicine, though relatively new, proves to be economically beneficial. Vaccines, one of form of preventive medicine, save an estimated 42, 000 child lives annually and preventive screenings are correlated with a significant increase in life expectancy in the 30-49 age group.¹⁹ The economic benefits include both a direct correlation to disease and an indirect effect for the average worker and overall economy. For example, research suggests that a one percent reduction in weight, blood pressure and cholesterol could potentially reduce medical costs by 83 USD to 103 USD annually per person.²⁰ Research also shows that diabetic workers miss an average of two more days at work than non-diabetics each year.²¹

Despite research providing significant support for preventive medicine, there is often a lack of community support, which is a critical proponent of effective preventive medicine. A lack of public education regarding the benefits of preventive medicine hinders the ability of healthcare providers to efficiently implement this type of care. In many developing Member States, clinics may be inaccessible to the majority of the community or may not exist within the community at all. Cultural differences may also act as a barrier to implementing and improving preventive medical practices within certain communities. For example, an estimated 2.2 million children under the age of five die every year from diarrheal diseases and pneumonia; yet hand washing with soap could potentially protect one out of three children who contract diarrhea and one out of six children from respiratory infections.²² Hand washing is a common practice around the world, but typically washing only includes the use of water, and soap is essential to kill bacteria and other pathogens. Many developed Member States need complete dietary reform as heart disease accounts for nearly 31 percent of deaths in the US alone, and more than two in three adults are obese.²³ Nearly 90 percent of people living with type two diabetes are considered overweight or obese.²⁴ Another considerably expensive practice is tobacco use, as a recent WHO study showed that the cost of tobacco use to the economy is nearly USD 76 billion in the United States alone, and smoking accounts for 6 percent of all healthcare costs.²⁵ HIV prevention is one problem that many experts believe could be alleviated by preventive methods, as many developing and even some developed Member States do not have standardized reproductive or family planning education.²⁶ Research has shown that preventing HIV infection can save approximately USD 355,000 in costs of lifetime treatment for every infection. The United Nations Educational, Scientific and Cultural Organization (UNESCO) has specifically created a publication to promote sexual education particularly focused on HIV prevention called the Comprehensive Sexuality Education. The UNESCO program is continually being expanded to include even more topics about prevention.²⁷ The World Health Organization (WHO) and other organizations, like UNESCO, are continuously promoting preventive medical around the world in order to promote public health and preventive measures.

¹⁸ "What is Preventive Medicine," American Board of Preventive Medicine, <https://www.theabpm.org/aboutus.cfm> (accessed May 24, 2015).

¹⁹ "Lifetime Preventive Care Plan," Public Health, <http://www.publichealth.org/public-awareness/preventive-care-schedule/> (accessed May 24, 2015).

²⁰ Ibid.

²¹ "National Prevention Strategy," US Department of Health and Human Services, <http://www.surgeongeneral.gov/priorities/prevention/strategy/> (accessed May 24, 2015).

²² "Show Me the Science. Why Wash Your Hands?" Centers for Disease Control and Prevention, October 17, 2014, <http://www.cdc.gov/handwashing/why-handwashing.html> (accessed May 24, 2015).

²³ Ibid. (accessed June 14, 2015).

²⁴ Ibid. (accessed June 14, 2015).

²⁵ "Costs to the Economy," World Health Organization, <http://www.who.int/tobacco/en/atlas13.pdf> (Accessed August 3, 2015).

²⁶ "Sexuality Education," United Nations Educational Scientific and Cultural Organization, <http://www.unesco.org/new/en/hiv-and-aids/our-priorities-in-hiv/sexuality-education/> (accessed May 24, 2015).

²⁷ Ibid.

History

Despite being a seemingly modern practice, the concept of public health policy is millennia-old. As populations grew and medical practices evolved, many preventive measures were established to stop the spread of disease, which is still the ultimate goal of preventive medicine today.

One of the first notable public health policies was the practice of quarantine, which dates back to the first formal use of the word in Italy during the 14th century, when the 'Black Death' was killing thousands throughout Europe. In order to prevent spread of disease into towns and cities, travelers were required to stay in areas away from townsfolk, isolated until deemed disease free by local authorities.²⁸ Quarantine practices are still considered an effective measure of stopping the spread of disease. With modern day tools, the idea of quarantine has extended to disease surveillance; where there are global efforts using technology to assess disease outbreaks and respond efficiently in a shorter amount of time. Polio myelitis is one disease that uses surveillance techniques to evaluate the current spread of the disease using the acute flaccid paralysis (AFP) as the highest priority in monitoring the disease.²⁹ There are four specific steps in monitoring AFP that include: reporting children affected, transporting stool samples, isolating the disease, and mapping the location of outbreaks.³⁰ This type of monitoring has been used most recently during the Ebola outbreaks in western Africa: the WHO encourages rapid response teams that conduct contact tracing with surveillance alert systems at health-care facilities and on borders of affected States.³¹

During the 19th century, the concept of sanitation helped formulate a central public health administration in Western Europe. Of the many tasks performed by this administration, authorities took care of proper drainage, sewage, street cleaning and the environmental regulation of housing.³² By creating an administration with the sole purpose of better living conditions, positive change began to occur. For example, after Dr. John Snow discovered that the transmission of cholera occurred through water, improvements in public health ensured the closure of open sewers and drains in public places.³³

After continual findings, such as Snow's, the idea of how disease spreads or how diseases were able to infect large numbers of the population caused a greater focus on surveillance efforts. Robert Koch, a German physician, provided scientific evidence that cholera is an infectious disease transmitted by unsanitary water and food, which provided further evidence in support of Snow's theory, helping push forward progress in disease surveillance.³⁴ As the Industrial Revolution contributed to greater spread of people across greater distances, and as travel became more prominent, diseases began spreading more rapidly. As more people interacted at an international level, the introduction of foreign pathogens into new environments began to escalate.³⁵ During the Industrial revolution 25 to 33 percent of children died before their fifth birthday in England.³⁶

While the knowledge of transmission of diseases became a public initiative, health administration authorities saw the importance of public health education, which once implemented would vastly alleviate public health concerns. An initial target for governments was maternal health; expectant mothers were a considerably large population and birth rates were still very high during the early 20th century. Upwards of 30 percent of children died before their

²⁸ Graham Mooney, "History of Public Health," The Johns Hopkins University Bloomberg School of Public Health, <http://ocw.jhsph.edu/courses/historypublichealth/PDFs/ReadingList.pdf> (accessed May 24, 2015).

²⁹ "WHO-Recommended Surveillance Standard of Poliomyelitis," World Health Organization, http://www.who.int/immunization/monitoring_surveillance/burden/vpd/surveillance_type/active/poliomyelitis_standard/en/ (accessed August 3, 2015).

³⁰ "Surveillance," Global Polio Eradication Initiative (GPEI), <http://www.polioeradication.org/dataandmonitoring/Surveillance.aspx> (accessed August 3, 2015).

³¹ "Ebola Publications: Surveillance, Contact Tracing, Laboratory," World Health Organization, <http://www.who.int/csr/resources/publications/ebola/surveillance/en/> (accessed August 3, 2015).

³² Graham Mooney, "History of Public Health," The Johns Hopkins University Bloomberg School of Public Health, <http://ocw.jhsph.edu/courses/historypublichealth/PDFs/ReadingList.pdf> (accessed May 24, 2015).

³³ Kathleen Tuthill, "John Snow and the Broad Street Pump: On the Trail of an Epidemic," Dept. of Epidemiology University of California, Los Angeles (UCLA) School of Public Health, <http://www.ph.ucla.edu/epi/snow/snowcricketarticle.html> (accessed May 24, 2015).

³⁴ Ibid.

³⁵ A. J. Tatem, et al, "Global transport networks and infectious disease spread," *Advances In Parasitology* (2006): 62, 293-343.

³⁶ Bruce Haley, *The Healthy Body and Victorian Culture* (Cambridge, Massachusetts: Harvard University Press, 1978).

first birthday.³⁷ By educating mothers about child care, child health improved as more health services were utilized and education about practices in child-rearing improved the health of the children simultaneously.³⁸ Many urban development projects that included sewage cleanup and providing access to safe drinking water, proved to play a large part in the reduction of infant mortality.³⁹ Fertility rates also decreased, which showed that better spacing between children correlated to better maternal and newborn nutritional health care and overall health outcomes.⁴⁰ Maternal health is still very much a focus of the international community, and public education is one of the best means of instituting safe public healthcare practices, especially in developing Member States. To that end, the WHO participates in the Partnership for Maternal, Newborn and Child health, aiming to continue progress towards bettering maternal and newborn health outcomes, while taking into account cultural difference between different Member States and communities.⁴¹

With the discovery of DNA as our genetic material, and increased understanding of how certain diseases and conditions are related to the genetic code, preventive medicine grew to include the field of genetics. In particular, healthcare professionals began to include questions about family medical history in regular physical examinations and assessments of patients, in order to better understand their patient's likelihood of acquiring certain diseases, and risks for developing certain conditions. Noting correlations in family prevalence of diseases, doctors understood that commonalities in families including genes, environment, and lifestyle were connected.⁴² Knowing an individual's medical history can provide information of risk for disease, perpetuate the need for more "aggressive" screenings, and induce prevention strategies by focusing on these potential diseases.⁴³

Actions Taken by the WHO and the UN

The WHO made the distinction that preventive medicine also focused on non-communicable diseases. Noncommunicable diseases, otherwise referred to as chronic diseases, are defined by the WHO to include Cardiovascular Diseases, Cancers, Respiratory Diseases, and Diabetes.⁴⁴

The WHO has taken an active interest in preventive medicine in previous years. On 4 February 1952, during its 22nd meeting, the WHO acknowledged the importance of preventive medicine under resolution EB9.R16.⁴⁵ The meeting also resulted in the acknowledgment of the need for adequate medical care, as well as the need for proper administrative support when care was provided. The document encouraged that an expert committee be formed to oversee the process. This statement by the Executive Board was monumental, as it was one of the first considerable acknowledgment and action related to preventive medicine within the Executive Board itself.⁴⁶

In years following, the WHO began to take additional action in training professors and medical professionals in preventive medicine, encouraging interest in preventive medicine amongst health practitioners, and began providing assistance to institutions educating professionals.⁴⁷

The WHO provided assistance to the Nagpur Medical College in Nagpur, India in 1958.⁴⁸ The purpose of providing the assistance to Nagpur Medical College was part of a five year plan to allow the institution to develop a program

³⁷ Ibid.

³⁸ S. Desai and S. Alva, "Maternal Education and Child Health: Is There a Strong Causal Relationship?" *Demography* (1998): Vol. 35(1), 71-81.

³⁹ Ibid.

⁴⁰ Ibid.

⁴¹ "PMNCH History," The Partnership for Maternal, Newborn & Child Health, <http://www.who.int/pmnch/about/history/en/> (accessed May 25, 2015).

⁴² "Why Is It Important To Know My Family Medical History?," Genetics Home Reference, <http://ghr.nlm.nih.gov/handbook/inheritance/familyhistory> (accessed May 25, 2015).

⁴³ Paula W. Yoon, "Family History as a Screening Tool for Public Health and Preventive Medicine," Centers for Disease Control and Prevention, 2004, <http://www.cdc.gov/genomics/gtesting/file/print/Yoon.pdf> (Accessed May 25, 2015).

⁴⁴ "Noncommunicable Diseases," World Health Organization, <http://www.who.int/mediacentre/factsheets/fs355/en/> (accessed June 12, 2015).

⁴⁵ "Medical Care in Relation to Public Health," World Health Organization, http://apps.who.int/iris/bitstream/10665/86839/1/EB9R16_eng.pdf?ua=1 (accessed 20 May 2015).

⁴⁶ Ibid.

⁴⁷ Ibid.

that would encourage more substantial education in preventive medicine.⁴⁹ Funds provided by the WHO were provided under the Expanded Programme of Technical Assistance for Economic Development. These funds were allocated for all personnel, materials, supplies, equipment, incidental expenses, and medical care associated with the program. As a result of the assistance, the college was able to better educate both clinical and pre-clinical professionals in the use of preventive medication. When final data on the study of the Nagpur College was collected, the college was only ten years into its existence, and had become one of the best medical education programs in the country. The study did credit a lack of staff as a drawback, or inhibitor, to the program.⁵⁰

Shortly after aide was provided to the Nagpur Medical College, the WHO Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel met in Geneva from 13-19 August 1963 and compiled a report on increasing interest in practitioners on the topic of preventive medicine. Number 269 of the World Health Organization Technical Report Series: Promotion of Medical Practitioners' Interest in Preventative Medicine, provides an all-encompassing explanation of the need, teaching, and application of preventive medicine for the medical practitioner.⁵¹ Beginning with why the need for preventive medicine is so important, the report cites the reduction of disease as a distinguishing factor, followed by the improvement of health care practice. The report focuses on preventive medicine in hope that *"the urgent need for prevention will be clearly understood in the light of the changing pattern of disease throughout the world, however complex and difficult to impart the subject may be."*⁵²

Furthermore, preventive medicine and primary care medicine have revolutionized prenatal, maternal, and postpartum care amongst the child bearing population of African Member States. The UN has recognized a report published by the United Nations Special Initiative on Africa in March of 1998.⁵³ This publication addressed the creation of a stronger health sector amongst African Member States. This created a stronger health sector and also emphasized a priority on preventive and primary health care. This document also recognizes the limited access to health care as a disabling factor to the development of the continent as a whole, citing debilitating illnesses such as: HIV/AIDS, Malaria, Tuberculosis, and childhood diseases as a main focus of preventive care. Additionally, UNICEF has recognized the efforts made by African Recovery Programme Member States toward efficient childhood health care.⁵⁴

In a statement at the WHO Congress on Traditional Medicine in Beijing, Dr. Margaret Chen, Director General of the World Health Organization, addressed the congress with three concepts on traditional medicine practice. Additionally, she responded to a WHO report entitled *Now More Than Ever*.⁵⁵ In her response to this report, Dr. Chen stated for primary and preventive health care, that primary care should revolve around the people that are receiving treatment. She then further stated that preventive care tackles the cause of poor health as well as potential future problems. Chen concluded with an explanation of the importance of preventive care by stating that it offers better outcomes, with higher satisfaction and lower cost.⁵⁶

According to the Global Health Observatory (GHO), data released by the WHO reported that life expectancy for global populations has increased by approximately six years.⁵⁷ For developing Member States, the average life span

⁴⁸ "Assignment Report on Assistance in Preventive and Social Medicine to the Nagpur Medical College, Nagpur (India)," World Health Organization, January 27, 1958, <http://apps.who.int/iris/bitstream/10665/149035/1/sea-med-educ-6.pdf?ua=127> (accessed 21 May 2015).

⁴⁹ Ibid.

⁵⁰ Ibid.

⁵¹ "Promotion of Medical Practitioners Interest in Preventive Medicine," World Health Organization, 1963, http://apps.who.int/iris/bitstream/10665/40575/1/WHO_TRS_269.pdf?ua=1 (accessed May 21, 2015).

⁵² Ibid.

⁵³ "Target: A Stronger Health Sector," United Nations Special Initiative on Africa (UNISA), <http://www.un.org/en/africarenewal/subjindx/114sphe1.htm> (accessed June 3, 2015).

⁵⁴ Ibid.

⁵⁵ Margaret Chen, "Address at the WHO Congress on Traditional Medicine," World Health Organization, 2008, <http://www.who.int/dg/speeches/2008/20081107/en/> (accessed May 21, 2015).

⁵⁶ Ibid.

⁵⁷ "Life Expectancy," Global Health Observatory, http://www.who.int/gho/mortality_burden_disease/life_tables/situation_trends_text/en/ (accessed May 20, 2015).

increase was approximately two years.⁵⁸ While for developed Member States, the average life span increase was nearly six years.⁵⁹ Currently, the increased life span in developed Member States can be accredited to access to and education encompassing all aspects of health care. However, in African Member States, though the increase is small, it can be accredited to the increase in access to key antiretroviral therapies used in combating the Member States' HIV/AIDS epidemic.⁶⁰ However, to allow the continuous growth of these rates, education and resources cannot become stagnant. Public education on preventive medicine must continue to grow.

Current Situation

To date, the WHO has allowed for preventive medicine to fall under the definition of traditional medicine. In WHO/EDM/TRM/2000.1, *General Guidelines for Methodologies on Research and Evolution of Traditional Medicine*⁶¹, preventive medicine is addressed in the following statement:

*“Traditional medicine is the sum total of knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.”*⁶²

With growing interest in the utilization and benefits of preventive medicine, education initiatives have grown among Member States. They have also grown in connection with programs such as telemedicine.

According to a 2010 report by the WHO entitled *Telemedicine Opportunities and Developments in Member States*, telemedicine is a growing field that allows Member States that maybe be inaccessible due to geographical or other reasons, access to health care/medical information through the use of communication technologies.⁶³ Although there is no specific definition for the term telemedicine, it has been acknowledged as follows:

*“The delivery of health care services, when distance is a critical factor, by all health care professionals using information and communications technologies for the exchange of valid information for diagnosis, treatment and prevent of disease and injuries, research and evaluation and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities.”*⁶⁴

The practice of telemedicine has been monumental in assisting developing Member States. There has been a 67 percent response rate among African Member States, where the largest impact was made in maternal and prenatal care. States in Southeast Asia have presented a 73 percent response rate to the practice, and the western pacific, a 48 percent response rate.⁶⁵ According to the World Bank, the highest response rate was also seen among developing Member States, thus furthering the claim that telemedicine serves as a viable resource for developing areas.⁶⁶ Telemedicine has two key communication pathways: health care professional to health care professional and health

⁵⁸ Ibid.

⁵⁹ Ibid.

⁶⁰ “Life Expectancy,” Global Health Observatory,

http://www.who.int/gho/mortality_burden_disease/life_tables/situation_trends_text/en/ (accessed May 20, 2015).

⁶¹ “General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine,” World Health Organization, http://whqlibdoc.who.int/hq/2000/WHO_EDM_TRM_2000.1.pdf?ua=1 (accessed May 23, 2015).

⁶² Ibid.

⁶³ “Telemedicine: Opportunity and Developments in Member States,” World Health Organization, http://www.who.int/goe/publications/goe_telemedicine_2010.pdf (accessed May 23, 2015).

⁶⁴ Ibid.

⁶⁵ Ibid.

⁶⁶ “Telemedicine: Opportunity and Developments in Member States,” World Health Organization, http://www.who.int/goe/publications/goe_telemedicine_2010.pdf (accessed May 23, 2015).

care professional to patient. Each of these routes allow for a large amount of knowledge to be conveyed to large and varied audiences. The process that allows telemedicine to function is very simple. A patient or professional sends an electronic message to another health care professional containing details on a medical case. The practitioner will then respond with his/her opinion regarding a diagnosis and the best way to manage the situation. Telemedicine carries such potential in the area of preventive medicine because it allows resources to be transferred from medical practices to a patient's home with ease.⁶⁷

Conclusions

With population growth and the trend of increased globalization, there has been a steadily increasing need to establish preventive measures to stop the spread of disease, which is still the ultimate goal of preventive medicine. Although the general idea of preventive medicine has not changed since its inception, the best-practices and methods of delivery have changed over the years, although some techniques, such as quarantine, are still widely-used today. With the development of information communication technology, telemedicine has become an increasingly important delivery mechanism for both clinical care and education within the international healthcare community.

Recently, there have not been any significant strides in increasing public education on preventive medicine. As a whole, public knowledge on basic health care principles such as hygiene have increased, but in-depth knowledge regarding topics such as child birth and health care have remained stagnant in many developing Member States. However, there has been a push to increase education for practitioners in their medical residency setting. According to the National Center for Biotechnology, over half of medical residency programs offer an international elective that will allow for the resident to use their skills to improve global health care and education. This strategy does come with boundaries to medical residents. Scheduling and funding were both notable concerns when utilizing the international health care electives.⁶⁸ Additionally, several universities have also implemented masters programs in public health to help increase training opportunities for professionals.

Committee Directive

Noting the need for a greater, cultural relevant, global health workforce, what are some initiatives that will strengthen public health education? How should the WHO address socioeconomic imbalances and environmental factors that have proven detrimental to preventive health practices? How can telemedicine directives be improved to further increase education on preventive medicine? What other technologies could be utilized or adapted to serve the needs of education on preventive health? Considering the uneven distribution of skilled workers, how will the WHO combat this shortage as the global population continues to grow? Where will the use of preventive medicine be most effective? Who will have the greatest benefit from education on preventive medicine?

⁶⁷ Ibid.

⁶⁸“Global Health Education in General Preventive Medicine Residencies,” National Center for Biotechnology Information, <http://www.ncbi.nlm.nih.gov/pubmed/25891059> (accessed May 23, 2015).

II. Promoting Health Policy Reform for the International Aging Population

Introduction

The United Nations (UN) defines the aging of a population as the process that results in rising proportions of older persons in the total population.⁶⁹ The Department of Economic and Social Affairs of the United Nations Secretariat (DESA) released study ST/ESA/SER.A/348 in 2013 as an update to the series of studies *World Population Ageing*, which have been conducted for the last thirteen years. These studies have been key in addressing the international aging population in the World Health Organization (WHO) and other international forums, including other UN committees. The *World Population Ageing* studies have provided basic information on international aging trends and research and discuss those trends in terms of the economic, environmental and social intersections that are affected and result from said trends. These studies have also allowed for both the international aging trends and the aforementioned intersections to be studied and compared over an extended period of time, which has facilitated accurate projected trends for the future.

The WHO considers the international aging population one of its top priorities and has devoted much of its resources to not only studying the world's aging population but also to improving the situation of those who fall, or will fall, into the "aged" category of the population. According to the WHO, between the year 2000 and 2050 the world's population over 60 years of age will double from 11 percent to 22 percent.⁷⁰ The absolute number of people aged 60 years and over is predicted to increase from 605 million to 2 billion between the year 2000 and 2050.⁷¹ Research predicts that the aging population could double at twice the rate in developing Member States as compared to developed Member States.⁷² Within the same given time period the population 80 years and older will quadruple at the international level.

The trend of an increasing aging population in both developed and developing Member States is strongly linked with improvement within healthcare systems worldwide. However, as the world's populations continue to age at an unprecedented rate, health policies must be reviewed and reforms will need to take place.

History of International Population Growth

Population growth was relatively slow in most Member States prior to the end of World War II. This was due to various causes, such as: a shift in cultural trends regarding family structure, the post-World War II economy, pre and post-natal health care, and health care at the societal level. With the end of World War II, populations "boomed" in both developed and developing Member States. This phenomena was unprecedented and signaled a sharp spike in population growth at the international level for next several decades.⁷³

In a minority of current developed Member States, the population boom was partly correlated to the amount of influence that the Allied victory of World War II had on society. The phenomena was experienced in the United States of America and many European Member States. The victory for the Allies in World War II signaled a wave of patriotism and nostalgia in these Member States. This national feeling caused many citizens to feel it was their civic duty to produce as many new citizens as they were able to; to create a new generation for a new world. In the United States, the "baby boom" was the period between mid-1946 and mid-1964 and a "baby boomer" was an individual born during this time period.⁷⁴ This 18 year period marked an increased and sustained fertility and birth rate in the United States and saw the number of baby boomers grow from 2.4 million in 1946 to 72.5 million baby

⁶⁹ "World Population Ageing 2013," Department of Economic and Social Affairs: Population Division, <http://www.un.org/en/development/desa/population/publications/pdf/ageing/WorldPopulationAgeing2013.pdf> (accessed May 20, 2015).

⁷⁰ "Ageing and Life Course: Facts About Ageing," World Health Organization, <http://www.who.int/ageing/about/facts/en/> (accessed May 20, 2015).

⁷¹ Ibid.

⁷² Ibid.

⁷³ Sandra Colby and Jennifer Ortman, "The Baby Boom Cohort in the United States: 2012 to 2060 Population Estimates and Projections," United States Census Bureau, <https://www.census.gov/prod/2014pubs/p25-1141.pdf> (accessed May 20, 2015).

⁷⁴ Ibid.

boomers in 1964.⁷⁵ The baby boom in western Europe occurred a few years after the baby boom in the United States. The main cause of this delay was due to the slow improvement of the European economy following the end of World War II.⁷⁶ Once the fertility and birth boom began to occur, many western European Member States experienced trends comparable to those seen in the United States, noting the difference in pre-war population size.⁷⁷ In many eastern European Member States, and the then Soviet Union, the populations and economies had been decimated due to World War II.⁷⁸ The Nazis had practiced a “war of annihilation” on the majority of eastern Europe, and the Soviet Union had sustained unprecedented and historical numbers of casualties in the war. Due to the political fallout between the Allied powers during key economic rebuilding years and the spread of the Soviet Union, the majority of eastern European Member States were not able to build their economies back to a level that was conducive to fostering a population boom.⁷⁹

Health care also played a key role in the population booms of the 20th century. Current developed Member States had and continue to possess some of the most advanced health care programs and services in the world. Most medical innovations regarding pre and postnatal health care occurred in what is now considered the Global North.⁸⁰ The first attributed concept of consistent and standardized prenatal care was attributed in the late 19th century to Dr. John Ballantyne, who practiced medicine in several large cities in the United Kingdom during his career.⁸¹ Ballantyne saw improved prenatal care as not only key to preventing fetal abnormalities but also as a way to possibly improve the almost endemic rates of maternal, fetal and neonatal deaths.⁸² This, along with further proposals made in the early and mid 20th century soon led to sweeping changes within pre and postnatal health care and has led to both becoming the most used preventive form of health care in the majority of developed Member States, thus resulting in high birth rates and low infant mortality rates, creating a steady rise in the population.⁸³

Prior to the end of World War II, developing Member States had some of the slowest population growth in the world.⁸⁴ By the end of the 1940s, developing Member States, like developed Member States, began to have population booms and a steady increase in population until the mid-1960s.⁸⁵ This was due to a sudden increase in access to basic health care and eventual health care advances that both decreased the death rate and increased the birth rate.⁸⁶ Population growth has continued in a sustained positive trend in the majority of developing Member States since this initial population boom.

History of Care for Aging Populations

For most of history, the portion of the population that was considered “aged” or “aging” was relatively small compared to that of younger portions of the population. This was directly linked to health care and the quality of life during various times in history. Care for the aged population, or “elder care”, has varied greatly from state to state throughout history. For most of history, in a majority of societies, elder care was expected to be provided by family members.⁸⁷ It was not consistently or officially mandated by law but was an understood social contract among family members. Failure to comply with this contract, or to execute it poorly, was considered taboo and could create adverse consequences for a family. It was not until the last century that many western states began to

⁷⁵ Ibid.

⁷⁶ Robert C. Ostergren and Mathias Le Bosse, *The Europeans: A Geography of People, Culture, and Environment* (New York: The Guilford Press, 2011), 101.

⁷⁷ Ibid.

⁷⁸ Ibid, p. 102.

⁷⁹ Ibid.

⁸⁰ Greg R. Alexander and Milton Kotelchuck, “Assessing the Role and Effectiveness of Prenatal Care: History, Challenges, and Directions for Future Research,” *Public Health Reports* (July-August 2001): 306-307, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497343/pdf/12037259.pdf> (accessed May 20, 2015).

⁸¹ Ibid, p. 307.

⁸² Ibid.

⁸³ Ibid, 307-309.

⁸⁴ “Human Population: Population Growth,” Population Reference Bureau, <http://www.prb.org/Publications/Lesson-Plans/HumanPopulation/PopulationGrowth.aspx> (accessed May 20, 2015).

⁸⁵ “World Population Growth,” World Bank, http://www.worldbank.org/depweb/beyond/beyondco/beg_03.pdf (accessed May 20, 2015). p. 16.

⁸⁶ Ibid.

⁸⁷ GHY Ting and J Woo, “Elder Care: Is Legislation of Family Responsibility the Solution?,” *Asian Journal of Gerontology & Geriatrics* (Volume 4): 72, <http://hkag.org/Publications/AJGG/V4N2/OA2009-62.pdf> (accessed May 20, 2015).

legislate standards regarding and allotting funds to elder care.⁸⁸ Many eastern Member States are just beginning to propose elder care legislation and continue to support the more traditional, familial responsibility of elder care.⁸⁹

Current Situation

The next few upcoming decades will be the first time in recorded history that a majority of the international middle-aged and older population will have living parents.⁹⁰ This is predicted to create a societal and cultural shift in family dynamics, especially in states where it is not common to have parents still alive so late into one's life. Many Member State's with national health care systems and extensive state-funded programs are finding that funding is not adequate to account for the extreme increase in the aging population that is currently occurring.

Case Study: Sweden

In developed Member States, current issues regarding logistic and finance problems in Sweden best illustrates some of the current issues regarding the care of an aging population and the need for policy reform. Like many developed Member States, legislation that created programs to care for aged population and allotted funding for these programs failed to account for substantial population increases and the survival of this population well into old age.⁹¹ Swedish law makers began to make legislative changes as early as 1990 to the national health care system. Some of these changes sparked intense debate among both lawmakers and the public, as it was believed that these changes were not doing enough to ensure that members of the aged population would be properly looked after.⁹² In 2000, the Swedish government introduced an action plan that was designed to strengthen primacy care, psychiatric care and the care of older people.⁹³ This legislation was the first major step in improving collaboration and development between counties and municipalities in regards to services for older people and also created a responsible allocation system to help provide much needed financial support.⁹⁴ Between 2001 and 2004, the responsible allocation program added roughly 1 billion USD to these programs.⁹⁵ Community services and the level of care was reevaluated and drastically improved as well.⁹⁶ Without this early action by the Swedish government, the projected level of care for the older population in Sweden was going to drastically decrease, along with their quality of life. Policy reform was the only way this was avoided and new policy reforms are also being currently addressed for a possible new update to the legislation.⁹⁷

Case Study: Brazil

Developing Member States face a much more difficult situation than developed Member States. Many developing Member States are just beginning to form basic health care systems, or have only had these systems for a short period of time and reform is not in the forefront of the government's mind. In Brazil, the lack of reform has been causing problems in funding and quality of care for almost a decade.⁹⁸ Despite a citizen's health being listed as a right in the Brazilian constitution, there is still only a major focus on primary health care within the health system. There is very limited discussion or reform in regards to the health of the aging population, although most politicians agree that it is an area of high priority.⁹⁹ There is also a split in the type of health care that there is access to based on geography. In rural areas, basic primary health care and some prenatal care are the main health services that

⁸⁸ Ibid

⁸⁹ Ibid.

⁹⁰ "Ageing and Life Course: Facts About Ageing," World Health Organization, <http://www.who.int/ageing/about/facts/en/> (accessed May 21, 2015).

⁹¹ Anders Anell, et al, "Sweden: Health System Review," *Health Systems in Transition* (Volume 14, Number 5): 17, http://www.euro.who.int/_data/assets/pdf_file/0008/164096/e96455.pdf (accessed May 21, 2015).

⁹² Ibid, p. 109.

⁹³ Ibid.

⁹⁴ Ibid.

⁹⁵ Anders Anell, et al, "Sweden: Health System Review," *Health Systems in Transition* (Volume 14, Number 5): 109, http://www.euro.who.int/_data/assets/pdf_file/0008/164096/e96455.pdf (accessed May 21, 2015).

⁹⁶ Ibid, p. 110.

⁹⁷ Ibid.

⁹⁸ "Flawed but fair: Brazil's Health System Reaches Out to the Poor," World Health Organization, <http://www.who.int/bulletin/volumes/86/4/08-030408/en/> (accessed May 21, 2015).

⁹⁹ Ibid.

Brazilians have access to.¹⁰⁰ In urban areas there is a battle for dominance between hospitals, which tend to service private health care users, and the primary health care clinics.¹⁰¹ The focus is still primarily on making sure that every citizen has access to basic health care of some kind rather than ensuring that certain populations receive the specialized treatment that they need.¹⁰²

Change in Health Care

With an aging population, different types of care are needed, earlier than expected and for longer periods of time. The need for long-term care is on the rise as older members of the population continue living longer lives. Many older people are no longer able to maintain total independence due to: limited mobility, frailty, physical problems or mental health problems.¹⁰³ The WHO predicts that the number of older people who are no longer able to maintain independence in developing states will quadruple by the year 2050.¹⁰⁴

There is also the issue of noncommunicable diseases and “aging well”. Although both infectious and noncommunicable diseases are declining, a majority of the aging population in most states die of noncommunicable diseases.¹⁰⁵ Living a healthy and active life style well into old age is on the rise around the globe in both developed and developing states. The need for Dementia and Alzheimer's care is also on the rise around the globe.¹⁰⁶

Actions Taken by the United Nations

There have been multiple studies conducted and resolutions passed by multiple UN committees regarding the international aging population. The previously mentioned *World Population Ageing* series released by DESA allows for the UN and its committees to study and predict the effects that aging populations have on social, economic and environmental intersections. “Dementia: A Public Health Priority” was a study that was released by the WHO in 2012 that gave a comprehensive and international perspective on the issues surrounding Dementia and Alzheimer's in respect to the international aging population.¹⁰⁷ The study reported that there is currently 35.6 million people living with dementia and that this number is projected to double by 2030 and triple by 2050.¹⁰⁸ This study also provided a summarized overview of the financial effect that dementia currently has on health care systems and government, and the projected financial trends if no action is taken. The study also provides key areas where states can look to develop and improve care and response for the portion of the population affected by Dementia. “Social Development and Ageing: Crisis or Opportunity?” was another study that was released by the WHO that advocates that aging be seen not as a crisis but as an opportunity in social development and advocated for an engaging approach to health and the aging population as a whole.¹⁰⁹ The majority of the international aging population is located in developing states.¹¹⁰ This study proposes the idea that these older generations within developing states are both an important untapped resource in the path towards development but also key to ensuring the success of the process.¹¹¹ In 1991, the UN issued the *United Nations Principle for Older Persons* which not only highlighted the rights of older persons but also addressed the UN's responsibility to the welfare of older persons.¹¹²

¹⁰⁰ Ibid.

¹⁰¹ “Flawed but fair: Brazil's Health System Reaches Out to the Poor,” World Health Organization, <http://www.who.int/bulletin/volumes/86/4/08-030408/en/> (accessed May 21, 2015).

¹⁰² Ibid.

¹⁰³ “Ageing and Life Course: Facts About Ageing,” World Health Organization, <http://www.who.int/ageing/about/facts/en/> (accessed May 21, 2015).

¹⁰⁴ Ibid.

¹⁰⁵ Ibid.

¹⁰⁶ “Ageing and Life Course: Facts About Ageing,” World Health Organization, <http://www.who.int/ageing/about/facts/en/> (accessed May 21, 2015).

¹⁰⁷ “Dementia: A Public Health Priority,” World Health Organization, http://www.who.int/mental_health/publications/dementia_report_2012/en/ (accessed May 21, 2015).

¹⁰⁸ Ibid. p. 11.

¹⁰⁹ “Social Development and Ageing: Crisis or Opportunity?,” World Health Organization, http://www.who.int/ageing/publications/social_development/en/ (accessed May 21, 2015).

¹¹⁰ Ibid. p. 3.

¹¹¹ Ibid. p. 5.

¹¹² “Ageing,” The United Nations, <http://www.un.org/en/globalissues/ageing/> (accessed May 21, 2015).

The document contained 18 specific rights of older persons, which addressed: personal independence, community participation, care, self-fulfillment and personal dignity.¹¹³

There have been multiple international conferences regarding the international aging population and the policy reform needed to best serve said population. In 1982, the First World Assembly on Ageing was held and called for specific actions on health and nutrition for older persons and called for a collection and analysis of data regarding the current state of the international aging population at that time.¹¹⁴ In April 2002, the Second World Assembly on Ageing was held and aimed at designing a new international policy on aging for the new century.¹¹⁵ In 2007 and 2008, the Madrid International Plan of Action on Ageing (MIPPA) was implemented. It called for a change in attitudes, policies and practices regarding the international ageing population and called for these changes to take places at all levels of government and society.¹¹⁶

Committee Directive

Although the WHO and the UN have placed the aging population high on their list of priorities, there is still a vast amount of work that must be done to current WHO policies regarding the international ageing population. When looking at the current WHO studies and policies, what could be changed or improved upon? What aspects are possibly outdated and need to be updated to best serve the international ageing population? Find and target key areas of improvement within current international health care policies. What is working? What needs reform? Does the international community need a standard of health care regarding aging populations? If so, what might it entail?

¹¹³ Ibid.

¹¹⁴ Ibid.

¹¹⁵ "Ageing," The United Nations, <http://www.un.org/en/globalissues/ageing/> (accessed May 21, 2015).

¹¹⁶ Ibid.

Technical Appendix Guide (TAG)

Topic I: Improving Public Education on Preventive Medicine

Ritu Sadana, et al, "Strengthening Public Health Education and Training to Improve Global Health," World Health Organization, 2007, p. 161-244, <http://www.who.int/bulletin/volumes/85/3/06-039321/en/>.

This article gives an excellent overview of the current situation regarding preventive medicine. It highlights the current finding of the WHO and also gives some insight as to where the WHO predicts the direction of health education is going to go.

"Health Workforce," World Health Organization, <http://www.who.int/hrh/education/en/>.

This article gives a brief overview of the current situation regarding the status of the healthcare workforce at the international level. This article also has several links to other articles and databases that provide useful information regarding the international healthcare workforce.

"The Determinants of Health," Health Impact Assessment, <http://www.who.int/hia/evidence/doh/en/>.

This article gives an important breakdown of the research that the Health Impact Assessment (HIA) has and continues to conduct regarding health at the international level. The article not only breaks down health in regards to age and gender, but also based on regional influences on health.

"The World Health Report," World Health Organization, 2013, <http://www.who.int/whr/en/>.

This report gives an entire breakdown of the research the WHO has been gathering since 2010. It provides vital statistics on health at the micro and macro levels of society and also reports on new information regarding past health trends that were being studied. The report also highlights areas of improvement and concern, and gives expert opinions as to what might be done to create a continued improvement of health at the international level.

Arthur J. Visel, "John R. Paul and the Definition of Preventive Medicine," *Yale Journal of Biology and Medicine* (May-Aug 1982): 167-172, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2596460/>.

Delegates can access the full paper online. The paper provides details about John R. Paul, a professor of preventive medicine at the Yale University School of Medicine. Dr. Paul was considered a pioneer in the field of preventive medicine, and this paper provides insight to his definition and philosophy of preventive medicine as it compares to other disciplines, and the intersection of preventive medicine with these other disciplines.

Rika Maeshiro, et al, "Patients and Populations: Public Health in Medical Education," *American Journal of Preventive Medicine*, October 2011, <http://www.ajpmonline.org/issue/S0749-3797%2811%29X0013-2>

The webpage serves as the online database for the American Journal of Preventive Medicine. This particular source contains full free articles which provide discussion, research, and insight into various topics such as integrating public health into medical education, and can expand delegate knowledge on various public health topics to better enable them to understand and formulate positions on this topic.

Topic II: Promoting Health Policy Reform for the International Aging Population

"World Health Statistics," World Health Organization: Global Health Observatory, 2015, http://www.who.int/gho/publications/world_health_statistics/en/.

This database provides every World Health Statistics Report from 2005 to the present. These reports provide both generalized health data by Member State and detailed health data broken down along various categorical lines by Member State.

"Global Health and Ageing," World Health Organization and the US National Institute of Ageing, 2011, http://www.who.int/ageing/publications/global_health/en/.

This article gives a global perspective on ageing. It highlights the areas of immediate concern in regards to ageing populations and discusses concerns that may arise in the future. It also provides important data at the international level regarding ageing populations. It also lays out research strategies for the future so that trends can continued to be studied in the most effective way possible.

“World Populations Ageing Report,” Department of Economic and Social Affairs Population Division, 2013,
<http://www.un.org/esa/socdev/documents/ageing/Data/WorldPopulationAgeingReport2013.pdf>.

This report provides both statistical data and overviews of what issues the international ageing population is facing as a whole. It provides some background on these issues and also provides action plans for the improvement of said issues.

“Age Friendly Environments,” World Health Organization: Ageing and Lifecourse,
<http://www.who.int/ageing/projects/age-friendly-environments/en/>.

This database provides an overview of what the WHO classifies as “age friendly” and resources that provide information regarding why the concept of “age friendly environments” are so important and what can be done to maintain and create more of them.

"Why 'ICT for Health'?", ICT for Health,

http://www.ictforhealth.net/index.php?option=com_content&view=article&id=45&Itemid=27.

This website provides information about the ICT for Health project, which seeks to address various challenges to providing medical care including the ageing of the population in general through the use of Information Communication Technology (ICT). Delegates may want to use this resource as a starting point for further research into the possible application of ICT in order to provide solutions to some of the issues addressed in the background guide.

Isabella Aboderin, "Understanding and Advancing the Health of Older Populations in sub-Saharan Africa: Policy Perspectives and Evidence Needs," *Public Health Reviews* (2014): Vol. 32, 2: p. 357-376,
https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=6&cad=rja&uact=8&ved=0CE0QFjAFahUKEwjJh-L2m6XHAhWQ_YAKHWXMCro&url=http%3A%2F%2Fwww.publichealthreviews.eu%2Fshow%2Fp%2F40&ei=kBzMVcn_EJD7gwTlmKvQCw&usg=AFQjCNG6SLdU3vdgScfrxvVChqLzm7vWZQ&bvm=bv.99804247,d.eXY

This article provides analysis and discussion regarding the debate over health policy challenges and changes in a specific region: sub-Saharan Africa. Populations are aging at different rates in different areas of the world, and no two regions face the exact same challenges because of the differences from place to place. Along with cultural, socioeconomic, and differences in medical practices, different regions have different capacities to handle aging populations. By focusing on a particular region, delegates can get a sense of some of the challenges this regions is facing, and how blanket solutions might not be ideal given the varying challenges different regions face.