

**Hofstra University Model United Nations Conference**

World Health Organization

Maryum Alam

Chairperson

Dear Delegates,

It is with great honor that I welcome you to Hofstra University's fourth annual Model United Nations Conference for high school students. My name is Maryum Alam and I will be your World Health Organization (WHO) Chairperson.\* I am currently a junior at Hofstra University, pursuing a dual major in Political Science and Biology and a minor in Chemistry. Born and raised in New York, I was involved in my high school's Model UN club for four years, and decided to join Hofstra's club last year.

This is the first time HUMUNC is holding a WHO committee, which is particularly exciting for me. The topics I chose for this committee revolve around the eradication of vaccine-preventable diseases and improving women's health, both of which incorporate a wide variety of international issues and WHO objectives. Please use this background guide in addition to credible sources to research the topics pertaining to not only the committee but your country assignment as well. Don't hesitate to contact me via email if you have any questions or concerns. Good luck and I look forward to meeting you all!

Sincerely,

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\* At HUMUNC 2015, we are simulating a session of the World Health Assembly, the deliberative body of the WHO. The committee will be conducted very similarly to those in the UN General Assembly, and will have no impact on traditional MUN parliamentary procedure.

## Introduction to the Committee

Upon the establishment of the United Nations (UN) in 1945, world leaders soon convened at the UN Conference on International Organization in San Francisco to discuss the creation of a specialized agency on international health. That institution came to be known as the World Health Organization (WHO), whose constitution was approved the following year and was officially created in 1948 under the supervision of the UN's Economic and Social Council (ECOSOC). U Thant, the third Secretary General of the UN proudly remarked, "...for the first time in history, [the UN] provided mankind with mechanisms that would seek to improve the life of every man, woman and child on Earth...this was a goal perhaps more revolutionary than any political goal in history."<sup>1</sup>

Consisting of three major bodies—the World Health Assembly (WHA), an Executive Board, and a Secretariat—the WHO has been at the center for global health cooperation for over six decades. Chapter 1, Article I of its constitution mandates the organization to work for "...the attainment by all peoples of the highest possible level of health."<sup>2</sup> As such, the WHO works in the interest of global public health in a wide range of fields, including disease control, research, education, preventive health care, as well as the provision of international health assistance during emergencies. The agency's greatest success is notably the eradication of smallpox in 1980, a pandemic that plagued the human population for centuries. More recently, the WHO has shifted its attention to the fight against non-communicable diseases, which includes mental health and lifestyle diseases.<sup>3</sup>

The WHO coordinates with a number of UN bodies within ECOSOC, including the UN Development Program (UNDP) and UN Children's Emergency Fund (UNICEF), as well as

bodies in the General Assembly (GA) such as the Social, Cultural and Humanitarian Committee (SOCHUM). In the past two decades the WHO has partnered with non-profit organizations such as the Bill and Melinda Gates Foundation, Doctors Without Borders (Médecins Sans Frontières), and the International Committee of the Red Cross.<sup>4</sup>

## **Introduction to the Issues**

The vaccine has been hailed as medicine's greatest triumph; clean water is the only amenity that is believed to better prevent infectious diseases. It is the single most cost-effective way to reduce child mortality, the fourth Millennium Development Goal set forth by the UN in 2000. Yet, vaccine-preventable diseases are a commonplace in a number of states and increasingly difficult to eradicate in this age of globalization. Viruses and pathogens are always in circulation, but the only regions that are affected by outbreaks of preventable diseases are under-vaccinated ones. Despite vigorous vaccination campaigns, the number of cases of diseases that were thought to be eliminated in certain regions is on the rise, notably in developed states. Individuals and governing bodies often forego routine vaccinations due to personal dispositions or religious beliefs, resulting in significant anti-vaccination movements. Delegates should consider eradication mechanisms that don't only focus on delivering vaccines, but also on research and education to eliminate common misperceptions about immunization.

The health disparity between men and women is not just a health challenge, but a human rights challenge that the WHO has been trying to ameliorate for decades. Socio-cultural discrimination exacerbates this problem, where health infrastructures in low-income states are unable to accommodate women when it comes to nutrition, intimate partner violence, and reproductive and maternal health. A lack of gender mainstreaming in local, national and even international governing bodies has hindered economic growth across the globe, which both results in and is caused by gender inequality in health. Additional services and health programs can only improve this situation; therefore, delegates should explore policy options that address the aforementioned factors that contribute to this pressing international issue.

## **The Eradication of Vaccine-Preventable Diseases**

### History of the Vaccine

Prior to 1798, physicians around the world practiced an archaic form of vaccination, called inoculation, to prevent infection from common and deadly diseases such as measles or smallpox. Inoculation basically involved the subcutaneous transfer of infected tissue from a person suffering from the disease to someone who had not been exposed to the disease before. The procedure itself was incredibly risky, where unsanitary conditions and contaminated equipment led to deadly infections. However, in 1798, the famous Edward Jenner hypothesized that inoculation of a disease that afflicts other mammals (cowpox) would provide the same level of immunity against a virus that afflicted humans (smallpox).<sup>5</sup> The results of this study were successful, which provided the foundation for modern vaccines. Vaccination, whose benefits increased exponentially with sanitary conditions and proper administration, is the process of introducing a harmless substance (typically a weakened or dead pathogen) to mimic infection and evoke an immune response.<sup>6</sup> This process not only strengthens one's immune system, but eliminates the need for antibiotics or other anti-viral drugs that have typically been used to control the spread of disease. Over the course of the twentieth century, it became easier and cheaper to manufacture and administer vaccines, and thus vaccination became the most prevalent and universal medical practice to prevent the spread of countless diseases. Today, there are twenty five vaccine-preventable diseases, immunization for which prevents 6 million deaths annually.<sup>7</sup>

The most obvious and important benefit of immunization is in the prevention of disease proliferation. There are, however, other benefits associated with the administration of a vaccine, such as the opportunity to deliver multiple antigens within a dose (thus, immunizing an

individual for multiple diseases), as well as the distribution of other life-saving measures such as vitamin supplements for those suffering from malnutrition or insecticide treated nets to protect against malaria. As mentioned earlier, the use of vaccines eliminates the need for antibiotics or antimicrobial agents, whose prolonged and widespread use results in the development of antimicrobial resistance (e.g. multi-drug resistant tuberculosis).<sup>8</sup> Furthermore, the benefits of immunization aren't limited to children; adolescents and adults are also protected against life-threatening diseases such as meningitis and influenza, as well as certain cancers that are likely to emerge as a result of exposure to such diseases. These vaccines have directly and indirectly expanded the human lifespan by over thirty years.<sup>9</sup>

#### International Framework for Vaccination

Along with accelerating international trade and cross-border transportation, globalization has done the same for the spread of disease, where "...practically speaking, the only relevant point of view for microbial issues is global, since bacteria, parasites and viruses exploit appropriate ecospheres whenever they find them, regardless of national boundaries."<sup>10</sup> As such, the WHO tends to adopt global campaigns for disease control and immunization (Table 1). The World Health Assembly (the deliberative body of the WHO) adopted the International Sanitary Regulations in 1951—renamed to International Health Regulations (IHR) in 1969—which are policy recommendations to be adopted by WHO member states. The IHR is used to coordinate international action on matters regarding public health, by establishing monitoring mechanisms to prevent disease proliferation around the globe.<sup>11</sup> This entailed the creation of disease surveillance at airports, border posts, and maritime ports, as well as specified requirements for international travel between infected and non-infected states. These are the same regulations that urge states to mandate vaccinations for international travelers. However, until 2005, the IHR

only controlled the spread of three diseases: smallpox, cholera, and yellow fever.<sup>12</sup> Today, the revised IHR applies to a number of new epidemics, such as the Acquired Immune Deficiency Syndrome (AIDS), the Serious Acute Respiratory Syndrome (SARS), as well as outbreaks of diseases for which no vaccine is available, such as Ebola.<sup>13</sup> Despite the rigorous IHR protocol, many states in the global North and South are unable to keep up with immunization requirements for travelers, thus creating mechanisms for diseases to travel.

<b>Date</b>	<b>Disease Program</b>
1947 – 1951	International Tuberculosis Campaign
1967 – 1980	Intensified Smallpox Eradication Program
1974 – present	Expanded Program on Immunization (polio, diphtheria, whooping cough, tetanus, tuberculosis and measles)
1988 – present	Global Polio Eradication Initiative
2006 – 2015	Global Immunization Vision and Strategy
2011 – 2020	Global Vaccine Action Plan

**Table 1: Select Global Vaccination Campaigns by the WHO<sup>14</sup>**

### Eradication versus Elimination

Without mass vaccination, an infectious disease cannot be eradicated. Eradication, as defined by the WHO, is the “permanent reduction to zero of the worldwide incidence of infection.”<sup>15</sup> Eradicated pathogens cannot reemerge into outbreaks unless they inhabit an environmental or animal reservoir or are reintroduced (intentionally, in the case of a bio-attack, or accidentally). Such was the case for smallpox, whose eradication was successful due to the fact that the disease only afflicted humans. As a result, a mass vaccination campaign and the



establishment of a global surveillance system to detect new outbreaks of the disease was efficient and comparatively easy.<sup>16</sup> A disease that had killed 300 million people in the twentieth century alone was now wiped off the planet, an astounding accomplishment for a relatively unknown organization.<sup>17</sup> While eradication is a bit of an ambitious goal, the WHO has structured many programs based on the smallpox eradication model, such as the ongoing polio eradication initiative.

Elimination, on the other hand, is a more realistic goal that the WHO can potentially accommodate. Diseases can be eliminated locally and regionally without being globally eradicated. However, elimination does not protect against reintroduction, unlike eradication. For example, measles was eliminated in the United States (U.S.) but easily reintroduced in 2005, resulting in a major outbreak in the state of Indiana.<sup>18</sup> Pathogens and viruses that exist in environmental reservoirs or animal reservoirs cannot be eradicated, but can be globally eliminated if the immunization rate is maintained at a high level. This is the case for diseases such as tetanus (environmental reservoir) and rabies (animal reservoir).<sup>19</sup>

### Dangers of Lowering Vaccination Rates

Drops in vaccination rates, either due to personal exemptions or state policies can have lasting harmful effects. For example, during the 1970s, Japan maintained an 80% vaccination rate against pertussis, the virus that causes whooping cough.<sup>20</sup> In 1976, the state changed its policy after a fierce anti-vaccination movement to immunize less than 10% of children for the disease.<sup>21</sup> A pertussis epidemic soon emerged in 1979, resulting in over 13,000 cases and more than forty deaths—a number that was manageable in a state with adequate health infrastructure. The Japanese government reintroduced, and mandated, the pertussis vaccine soon thereafter, but the high immunization coverage wouldn't be restored until the late 1980s.<sup>22</sup> Another example is

the United Soviet Socialist Republics (USSR), whose collapse in 1991 led to the dissolution of its mandated vaccination schedule, causing a resurgence of diseases such as diphtheria, whooping cough, typhoid fever and polio across Eastern Europe and Asia.<sup>23</sup> These diseases continue to circulate, leaving national health infrastructures struggling to contain them. These are just a few examples of how outbreaks of diseases that are seemingly eliminated can be reintroduced if a vaccination schedule is not maintained.

The most recent immunization program adopted on by the WHO is the Global Vaccine Action Plan (GVAP), which established five global goals for “the Decade of Immunization:”

1. Achieve a world free of poliomyelitis;
2. Meet vaccination coverage targets in every region, country and community;
3. Exceed the Millennium Development Goal Four target for reducing child mortality;
4. Meet global and regional elimination targets;
5. Develop and introduce new and improved vaccines and technologies.<sup>24</sup>

### Current Issues

The GVAP lays out six strategic objectives to meet its goals:

1. All countries commit to immunization as a priority;
2. Individuals and communities understand the value of vaccines and demand immunization as both their right and responsibility;
3. The benefits of immunization are equitably extended to all people;
4. Strong immunization systems are an integral part of a well-functioning health system;
5. Immunization programmes have sustainable access to predictable funding, quality supply and innovative technologies;
6. Country, regional and global research and development innovations established to maximize benefits of immunization.<sup>25</sup>

The biggest challenge to the WHO’s global immunization program lies in the first GVAP objective: its ability to convince states to adopt immunization as an integral part of health infrastructure. There are two major philosophies of public health that dictate health policy. The

first approach values public health above individual liberties, where decisions about policy revolve around the greater global good of society. In the context of vaccination, this viewpoint is illustrated by state policies such as mandatory vaccination schedules, which is not only prominent in developed states but in developing ones as well. The rationale for such a policy is based on the phenomenon of collective immunity, a notion that the vast majority of a population can become immune to a disease through mass individual vaccination. In other words, so long as a preponderance of a population is vaccinated against a particular disease, a virus is less likely to take hold and infect a community. There is strong evidence and data for this viewpoint, and is the backbone of WHO immunization programs.<sup>26</sup> In fact, the smallpox eradication initiative was based on the Soviet Union's successful elimination of measles and smallpox during the 1950s, which resulted from a centralized, compulsory immunization strategy.<sup>27</sup>

Not all states follow the "greater good" vaccination approach, though. Countries that value individual liberties, such as the United States, provide mechanisms for citizens to obtain a vaccine exemption for religious or personal reasons, which vary from state to state.<sup>28</sup> Anti-vaccination movements in Western countries have taken advantage of this option, citing fears of personal infringement, adverse reactions to the vaccine itself (i.e. causal relationships between vaccines and autism, seizures, death, etc.) and overall repugnance for the pharmaceutical companies that manufacture, and thus profit, from the mandatory purchase of vaccines.

The WHO has made tremendous gains through mass immunization campaigns in the past five decades, where eighty percent of the world's children under five are meeting basic immunization requirements, and by doing so averting seventeen percent of deaths.<sup>29</sup> Nevertheless, the WHO is still struggling to reach its ninety percent immunization coverage goal for 2020.<sup>30</sup> Additionally, it is important to note that the vast majority of the immunized

population remains in developed states, which possess adequate health infrastructures to address the average health needs of a society. A mass vaccination program cannot be implemented without available health infrastructures at the local level, something that developing states cannot accomplish due to lacking political will or finances. As a result, there aren't sufficient hospitals, staffers or medical equipment to achieve and maintain a high vaccination rate. More importantly, developing states are ill-equipped when it comes to educating the public—especially new mothers—about the importance of vaccinating their children, whose immune systems are particularly vulnerable to debilitating illnesses.<sup>31</sup> Additionally, the benefits of establishing effective health infrastructure aren't limited to individual well-being. Improving health systems—which is one of the few ways individuals in low-income countries interact with their government—can even lead to an increase in public trust for their public institutions, which not only improves accountability, but legitimacy and governance too.<sup>32</sup>

There are institutional problems within the WHO that prevent the expansion of health infrastructure. The UN agency is miserably under-resourced, dependent upon voluntary contributions from member states and non-governmental organizations (NGOs)—called “extrabudgetary funds,” over which the WHO has no control over—for over seventy percent of its budget. The allocation of these funds is dictated by donors, whose interests and objectives don't necessarily align with that of the WHO.<sup>33</sup> Moreover, NGOs and member states contribute funds for the accomplishment of short-term, numerical goals, such as the immunization of “ninety percent of the population in eighty percent of districts,” without allocating adequate funds for the building of an infrastructure to sustain that vaccination rate.<sup>34</sup> As a result, the World Bank takes on the burden of financing health projects around the globe, rather than the WHO.<sup>35</sup> In order to integrate public and private immunization goals and lessen the financial burden on

international institutions alone, a number of private-public partnerships have come together such as the Global Alliance for Vaccines and Immunization (GAVI). GAVI is a public-private partnership between UN agencies like the WHO, the World Bank, and UNICEF, and private organizations like the Bill and Melinda Gates Foundation and the Rockefeller Foundation to incorporate routine immunization as an integral part of the primary health care system of developing states. More recently, GAVI was responsible for championing the creation of the Global Vaccine Action Plan (GVAP).<sup>36</sup>

In addition to budgetary constraints and differences in health infrastructures, varying distribution systems at the national level continue to hinder efforts to expand the global vaccine umbrella. The first type of distribution system is a centralized one, where the administration, regulation, and purchase of vaccines is controlled by the national government. Alternatively, in a decentralized system (typically practiced by capitalist states), the distribution of vaccines is controlled by a number of entities, such as pharmaceutical companies.<sup>37</sup> An analysis of the two distribution systems on data obtained from 1980 to 1997 by the World Bank indicated stark differences on childhood immunization. In lower-income states, a decentralized distribution system was more effective at immunizing the population as compared to a centralized one. Conversely, a centralized distribution system was more successful at immunizing the population in middle-income states. The World Bank attributed this disparity to differences in infrastructure, where lower-income states cannot depend on the central government to adequately deliver vaccines in poor conditions. Thus, private companies take on the bulk of national immunization coverage, relying on profits over often unreliable national assistance while middle-income states with centralized systems are more effective at immunizing their population in comparison to

their decentralized counterparts due to reliable government infrastructure.<sup>38</sup> This divergence continues to impede WHO efforts to expand immunization coverage.

The aforementioned issues—differing philosophies of public health, discrepancies in health infrastructures, and distinct vaccine distribution systems—have all contributed to variations in immunization policies across the globe. Like any other policy, these policies have attracted public opposition with the emergence of anti-vaccination movements in the global North and South. These movements—lacking scientific evidence and reliant upon conspiracy theories—are political in nature, yet have spiraled in such a way that have left children as their main victims.

#### Case Study 1: Polio in Nigeria

Polio is a highly contagious neuromuscular disease caused by the poliovirus, leaving mostly children under the age of five paralyzed for the rest of their lives. Since the poliovirus is a human pathogen, in 1988, the WHO established a Global Polio Eradication Initiative (GPEI), working alongside UNICEF, the U.S. Centers for Disease Control and Prevention (CDC) and the Bill and Melinda Gates Foundation. The WHO predicts that the complete eradication of polio “would save at least forty to fifty billion US dollars over the next twenty years, mostly in low-income countries.”<sup>39</sup> Since the GPEI was launched, global polio cases have dropped by over ninety-nine percent—yet the disease remains endemic in three states: Afghanistan, Pakistan, and Nigeria.<sup>40</sup>

Nigeria has had a troublesome history with the polio vaccine. In 2003, three Northern Nigerian states shut down the federally sponsored polio immunization campaign, justifying the

suspension on the grounds of vaccine safety. The formal boycott, authorized by the Nigerian Muslim organization Jama'atul Nasril Islam (JNI) stated that the organization “had reasons to suspect contamination of the polio vaccines with HIV/AIDS, anti-fertility substances, and dangerous elements.”<sup>41</sup> Suspicions about the polio eradication initiative were in part powered by the 1996 Pfizer scandal, where the U.S. pharmaceutical company used experimental drugs on patients in the Nigerian state of Kano during a meningitis outbreak. The suspension was almost immediately adopted by the mostly Muslim Northern states, leading to a significant outbreak of polio across Africa, the Middle East and Asia, costing the international community over \$500 million in efforts to contain it.<sup>42</sup>

Rumors about vaccine safety have sparked a number of anti-vaccination movements—most of which are baseless and without any scientific evidence—but the polio boycott in Nigeria was a rallying point for a bigger issue. Former U.S. Ambassador to Nigeria John Campbell believed there “was fear and disaffection at the popular level that fastened on immunization...this was not really about technical issues...the issue was Northern Nigeria’s thorough disaffection with the government.”<sup>43</sup> Indeed, the contentious 2003 election that chose General Olusegun Obasanjo as the nation’s president reignited sectarian violence between the North and the South, where Northern Nigerians believed a Southern, Christian leader wouldn’t protect their interests and improve the economic and health disparity between the two regions.

Under increasing pressure from the WHO Director-General David Heymann and the CDC, President Obasanjo agreed to accelerate talks with the Organization of the Islamic Conference (OIC) to publicly dismiss fears about the polio vaccine. A coordinated effort from a number of international agencies, including the WHO, UNICEF, GPEI Secretariat and even then-UN Secretary General Kofi Annan ultimately pushed the OIC to acquiesce and issue a

number of *fatwas*, or Islamic religious rulings, to dismiss the misperceptions about the vaccine. This led to federal and state leaders to lift the ban by June 2004, resuming the immunization program by 2005. In less than 18 months after a few Nigerian states had completely stopped immunization, the WHO provided evidence that almost eighty percent of new global polio paralysis cases had originated in Kano.<sup>44</sup>

Over a decade later, Nigeria has yet to eradicate polio. This task is very difficult in a state with widespread poverty and failing health infrastructure, a condition that is far worse in the North than the South. Remote villages in the North don't have even access to clean water, leaving contaminated water sources to serve as a reservoir for the poliovirus. Melissa Corkum, UNICEF's spokesperson on the polio campaign in Nigeria told the BBC in 2013, "We still continue to miss too many children...in a campaign where you aim to reach 32 million children house-to-house there are a number of challenges," referring to the fact that a majority of the Northern Nigerian population is nomadic.<sup>45</sup> To accommodate this discrepancy, the federally sponsored program has been modified to appeal to particular regions to accelerate the immunization process. Consequently, local leaders—not national ones—have been the most important figures in pushing their communities to immunize their children, not only because they are more credible in the eyes of average citizens but also due to their personal relationships and ties with their community, reinforcing the idea that all politics is undeniably local.<sup>46</sup> Years later, the atmosphere in Nigeria has changed. The BBC actually reported the arrest of Muslim clerics and journalists in 2013 for publicly speaking against the safety of vaccines.<sup>47</sup>

Despite extensive international efforts to contain polio in Nigeria, the country has been facing a new anti-vaccination movement crusaded by the anti-Western, extremist Islamist insurgency Boko Haram, whose motivation to halt immunization efforts is not unlike that of the



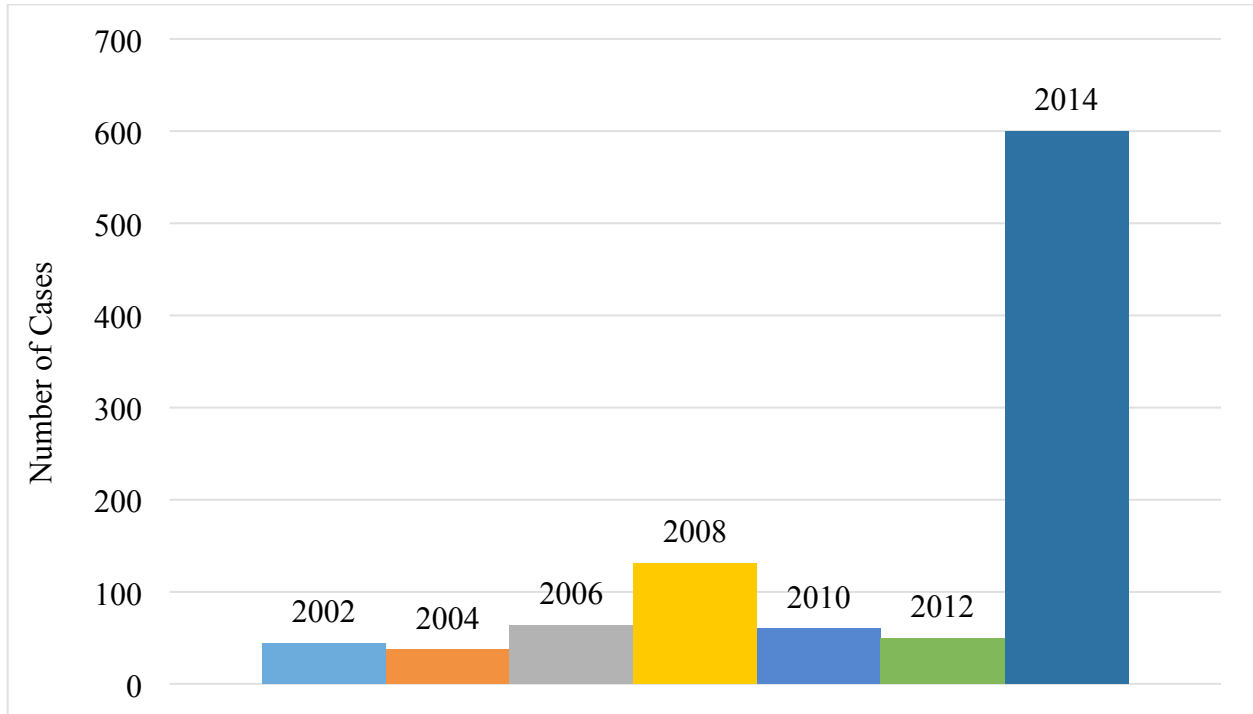
Taliban in Afghanistan and Pakistan. Federal health services in the Northeastern state of Borno, for example, have been shut down after a number of hospitals and medical staff were targeted and killed by the group. Some regions are considered to be “no-go” areas out of the reach of the Nigerian government, leaving hundreds of thousands of children unvaccinated for not only polio, but for a variety of other diseases.<sup>48</sup> As a result, the current health situation in Borno remains muddled, based solely on eyewitness accounts of individuals that have fled the region.<sup>49</sup>

Today, polio cases in Nigeria have dropped significantly, but still fall short of the WHO goal of achieving at least ninety percent immunization coverage. From February 2012 to February 2013, oral polio vaccine (OPV) coverage increased by 60% in the Northern states of Nigeria after a vigorous campaign by GPEI leaders to integrate the national and local protocol for polio immunization.<sup>50</sup> As of August 2014, only five new cases of polio were reported by UNICEF (compared to over fifty cases reported last year), all of which are contained in four Nigerian states: Yobe, Kano, Bauchi and Borno.<sup>51,52</sup>

### Case Study 2: Measles in the United States

Measles is an airborne viral respiratory disease whose victims suffer from severe pneumonia, and without the proper medical care often results in death. Like polio, measles is a human pathogen and can be eradicated. Before states adopted widespread measles vaccination policies in 1980, measles caused over two million deaths each year. Although the global measles mortality rate has dropped by over seventy percent from 2000 to 2012, it continues to be one of the leading causes of death in children under five.<sup>53</sup> Nevertheless, the measles vaccination rate has slowed down in the past few years in developed states—particularly in the United States.

Working in conjunction with the Expanded Program on Immunization of 1974 (which suggested states take on a national vaccination protocol for a number of diseases, with polio and measles vaccines as a priority), the U.S. adopted a concerted and vigorous immunization campaign in the 1970s and 1980s, leading to a substantial decrease in the number of measles outbreaks.<sup>54</sup> This task was less daunting with a fully operational and developed health infrastructure—something that developing states do not possess—paired with a centralized vaccine distribution system, regulated by the Department of Health and Human Services and the Centers for Disease Control and Prevention (CDC). In 2000, measles was declared to be eliminated in the United States. However, because measles was not eradicated, it only took one unvaccinated girl incubating the disease from a trip in Europe to start the largest measles outbreak since 1996. Over ninety-seven of these cases were brought over by travelers, resulting in a number of import-associated outbreaks, the worst of which are in Ohio, California and New York.<sup>55</sup> Over 590 cases were reported in 2014, affecting over 32,000 people (Figure 1).<sup>56</sup>



**Figure 1: Measles Cases in the United States by Year**<sup>57</sup>

The rising number of measles cases has perplexed the nation. The majority of Americans follow standard immunization procedures, typically because they are mandated by individual states in order for their children to attend school, or travel abroad. Still, personal exemptions are relatively easy to obtain for those who choose to forego vaccination, for parents who home-school their children, for example, or secluded populations such as the Amish community. Such populations are small in number, but these under-immunized populations are at the greatest risk of infection. In the state of Indiana, the initial notification of measles indicated that approximately eighty-nine percent of the individuals who declined the MMR vaccine (measles, mumps and rubella are administered in two doses of a vaccine in the U.S.) got measles. Unfortunately, many infants who are too young to receive the measles vaccine also contract the disease because of decreasing collective immunity in the population.<sup>58</sup> These populations used to

be particularly intransigent when it came to immunization, but in light of the ongoing measles outbreaks have begun routine vaccination for their children.<sup>59</sup>

A growing national anti-vaccination movement is also responsible for a rise in the number of vaccine exemptions. The movement, championed by celebrities Jim Carrey and Jenny McCarthy, urges Americans to refute the national MMR program altogether, citing safety fears. These fears include the belief that vaccines, or chemical components used in the manufacture of vaccines, can cause developmental disorders such as autism.<sup>60</sup> There is absolutely no scientific evidence for these claims, and studies from a number of credible institutions have disproved such theories.<sup>61</sup> Furthermore, Americans believe that mandating vaccines in general is a severe violation of their individual liberties and an attempt by the federal government to assert more control over states. Nevertheless, in this age of social media, the Internet has become a significant channel for the anti-vaccination movement.<sup>62</sup>

### Bloc Positions

Western: Many Western states possess adequately developed health infrastructures to administer vaccines. Nevertheless, several Western states are moving towards adopting a decentralized vaccine distribution systems, including the United Kingdom, resulting in heterogeneous immunization rates within states. These states have established national recommendations for protection against vaccine-preventable diseases, but many continue to remain under-utilized. In

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<sup>†</sup> The link between autism and vaccines has been cited because many parents noticed “something changed” after their child received the MMR triple shot, after which a diagnosis of autism was made. These allegations emerged after the controversial study of Andrew Wakefield and colleagues was published 1998 in the English journal, *The Lancet*, drawing a connection between the MMR vaccine and autism. The methodology and reasoning behind the paper was highly contested, and was eventually retracted in 2010.

addition to measles outbreaks in the U.S., the European Center for Disease Prevention and Control (ECDC) reported 7,116 cases of measles in the European Union (EU), seventy-seven percent of which are in Germany, Italy and the Netherlands.<sup>63</sup> The ECDC has urged EU member states to follow certain immunization requirements—especially for those who are traveling abroad—yet states such as France face staunch anti-vaccination movements similar to the U.S.<sup>64</sup>

Africa: African states have the lowest rates of immunization of any region in the world. Failing infrastructure, political instability, and ongoing conflict in some states have left international organizations such as the WHO as well as NGOs struggling to immunize vast swaths of the under-vaccinated population. Sub-Saharan Africa has the highest child mortality rate, even though this rate has decreased by forty-five percent since 1990.<sup>65</sup> Substantial anti-immunization campaigns, derived from a common mistrust of Western states have emerged across the continent, in Uganda, Tanzania and Kenya, resulting widespread outbreaks of measles and tetanus. Such diseases proliferate even faster in rural regions that do not have access to clean food or water. Surveillance of vaccine-preventable diseases has been difficult because most of the highly rural and nomadic culture of the region, in which reports of the health situation remains murky.<sup>66</sup> Moreover, the recent Ebola outbreak in Africa has forced the already crippling infrastructure to devote scarce resources to fight the outbreak, rather than immunize.<sup>67</sup>

Middle East: Middle Eastern states have been incredibly susceptible to drops in immunization rates. Immunization programs have been disrupted due to ongoing conflicts in the region, resulting in a resurgence of a number of diseases. For example, over thirty-six cases of polio

were reported in Syria since 2013, the first major outbreak since the state had eliminated polio in 1999.<sup>68</sup> This strain, closely associated with the one in Pakistan, has spread as the number of refugees incubating the disease (estimated at a few thousand) have fled the state.<sup>69</sup> Lebanon, Iraq, Jordan and even Turkey are at risk of additional outbreaks because of difficulty monitoring immunization for cross-border travelers.<sup>70</sup> The ongoing measles epidemic—with over 7,000 cases reported—is also an indication of the dire humanitarian situation Syria, and now Iraq, are facing. This leaves the WHO and NGOs like Médecins Sans Frontières (MSF) struggling to immunize a war-torn society, where “queues for vaccinations are avoided for fear they might attract airstrikes or rocket attacks.”<sup>71</sup> On the other hand, immunization rates in Saudi Arabia and Iran (who possess a centralized immunization strategy), have been relatively high for the DTP-3 (diphtheria, tetanus and pertussis) vaccine (98% and 99%, respectively).<sup>72</sup>

Eastern Europe: Eastern European states are still reeling from the collapse of the USSR, which established a mandated centralized immunization system for its citizens. Anti-immunization movements in former Soviet satellite states, for example, began in the *perestroika* era of reform in the 1980s when anti-government bias was increasing. When the USSR collapsed, Russia actually faced the highest incidence of pertussis (amongst other diseases) than any other country in the developed world, partly due to the fact that individuals lost faith in federal-sponsored immunization campaigns.<sup>73</sup> Today, these anti-vaccination movements have spread to neighboring states. In Slovakia, an anti-vaccination movement emerged at the turn of the 21<sup>st</sup> century, exploiting general fears and misperceptions to discredit the government by, for example, launching television programs about children who “died after receiving the MMR vaccine.”<sup>74</sup>

Latin America and the Caribbean: Although the Americas were declared polio free in 2000, there are a number of vaccine preventable diseases that continue to plague this region.<sup>75</sup> Many of these developing states lack adequate infrastructure, resulting in lower surveillance and monitoring mechanisms to prevent the reintroduction of certain epidemics. A recent cholera epidemic in 2014 has overwhelmed the impoverished state of Haiti, which the UN is unable to fully accommodate due to lacking resources and funds.<sup>76</sup> Another devastating disease, yellow fever, remains endemic in ten Latin American states and the WHO believes that “Latin America is now at greater risk of urban epidemics than at any time in the past 50 years.”<sup>77</sup>

Asia: China’s centralized immunization strategy is not unlike that of the USSR, being largely successful in eliminating diphtheria and measles. The vaccine market is also relatively large in China, enabling the country to contain an outbreak of polio from Pakistan in 2011, for example. More recently, the Chinese government has been investing in a widespread immunization campaign to encourage citizens to get immunized for preventative diseases, such as hepatitis B and influenza.<sup>78</sup> Despite the steady decline of vaccine-preventable diseases such as tuberculosis, tetanus, measles and polio, the number of cases in Southeast Asia continues to be very high, leaving little hope for regional elimination. Polio remains endemic in Afghanistan and Pakistan, and has resulted in outbreaks of polio in neighboring India and China.

### Guiding Questions for the Delegates

1. What, if any, vaccine-preventable diseases continue to remain prevalent in your state?
2. What kind of vaccine distribution system does your state utilize (is it centralized or decentralized)? How does this distribution system operate in the larger context of health infrastructure (is the health infrastructure developed or developing)?
3. What additional steps should the WHO take to improve distribution of vaccines for the international community?
4. Have any anti-vaccination movements emerged in your state? If yes, has the government taken action to overcome these movements? Was this action successful or unsuccessful in countering such movements?
5. What can the WHO do to improve the financial constraints placed by increasing extra-budgetary funds?
6. What are the major obstacles to the achievement of the WHO's 2020 goal for ninety-percent vaccination on the national and local level?
7. How can the WHO improve public perception of vaccines with regard to upholding individual liberties whilst accomplishing its public health mandate?



## **Improving Women's Health**

### International Framework for Women's Health

None would dispute that health is a prerequisite for development. The founders of the UN acknowledged this as a fundamental human right, and incorporated it into Article 25 of the Universal Declaration of Human Rights (UDHR) of 1948: “Everyone has a right to a standard of living adequate for health and well-being of himself and of his family...motherhood and childhood are entitled to assistance.”<sup>79</sup> Yet, the framers of the UDHR failed to address the biggest determinants of health: sex and gender. Biologically, differences between males and females lead to distinctions in disease burdens between the sexes, while gender roles that society assigns to men and women contribute to differences in disease proliferation and health services provided by states. Of the eight Millennium Development Goals set forth by the UN, improving maternal health is the furthest from being achieved in 2015.<sup>80</sup>

While the WHO is the primary organ involved with matters regarding women's health, health-related issues have been dealt with by other bodies of the UN, including the Joint UN Program on HIV/AIDS (UNAIDS), UN Women, the Commission on the Status of Women (CSW), UN Population Fund (UNFPA), UN Development Program (UNDP), and UN Children's Emergency Fund (UNICEF). The UN General Assembly and Economic and Social Council (ECOSOC) work closely together on such matters to establish coherence amongst bodies of the UN system by incorporating and reinforcing the operational goal of the WHO.

In the past few decades, the UN system has moved to address the discrepancies in health between the sexes. In 1979, the GA, working alongside the CSW, passed the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Amongst many gender-

related issues, CEDAW recognized conditions of poverty as one of the most restrictive measures that obstruct a woman's access to health care, which is especially prominent in developing states. Furthermore, the convention provided policy recommendations for states to adopt, including the implementation of national strategies in order to improve women's health, strengthening of health care infrastructures, as well as the allocation of legal, financial, and administrative resources to address state-specific needs.<sup>81</sup>

The Fourth World Conference on Women in 1995 brought about the single most influential international conference on women's rights: the Beijing Platform for Action (BPFA). The BPFA defines women's health as a state of emotional, social, and physical well-being, which is dependent on socio-economic disparities more than biological ones. More importantly, the BPFA emphasized the lack of female autonomy in health decisions (e.g. fertility), which can influence family structure, female employment, and overall gender consciousness.<sup>82</sup> These socio-economic factors are inevitably associated with women's health, and can all lead to overall gender empowerment.

Another major international document that codifies the international push for gender equity in health is the Millennium Declaration of 2000, which set forth eight Millennium Development Goals (MDGs) to guide international policy in order to narrow the North-South gap. The fifth MDG explicitly concerns itself with improving maternal health, an integral part of women's health, by urging states to reduce the maternal mortality ratio by 75% from 1990 to 2015.<sup>83</sup> As mentioned earlier, this MDG is the furthest from being achieved by 2015.

In order to include a gender perspective on UN policies and programs, the ECOSOC adopted Resolution 1997/2 to coordinate gender mainstreaming in not only the specialized

agencies (including the WHO), but the entire UN system. The resolution defines gender mainstreaming as the following:

...the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring, and evaluation of policies and programmes in all political, economic, and societal spheres so that women and men benefit equally and inequality is not perpetuated...the ultimate goal is to achieve gender equality...<sup>84</sup>

More recently, UN Secretary General Ban Ki-moon, the ECOSOC Ministerial Review on Global Health, and a number of regional and national movements by states and NGOs pushed for the development of the Global Strategy for Women and Children's Health in 2010. This strategy highlights areas that are in desperate need for reform, to not only support state-led plans for improving women's health, but to establish an integrative approach to incorporate public-private partnerships for the delivery of primary health care services for women around the globe.<sup>85</sup> Within the WHO, two major departments emerged in 2012 as a result of this strategy: the Department of Gender, Equity and Human Rights (GER), and the Department of Gender, Women and Health (GWH).<sup>86,87</sup>

<b>Date</b>	<b>Relevant UN Bodies and Influential Milestones on Women's Health</b>
1946	Commission on the Status of Women (CSW)
1979	Convention on the Elimination of All Forms of Discrimination (CEDAW)
1993	Declaration on the Elimination of Discrimination of Violence Against Women
1995	UN Beijing Women's Conference; Beijing Platform for Action (BPFA)
1997	ECOSOC Resolution 1997/2
2000	Millennium Declaration
2010	Establishment of the Specialized Agency UN Women
2010	Global Strategy for Women's and Children's Health (WHO)

**Table 1: Summary of International Framework for Women's Health<sup>88</sup>**

### Current Issues

Despite extensive international efforts, a number of obstacles remain when it comes to improving women's health. To illustrate the complexity of the issue, in 2000, the World Bank attributed the following causes of gender inequity in health:

1. Biological (genetic, physiological and hormonal differences);
2. Women's longer life expectancy;
3. Nature and rate of change of women's labor force participation compared to men;
4. Women's differential access to social protection mechanisms (health and social insurance);
5. Cultural norms, religious beliefs, family arrangements and behaviors determining gender roles and gender hierarchy in society;
6. Gender differences in educational attainment;
7. Income differences between the genders resulting from interaction of all the previous factors;
8. Interaction between race, ethnicity, income, and gender.<sup>89</sup>

The aforementioned factors all converge on one similarity across states: the underutilization of health services by women. In Thailand, for example, men are six times as likely as women to seek treatment for malaria, a debilitating disease that afflicts men and women similarly.<sup>90</sup> Another example is India, where hospital records show higher numbers of treatments for men than women, although repeated health assessments of the state indicate higher reports of female illnesses than male illnesses.<sup>91</sup> There are three groups of factors that influence the underuse of health services for women. The first group is that of service factors, such as the affordability and accessibility of health services (which can vary based on a woman's employment and income). Another service factor is the ability of a state's health and social infrastructure to meet a woman's health needs (i.e. is the state able to address health issues related to sexual violence?)<sup>92</sup>

The second group of factors is related to the individual dynamics of the user. This group includes social constraints, such as restrictions on female mobility (e.g. preventing women from leaving the home, from seeking employment, etc.), as well as an increased time burden for women to actually obtain access to health services. Marital status, the role of women in the family, lack of information about the availability of services as well as awareness of a woman's right to health, all play a major role in a woman's decision (at the individual level) to seek health services.<sup>93</sup> Moreover, while user dynamics in the utilization of health services is evident in middle and low-income states, these dynamics disproportionately affect women in poor countries.

The third group of factors that influence a woman's decision to pursue health care services are institutional factors. This includes the tremendous disadvantage women are placed in because of an overwhelming decision-making power and control vested in men over national and

local health budgets. A lack of gender mainstreaming of policies at this level exacerbates discrimination and stigmatization of women in health settings, especially poor women, and those who belong to minority ethnic groups.<sup>94</sup>

While the WHO has documented improvements in overall implementation of gender mainstreaming in health practices, it cites state accountability for programs as the main obstacle at the international and state levels.<sup>95</sup> Creating mechanisms to enforce adherence to WHO gender protocol, including the reporting of gender-related activities, is difficult for developing states. They struggle as they lack administrative, legal, medical, and physical infrastructures to address women's needs.<sup>‡</sup> Dr. Margaret Chan, the current Director-General of the World Health Organization stated for the Commission on Information and Accountability for Women's and Children's Health:

Timely, reliable and accessible health information is critical for accountability. Having this solid information at country level is essential to measuring and monitoring results. One of our top priorities must be investing in helping countries build the capacity needed to capture this health information—that means giving them the financial and technical resources required to monitor things such as births, deaths, and causes of deaths to achieve the accountability revolution needed to save women and children from dying.<sup>96</sup>

### Conditions Specific to Women

#### *Maternal and Reproductive Health*

Reproductive health is defined by the UN as a “state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system...consequently, poor reproductive health is associated with disease, abuse,

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<sup>‡</sup> For details on why the WHO struggles to build infrastructure in developing states, see pages 11-12 of this background guide.

exploitation, unwanted pregnancy, and death.”<sup>97</sup> Each year, 210 million women get pregnant, yet 60 million of these pregnancies end in either the death of the mother or the baby.<sup>98</sup> While the WHO works extensively with other agencies and NGOs to deliver health care services to treat preventable conditions associated with maternal health (e.g. unsafe abortion, sepsis, hemorrhage, hypertensive disorders, and obstructed labor—which account for over 75% of maternal deaths), there has been a shift to address women’s reproductive health prior to pregnancies in order to prevent the emergence of the aforementioned conditions altogether.<sup>99</sup> The WHO emphasizes the importance of female autonomy in reproductive decisions, including the ability to choose the time and frequency of reproduction.

In order to facilitate an increase in female autonomy and gender empowerment, the WHO implements programs that include measures to increase community education on safe motherhood, prenatal care and counseling (including advice on nutrition, immunization, etc.), improving medical assistance during delivery, as well as postpartum care. In states in which abortion is legal, there have been moves to increase access to safe abortion as well as post-abortion services. Overall, the WHO urges developing and developed states alike to increase the distribution of family-planning information and services, as well as begin educating young girls and women about reproductive health. Not all states comply with such recommendations, however, citing violations of national sovereignty and cultural integrity.<sup>100</sup>

Although, a lack of infrastructure as well as gender mainstreaming in developing states remain as major impediments to improving maternal health, international efforts have not entirely been in vain. In Bangladesh, increasing the number of midwives trained to international standards alone decreased the number of maternal deaths in delivery by over thirty percent. In Sierra Leone, the implementation of a state-sponsored health care service for women and

children under five improved maternal conditions by over 150% and reduced maternal mortality by over sixty percent.<sup>101</sup>

### *Violence against Women and Girls*

The UN defines Violence Against Women (VAW) as

...any act of gender-based violence that results in or is likely to result in physical, sexual, or psychological harm or suffering to women and girls, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.<sup>102</sup>

VAW in all shapes and forms leaves women likely to suffer from mental illnesses such as depression and anxiety, psychological isolation and societal marginalization. The WHO has urged states to reform and utilize legal frameworks and improve services on all levels to combat discrimination and condemn and prosecute the perpetrators of such heinous acts. Violence against women is most apparent with regard to intimate partner violence, but is also prevalent in situations of armed conflict, where women are placed at high risk of sexual assault, or prostitution as a means to survive.<sup>103</sup> Thus, health systems in developing and developed states should be trained to better cope with such situations to improve the overall emotional, social and physical well-being of women.



### Case Study 1: Afghanistan

The women of Afghanistan have endured extensive human rights violations over the past thirty years. A combination of severe societal trauma brought about by ongoing armed conflict and periods of foreign occupation as well as the brutally repressive rule of the Taliban regime have had a profound impact on the health of Afghan women. According to UNICEF and the US Center for Disease Control (CDC), Afghanistan is among the worst places on the globe for women.<sup>104</sup> Today, as the coalition forces of the North Atlantic Treaty Organization (NATO) as well as international aid groups draw down and shift responsibilities to a fragile political institution, resurgence in violence poses not only a security risk but a humanitarian one, and may undo international efforts to establish a viable health care infrastructure.

The Taliban (Arabic: “students of Islam”), an extremist Islamist movement whose roots trace back to religious schools in Pakistan, capitalized on the post-war instability left behind by a decade-long Soviet occupation of the state and seized control of Southern Afghanistan in 1994.<sup>105</sup> Within the next two years, the Taliban asserted control over vast swaths of the state and imposed a fundamentalist interpretation of *sharia*, or Islamic, law within their jurisdiction. The implementation of their version of *sharia* law entailed the brutal enforcement of a number of restrictions on women in society, including forbidding women from leaving the home, which prevented them from seeking employment, education, or any services in the public sphere. Women were only allowed to leave the home if accompanied by a male relative, and those who violated the regime’s new laws faced cruel punishments.<sup>106</sup>

One particular policy had a tremendous impact on decreasing health care services for women. In September 1997, the Ministry of Public Health ordered all hospitals in the state to suspend the provision of medical services to women (such a move was warranted as a means to

enforce the policy of sex segregation in society). After increasing pressure from the International Committee for the Red Cross, the Taliban reversed its policy and allowed the readmission of women into hospitals. By that time, however, the allocation of medical resources and supplies by the Taliban to hospitals incorporated absolutely no aspects of gender mainstreaming, as it was deemed socially and religiously acceptable for men to decide how women's health would be dealt with by the state. In May 1998, over seventy-five percent of all medical supplies and hospital beds—already scarce resources in the impoverished state—were allocated for men, while less than twenty-five percent were allocated for women. The physical, mental and social consequences of their actions soon became apparent. Within two years of the Taliban takeover and revolution to push women back into the home, over sixty percent of women reported a decline in access to healthcare, and seventy percent of them reported a decline in physical and mental health. Over ninety-five percent of these women indicated support for new policies that would bring women's rights to Afghanistan.<sup>107</sup>

As U.S. led NATO forces invaded Afghanistan in 2001 and the state that housed a number of extremist elements came into the attention of the international community, the UN brought the world's attention to its crumbling infrastructure. According to the World Food Program, only nineteen percent of the population at the time had access to clean water in urban areas; this figure was estimated at less than eleven percent in rural areas. A health infrastructure was virtually nonexistent in the state, leaving both male and female Afghans without amenities such as vaccines and antibiotics; this resulted in an average life expectancy at birth of forty-five years. The maternal mortality rate was estimated at around 1,700 out of 100,000 live births (in comparison, the U.S. maternal mortality rate at the time was 10 out of 100,000 live births).<sup>108</sup> Over 90% of deliveries took place in the home in the absence of any professional attendants, as

less than one-third of the state's districts at the time possessed specialized clinics for maternal health.<sup>109</sup>

While conditions have improved over the past thirteen years, Afghanistan's health care system remains weak. Between 2003 and 2010, female use of contraception doubled from ten percent to twenty percent, and access to professional antenatal care increased from less than fifteen percent to sixty percent. Maternal mortality has dropped by over sixty-five percent to 400 deaths out of 100,000 live births.<sup>110</sup> Despite these remarkable accomplishments, Afghanistan has a long way to go with regards to women's health. The province of Paktika in Southeastern Afghanistan, whose population is estimated around 190,000, does not employ any female doctors, for example.<sup>111</sup> Some argue that an approach by the state to implement a greater degree of gender mainstreaming in its policies to target socioeconomic issues such as poverty, education, employment, as well as assessing the impact of armed conflict on the well-being of women in general remain as major impediments to further progress.<sup>112</sup>

A WHO report in 2013 cited one societal norm—instilled in Afghan society from the Taliban regime—as the most restrictive factor in a woman's access to health services: the requirement that a woman be escorted outside of the home with a male relative. While there are not many laws that explicitly restrict women's movements in society, these conservative traditions manifest in the patriarchal, tribal society of Afghanistan's rural areas, and especially prevent women from obtaining access to health care services for themselves, such as contraception, or an amenity for their children, such as vaccines for preventable diseases. Furthermore, the presence of the Taliban in a nearby region serves as a major deterrent for tribal elders to advocate the utilization of state-sponsored services in any form, in fear of retaliation or other deadly actions by the Taliban.<sup>113</sup>

## Case Study 2: Russia

The collapse of the United Socialist Soviet Republics (USSR) in 1991 came as a major shock to the international system, which paved the way for Russia's transition from a communist society to a democratic one. This shift has had tremendous political, economic, and social implications for not only Russian society but for the newly independent satellite states as well. In the past twenty years, these changes have perpetuated gender inequality in health between the sexes, and arguably contributed to the rise in human rights violations against women in Russia.

Prior to 1991, the highly centralized USSR provided a number of social, health, and economic benefits for both men and women in society. In the context of women's health, this system provided a wide variety of health benefits, including prenatal support, paid maternity leave and contraception. This access to health care services in the operational infrastructure illustrated a rough parity between the sexes (i.e. both men and women had roughly the same access to health care). This generally unobstructed access to health care was complemented with a high literacy rate as well as a high labor force participation rate among women (roughly half of the USSR labor force was female).<sup>114</sup>

From 1989 to 1991, as the USSR began to disintegrate, its constituents witnessed an overall decline in the role of the state as a major provider of public services. In Russia, the introduction of a liberal, capitalist market system as well the democratization of the former political institution in subsequent years exacerbated social instability that began to plague the region, resulting in economic inequality across the state. Suddenly, the sole entity that was providing a plethora of health services no longer existed, resulting in an overall degradation in health conditions for both men and women. The maternal mortality ratio skyrocketed, to 1,500

out of 100,000 live births. This economic inequality then transformed itself into something else: gender inequality.<sup>115</sup>

Throughout the 1990s, reproductive, maternal, and neonatal care in Russia was the least adequate in comparison to other industrialized states. Health services that emerged specifically for women were limited to reproductive and maternal needs, although these were limited as well. Due to the fact that many Russian women were not aware of, or did not have access to, modern forms of contraception, abortion became the widely practiced form of birth control in Russia. One study actually indicates over “fourteen percent of the women in Russia with sixteen or more years of school had undergone eight to ten abortions.”<sup>116</sup> Furthermore, one of the greatest drawbacks of the Russian health care system was the absence of the integration of health education into public services. Consequently, women were unaware about nutrition, family planning, prevention of cancers, and many other health problems. Violence against women, for example, continues to remain under-emphasized in the public sector, in addition to community-based mental health services to decrease the high suicide rate.<sup>117</sup>

Today, while health services have improved in Russia, gender mainstreaming remains as a major obstacle in the improvement of women’s health services. While the maternal mortality rate has dropped to 400 out of 100,000 deaths, it remains as one of the highest amongst industrialized states, in addition to its abortion rate, at 53.7 abortions per 1,000 women.<sup>118</sup> In a huge departure from the Soviet era, over eighty percent of women in Russia are utilizing some form of contraception, obtained from either the public or private sector. More recently, the Russian government has acknowledged the state’s declining population as a threat to national security, and has adopted pro-natalist policies. Michele Rivkin-Fish, author of *Women’s Health in Post-Soviet Russia* argues

There are [additional] educational programs being offered by very progressive-thinking doctors and their educators. These are offering kids and young adults information about how to control their fertility, how to have timely pregnancies, methods of abortion...but these groups are under scrutiny by the government, so they are always in a vulnerable position...the government's agenda is to get women to have more babies. But this doesn't necessarily take into account women's reproductive rights or issues.<sup>119</sup>

### Bloc Positions:

Western: While most Western states possess adequately developed health infrastructures to address the health needs of the general population, some states continue to impede a woman's access to certain health care services. Movements by conservative political and religious groups in the United States, for example, seek to eliminate state-funded programs such as Planned Parenthood, which is geared to provide women with access to not only birth control and safe abortion, but general information about family planning, as well as sexual and reproductive health.<sup>120</sup> Maternal mortality rates are far lower in Western states in comparison to other regions of the world, however; mental health problems such as depression and suicide rates remain high amongst women in the general population. States in the European Union (EU), as well as the US have implemented a degree of gender mainstreaming in their health policies, but more can be done to address the socioeconomic factors that dictate women's health.<sup>121</sup>

Africa: According to a 2012 WHO Report of the Commission on Women's Health in the African Region, "women in this region account for over fifty percent of global deaths due to communicable diseases, maternal and perinatal conditions, and nutritional deficiencies."<sup>122</sup>

Crippling infrastructures, particularly health infrastructures, ongoing conflict, political instability, widespread poverty as well as socioeconomic factors, to name a few, contribute to

this widespread regional problem. While NGOs take on the bulk of the responsibility in the provision of health care assistance in a handful of states, health care access for women in rural areas is low. Additionally, violence against women “becomes particularly pernicious in respect to certain harmful traditional practices such as female genital mutilation, estimated to be inflicted on two million girls between the ages of four and twelve...over 92 million girls and women above 10 are living with the indignity of such abuse...”<sup>123</sup> Gender mainstreaming in many state policies is not fully adopted or implemented, which is imperative for closing gender gap in health.

Middle East: While there is considerable variation between states in the Middle East when it comes to women’s health, many states face similar challenges, including poor quality of health care services, ignorance about reproductive health issues, financial constraints, and overall gender inequality. Iran, for example, has had an interesting history of providing access to contraception and educating women about health and motherhood in order to curb population growth in the 1990s, yet withdrew such public health support for women to stimulate population growth in the past few years.<sup>124</sup> Over sixty percent of maternal deaths in the region occur in four states: Egypt, Yemen, Iraq, and Morocco.<sup>125</sup> More recently, the Islamic State of Iraq and al-Sham (ISIS), an extreme insurgent/terrorist group that has made territorial advances in Iraq and Syria has been especially brutal in their utilization of systematic sexual violence against women.<sup>126</sup>

Eastern Europe: The collapse of the USSR in 1991 dramatically changed women's health status in Eastern European states. The rapid deterioration of health systems during the 1990s contributed to a decrease in overall utilization of health care services by both men and women, but was pronounced with a rapid decrease in reproductive health care. Maternal mortality in these states is especially high in comparison to other industrialized states, as well as abortion rates, which ranged from 0.6 per woman in Uzbekistan to 3.7 per woman in Georgia.<sup>127</sup> According to the Inter Press Service News Agency, "While governments drag their feet on implementing national reproductive health policies, women are left at the mercy of a conservative society that offers very little space or support for family planning."<sup>128</sup>

Latin America and the Caribbean: In the past two decades, states in this region have made significant improvements in women's health, especially with regard to reducing the maternal mortality ratio by over 40%. Nevertheless, unequal access to health care services remains as a major impediment to gender equity in health in the region. Over 4.4 million abortions were performed in Latin America in 2008, 95% of which were unsafe.<sup>129</sup> Rural, indigenous populations of Nicaragua, for example, are three times as likely to suffer from death as a result of maternal complications, and possess higher rates of teenage pregnancy.<sup>130</sup> Nevertheless, there have been movements in a number of states by NGOs and other international organizations to increase awareness about women's health issues. In the Dominican Republic, NGOs such as Family Care International pressured the state to develop and implement policies to criminalize gender-based violence.<sup>131</sup>



Asia: Asian states, particularly those in South and Southeast Asia, have one of the worst health infrastructures in the world, second only to Africa. Interestingly, the Philippines remains the best performing country in Asia in terms of the magnitude of gender disparity, according to the Philippine Commission on Women (PCW).<sup>132</sup> India is amongst the worst states with regard to its maternal mortality rate (190 deaths out of 100,000 live births<sup>133</sup>), which is surprisingly higher than Pakistan's maternal mortality rate (170 deaths out of 100,000 deaths<sup>134</sup>). The Chinese government adopted a vigorous policy, called the "Eleventh Five-Year Plan," to reduce the national maternal mortality rate from 47 deaths out of 100,000 live births to 30 deaths out of 100,000 live births.<sup>135</sup>

Guiding Questions for the Delegates:

1. What are the major issues that face your state when it comes to women's health? Is gender inequity in health pronounced in your state? Do women have access to health care, including reproductive and maternal services, as well as mental health care?
2. Does your state implement gender mainstreaming in its health policies? How does the presence of gender mainstreaming, or lack thereof, affect women's health in your state?
3. Are there any unique policies regarding women's health that your state has addressed over the course of its history?
4. Which factors (service factors, user factors, or institutional factors) predominantly influence women's utilization of health services in your state?
5. How can the WHO and UN system improve access to health care services for women in states with growing patriarchal, conservative movements that seek to limit the role of women in society?
6. Based on the current international framework, how can the WHO and relevant UN bodies improve women's health in states around the globe?

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