Preface:

Welcome to the World Health Organization at MPHMUN 2018! Your chairs will be Amina Kilpatrick and Maya Heimes. This committee will be run resolution style, and delegates are recommended to bring pre-written resolutions (no writing will be done during committee). MPH has started a new eco-friendly policy which has all delegates that want to be eligible for an award submit a position paper (for all three topics) by Oct 19 at 11:59 pm to whomphmun@gmail.com. Bring to the committee a position paper and resolution for all three topics. If you have any questions, comments, or concerns, you can contact us at whomphmun@gmail.com. We are very enthusiastic to see you all at MPHMUN 2018!

Best,

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Introduction to the Committee:

The World Health Organization is one of the oldest bodies in the United Nations, founded on April 7, 1948. The focus of the organization is on international physical, mental, and social well-being. The main areas of the organization include improving health systems, corporate services, communicable and noncommunicable diseases, preparedness, surveillance and response, and corporate services. The WHO also works in collaboration with other programs, NGOs, and 194 member states in six regions with more than 150 regional offices.

The original focus of the WHO more than 70 years ago was the eradication of infectious diseases including polio, smallpox, and diphtheria. With advanced technologies and improved infrastructures, these diseases do not pose the same threat today. Instead, WHO has shifted the focus on noncommunicable diseases such as cancer and health disease, and begun promoting healthy eating and exercise globally. In addition, there was been a focus on mental health care and extending and addressing those issues. At MPHMUN, we will focus on three important and relevant topics in the global health community. These topics are AIDS orphans in sub-Saharan African, health effects of deportation threats, and health standards in prisons. Delegates are expected to think creatively for solutions to these global health threats.

Topic 1: AIDS orphans in sub-Saharan Africa

Introduction:

Human immunodeficiency virus (HIV) attacks the body's immune system and reduces the ability to fight off infections. The infection targets the CD4 (T cells) which makes it more likely for someone to be infected with diseases. Currently, no effective cure exists, however, with proper medical care, HIV can be controlled. Antiretroviral therapy (ART) increases the life expectancy of those affected with HIV and slows the damage of caused by the virus. Acquired immunodeficiency syndrome (AIDS) is stage 3 HIV and is the most severe phase of the infection. People with AIDS have such badly damaged immune systems that they get an increasing number of severe illnesses called opportunistic infections.

In 2016, there were 17.8 million adults living with HIV in Eastern and Southern Africa. It is very likely that children whose parents have AIDs are unable to work. This results in reduced crop production and lowering of food availability within the family and community. In addition, children are also subject to child labor as a result of needing to provide for families. These children are less likely to go to school than their counterparts with healthy parents. They also experience trauma due to witnessing sickness and death at a young age, which can affect their adult life if untreated. There is also evidence of damage to their cognitive and emotional development. Globally, 16.5 million children have lost one or both of their parents due to AIDs. More than 80 percent of those children live in sub-Saharan Africa.

History:

The origination of HIV has been traced back to Kinshasa in the Democratic Republic of Congo in 1920s. Researchers have found that the disease crossed species from chimpanzees who had *Simian immunodeficiency virus*, which was passed to humans during bushmeat trading practices. This disease no longer affects animals and is now unique to humans. Prior to the 1980s, HIV was not well documented as symptoms were not clear. The modern epidemic began in the late 1970s. The first known case of HIV in North America was confirmed in 1968. Before the 1980s, the disease had spread to five continents, North America, Australia, Europe, Africa, and South America, and it is estimated that between 100,000 and 300,000 people were affected by HIV at that time.

The spread of HIV in sub-Saharan African began in the late 1970s. The biggest epidemic has occurred in the southern region of Africa. These countries have the highest rates of HIV/AIDs. In South Africa, 5 million people are living with HIV/AIDs, the largest number in the world. The two countries with the highest proportion of their population affected with the disease are Botswana with 38% and Swaziland with 33%. Countries in West Africa have not been as affected as Southern Africa or other regions in sub-Saharan Africa.

According to the World Health Organization, Africa is the region most affected by HIV/AIDs in the world. Young women are even more at risk for infection. In 2015, of the 26 million people living with HIV, 2.3 million were children under the age of 15. Of all children living with HIV in the world, 90% of them are from sub-Saharan Africa and 70% of all AIDs related deaths are in the African region. It is estimated that the HIV prevalence is 4.8% for the entire region.

Due to the widespread effects of HIV/AIDs in the African region in the 1980s and 1990s, many children are left without one or both parents to adequately care for them. Although medicine has advanced enough for the disease to be manageable with treatment, there are many barriers for people to access this treatment including lack of testing, cultural stigmas, and inability to afford the medicine. Only around 1 million children under the age of 15 had lost of or both parents to HIV/AIDs in 1990. A decade later, 11 million children were orphaned due to HIV/AIDs. In 2010, there were 20 million children orphaned due to the disease. Half the children in sub-Saharan who were orphaned because of the disease. The increasing number of children orphaned due to HIV/AIDs is creating a generation of children without parental support or family support systems. This hurts the development of African nations and their future of helping themselves.

Current Situation:

UNAIDS is currently leading the global effort to end AIDS as a public health threat. The UNAIDS Programme Coordinating Board, at its 37th meeting, decided to adopt a new strategy to end the AIDS epidemic by 2030. The UNAIDS 2016-2021 Strategy is aligned with the Sustainable Development Goals. The eight "result areas" defined by UNAIDS provide a roadmap for governments and NGOs working to battle the HIV/AIDS epidemic. These eight result areas cover areas from allowing everyone that has HIV access to quality treatment options to promoting healthy gender norms to end gender-based, partner violence.

Within Central and West Africa, the International Planned Parenthood Federation has worked with UNAIDS to carry out the strategy and further develop their own plans. The International Planned Parenthood Federation is working on integrating HIV/AIDS with

reproductive health services. They also work with gender issues with the African AIDS Research Network, which is part of the UNAIDS 2016-2021 Strategy.

Aside from the International Planned Parenthood Federation, there are many other NGOs that are working within Africa to help the AIDS orphans. Almost all of these NGOs incorporate aspects of the UNAIDS 2016-2021 Strategy or work with UNAIDS. Specific NGOs working within Africa include Homes for Kids in South Africa, Children in Distress Network, Nurturing Orphans of AIDS for Humanity, and the Centre for Aids Development, Research and Evaluation.

Questions:

- When considering the topic, should steps be incorporated to prevent HIV?
- Once a child is orphaned, where should they live? Consider all living situations.
- Is there a way to relieve the stress upon the extended family, when they are taking care of the orphans?
- How can there be an increase in single parents taking care of their children, when their spouse has died due to AIDS?

Further Reading:

Current challenges and prospects of HIV/AIDS in Sub-Saharan Africa, from a University of Nigeria attendee (This is just the abstract; full download button at the bottom of the linked website):

https://www.researchgate.net/publication/316598262/download

Excerpt from "*Disease and Mortality in Sub-Saharan Africa. 2nd edition.*", presented by National Center for Biotechnology Information:

https://www.ncbi.nlm.nih.gov/books/NBK2289/

Chart of AIDS prevalence in Sub-Saharan Africa based on data from WHO:

http://apps.who.int/gho/data/node.main.n247?lang=en

Malawi's approach to reducing AIDS:

https://www.aljazeera.com/indepth/features/2016/07/malawi-reduced-hivaids-infection-rate-160718084113107.html

Topic 2: Health effects of deportation threats

Introduction:

Many people seek to move to a new country for better educational or employment opportunities, to reunite with family, or to seek asylum from danger in their home country. Restrictions on immigration in many countries around the world, coupled with the rise of conflicts in other countries, has created a problem for people seeking new life in a different country. The United States experiences the most international migration with more than one-fifth of the world population migrating to the U.S. However, in the US, obtaining citizenship or maintaining legal status can be a long and arduous process. Due to the general fear of deportation, undocumented families in the U.S. tend to have a lower quality of life and lower-paying jobs, since they do not have the right to unionize. Those who do not have legal status in the US, or are undocumented immigrants, face a lot of stress and anxiety on a daily

basis. Immigrant populations in other countries also experience similar fears around deportation. Children of undocumented immigrants, regardless of whether they have legal status or not, deal with stress and anxiety of losing their parents at any moment. Furthermore, families that include undocumented people are less likely to use (if they have access to at all) government resources that family members with legal status may be entitled to, due to fear of discovery.

History:

Deportation is the expulsion of a person or multiple people from a country or region. In general, nations reserve the right to deport persons, even those who are longtime residents or possess permanent residency. Foreign-born residents who have committed serious crimes entered the country illegally, or otherwise lost their legal status allowing them to be in the country may be removed or deported. In some cases, such as in Saudi Arabia and the UAE, even citizens can be deported. Some (mostly western) countries also are able to deport citizens, if they are of another nationality or if they had gotten their citizenship through fraud.

Cases of mass deportation tend to gain the most attention in the press and the international community. For example, under the "Final Solution," Nazi Germany deported homosexuals, Jews, Poles, and Romani from their native places of residence to concentration camps or extermination camps, thus rendering "deportation" synonymous with "extermination." In the U.S. during the 1950s, "Operation Wetback" resulted in the removal of approximately 1.3 million Mexican immigrants—some of them American citizens—from the United States. Mexican immigrants were "returned" to often-unfamiliar parts of Mexico, where they struggled to rebuild their lives if they did not succumb to sunstroke, disease or other deadly illnesses while in custody or transport.

While these cases of mass deportation have been heavily criticized, ongoing deportations also give a reason for concern. In the past decade, nearly 2 million persons have been removed from the U.S.; 81% of them to Latin America. This continuous threat of deportation, coupled with historically-based fear of mass deportation, poses significant negative health effects for immigrant communities who perceive themselves as targets of deportation.

Current Situation:

To date, research on immigration, migration, asylum-seeking and detention has focused primarily on the effects that being detained has on individuals (adults and children) and the effects of parental detention on their children. However, there has not been as much research on the long-term stress children and families experience. For example, the first study to show correlations between detention and adverse mental health consequences, particularly among children, was based on a survey of the psychological status of 600 Vietnamese children detained in a Hong Kong camp. The majority of children exhibited symptoms of depression and anxiety. In the United States, researchers have found that a parent's unauthorized status is a predictor of multiple adverse outcomes for children, including emotional well-being, academic performance, and health status. Children of unauthorized immigrants are more likely to report anxiety, fear, sadness, PTSD symptoms, anger, and withdrawal.

However, these negative psychological effects are not just present in children; they manifest in adults as well. In a study of 15 asylum seekers (primarily adults) in the United Kingdom, researchers found that all 15 asylum seekers manifested depressive and post-traumatic stress symptoms, including profound despair, high rates of suicidal ideation and deliberate self-harm, including attempted hanging. Even upon release from detention, negative health

impacts remain. In a 2006 study of 55 Afghan asylum seekers resident in Japan, the 18 who had been held in immigration detention for a median of seven months manifested more severe symptoms of anxiety, depression, and PTSD, even after adjusting for pre-migration trauma and other demographic characteristics.

For adults, marriage into citizenship is also a struggle. For example, in China, many illegal immigrant foreign brides are forced to marry poor Chinese men, known as "bare branches" of society. In North China, where there's a prevalence of Burmese brides, these women are looked down on for both their status and their looks.

Emerging research focuses on the effects that the threat of detention has on individuals, particularly children. For example, social-ecological models of child development posit that multiple contexts, from the distal (policies, parents' work conditions) to the proximal (family processes), interact to influence children's development. Through the social-ecological perspective, when a parent is at risk of deportation, a child is impacted via the multiple other contexts that are affected by the parents' vulnerability, such as poor work conditions, economic stress, and psychological distress. At the same time, the child may benefit from protective factors in various contexts; for example, a strong marital or parent-child relationship may buffer the otherwise adverse impact that the parent's unauthorized status may have on the child.

This research has, unfortunately, proven accurate in predicting the impact of detention policies on vulnerable communities. For example, in the late 1980s to 1990s, a rise in regional wars around the world increased the number of persons displaced from their homelands. In response, some countries that received the displaced persons initiated policies of "humane deterrence" to stem the flow of asylum seekers. Australia established mandatory, indefinite

detention for all asylum seekers in an effort to deter individuals from seeking asylum in the country. Research on the detainees demonstrated that prolonged detention had adverse mental health and psychosocial impacts on adults, families, and children and that these effects may be prolonged, extending well beyond the point of release into the community.

Policy recommendations typically focus on four areas: 1) articulating direct, clear, and reasonable pathways to citizenship for all unauthorized migrants/asylum seekers; 2) protecting and promoting children's fundamental rights; 3) ensuring that enforcement efforts have appropriate protections for children; 4) keeping families together throughout the process. Key recommendations emerging from this research focus on two levels of intervention: 1) providing direct support for individuals in detention or under the threat of detention, particularly in the area of mental health services, in order to mitigate the impact; 2) developing research-informed policies that reduce the most profound impacts of detention and the threat of detention.

Questions:

- What can be done to decrease the number of deportation threats without infringing on national sovereignty?
- How can the overall stress in the house of the extended family, as they may be taking care of the child, be decreased in all nations and circumstances?
- Is there a way to relieve the stress of a child (that is a citizen) when their parents may be deported, or have been.
- How can children easily gain the healthcare their parents once had? Should this be considered?

● After the stress has taken a toll on the family, what ways can they be rehabilitated?

Further Reading:

An evaluation of the global health status of illegal refugees, by the US National Library of Medicine:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4074451/

A look at Thailand's universal health care system, which includes coverage for both legal and illegal migrants!

https://www.npr.org/sections/goatsandsoda/2016/03/31/469608931/only-one-country-offers-universal-health-care-to-undocumented-migrants

"*Migration, Refugees, and Health Risks*", by the International Centre for Migration and Health in Vernier, Switzerland:

https://wwwnc.cdc.gov/eid/article/7/7/pdfs/01-7733.pdf

"*Ethics of advocacy for undocumented patients",* from the American Nurses Association

http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-22-2017/No3-Sep-2017/Ethics-of-Advocacy-for-Undocumented-Patients.html

Topic 3: Health standards in prisons

Introduction:

More than 10.2 million people—men, women, and children—are in prisons globally, with approximately one-third of these people awaiting trial. While the United Nations has held standards for the treatment of prisoners since 1955, including healthcare for prisoners, these 10.2 million people face much greater health risks simply by virtue of being imprisoned. Many point to the steadily increasing rate of incarceration worldwide as the root cause for growing health problems in prisons. For example, as the development of facilities does not keep pace with the rise in prisoners, prisons become overcrowded and ripe for the spread of communicable diseases. One response to this problem is the privatization of the prison system—states contract with private companies to build and operate prisons. While the free-market approach may address the facilities gap (more prisons are constructed and operated when private companies are able to profit from them), healthcare problems continue. Also, when prison facility development is privately funded, an unintended outcome can be financial incentives for development and implementation of prisons, leading to a value equation where increases in incarceration lead to increases in revenue for the companies that finance the prisons and containment of costs for incarceration provide higher revenues. For example, in the Arizona case of Parsons v Ryan the state is accused of providing care "so shoddy that it amounts to cruel and unusual punishment: delayed or denied treatment, too few doctors and nurses, referrals and medication refills that fall through the cracks." In this case, the Arizona Department of Corrections contracts with a for-profit medical provider, Corizon Health, which has been cited in numerous other cases across the United States.

Research demonstrates that improved healthcare for prisoners is in the interest of the wider community as well. When health care systems are effectively run in prisons, communities experience an overall reduction in public health expenditures, improved reintegration into society, reduced recidivism (re-imprisonment), and overall reduction of the prison population.

History:

While prisons have been in use in some form for centuries, the modern prison came into use in the late 17th century as part of the Enlightenment's concepts of utilitarianism and rationalism. Instead of public forms of punishment such as execution, torture (e.g. whipping) or public shaming (e.g. stockades), modern prisons moved punishment out of the public eye and into facilities where inmates are forcibly confined and denied a variety of freedoms under the authority of the state. The confinement and restriction of freedoms in prisons has, however, varied widely throughout the centuries and around the world, particularly depending on the state's policies regarding the overall purpose of imprisonment. For example, policies that promote deterrence often support the development of prisons as sites of intensive suffering to deter people from committing crimes out of fear of being sent to prison. On the other hand, policies that promote rehabilitation support development of services within prisons that can help individuals reform such as education, health services, and job training.

Because of the wide-ranging philosophies, policies and conditions of prisons worldwide, the United Nations adopted the Standard Minimum Rules for the Treatment of Prisoners in 1955, which they updated in 2015 and renamed the Nelson Mandela Rules ("the Rules"), in honor of the South African president who was imprisoned for 27 years as a political prisoner. Currently, these rules are recommendations for best practices. There are no incentives to implement these

rules, nor are there any repercussions if a nation chooses not to implement them.

While such guidelines generally advance a rehabilitative policy for prisons, one section attends to the physical and mental health of inmates. The rules state that inmates must have access to health care "at the same level of care as in the community," and health care providers not be involved in prison management issues, such as disciplinary measures, and their clinical decisions must not be overruled or ignored by non-medical prison staff. In addition, patients must give their informed consent to any medical interventions and examinations, and their medical records must be maintained as confidential.

These Rules are intended to help mitigate the spread of diseases such as hepatitis, HIV/AIDS, MRSA, and tuberculosis, which occur at a higher rate among prison populations than the general population. The Rules are also designed to ensure that prisoners do not become unwilling participants in health studies or experiments, or that health care procedures and medications are used for purposes other than improving or maintaining the well-being of the inmates (e.g. unnecessary or overuse of psycho-pharmaceuticals).

Current Situation:

People in prisons face much greater health risks simply by virtue of being imprisoned. For example, in most countries in Europe and central Asia, rates of HIV infection are much higher among prisoners than the outside population. Since the early 1990s and continuing into the present era, reports of outbreaks of tuberculosis (TB) in eastern European prisons have been on the rise, and "TB strains transmitted in prisons are more likely to be drug-resistant or associated with HIV co-infection. The higher prevalence of HIV and hepatitis in prisons is often related to injecting drug use, and individuals in prison are more likely to share injecting

equipment than drug users in the community." stated the World Health Organization. In addition, approximately 10–15% of the prison population worldwide suffer from severe and enduring mental illnesses, such as such as schizophrenia and bipolar disorders. The rate is much higher for imprisoned youth; over half of youth in prisons that are reported to have "conduct disorders" and around a third of young girls are diagnosed with a form of major depression.

Indeed, across both public and privately managed prisons, a top health concern is that of mental health. Up to 40% of prisoners suffer from a mental health problem. Prisoners are 7 times more likely to commit suicide than people at liberty, while young people in prison are 18 times more likely to commit suicide than those in the outside community. Psychological disorders, including bipolar disorder, depression and trauma-related disorders, are widespread among inmates, and mental illness itself is a risk factor for getting jail time. "We've, frankly, criminalized the mentally ill, and used local jails as de facto mental health institutions," said Alex Briscoe, the health director for Alameda County in northern California.

Long-term care, particularly geriatric care, has recently become a critical part of the debate over prisoners' rights and health standards in prisons. In the U.S., the number of older prisoners is growing rapidly, with nearly 1 in 10 prisoners aged 55 years or older. Conditions commonly associated with advancing age—multimorbidity, sensory impairment, disability, dementia, and end-of-life care—present unique challenges in prisons, and can lead to worsening health, increased vulnerability to injury or victimization, and increased healthcare utilization and cost. Prisons are, in general, designed for younger inmates, and require physical tasks such as climbing into their beds or bunks and walking long distances for meals and for other facilities. Compared to prisoners aged 18–44, those 55 years and older have twice the rate of

accident-related mortality in prisons.

Questions:

- What negative consequences might the solution of simply increasing funding to prisons have?
- What is the root of global rising incarceration rates, and how does the world combat it (aside from the privatization of the system)?
- What is the true purpose of prisons? Reform? Punishment? To separate those who are dangerous from the general public? Something else?
- In what ways does prison reform affect not just prisoners' health, but the general public?

Further Reading:

1. An article including the standards in prisons and juvenile facilities.

https://www.ncchc.org/standards

2. Standard Minimum Rules for the Treatment of Prisoners

https://www.ohchr.org/EN/ProfessionalInterest/Pages/TreatmentOfPrisoners.aspx

3. An article explaining how prison health relates to public health

https://www.icrc.org/en/document/prison-health-public-health