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WORLD HEALTH ORGANIZATION

TOPIC A: Mental Health

TOPIC B: Childhood Vaccines

Dear Delegates,

Hello and welcome to the World Health Organization of Washington State Model United Nations 2003. I am excited and honored to be directing this committee, and I am eager to meet you. This year we will be addressing two very important concerns in the world today – the lack of adequate mental health care and the need to increase childhood immunization rates worldwide.

In selecting this year's topics, we tried to find subjects that would cover a wide range of related health and public policy issues that are not often discussed or not generally well understood. For example, mental health is related to illnesses that are not viewed the same as infectious diseases and are often not identified until it is too late. On the other hand, childhood vaccination touches on the issue of prevention, a part of health care that is important, but often neglected.

As you read through this study guide, I hope that you will find some aspects of the topics that will interest and encourage you to become passionate about the World Health Organization and the United Nations. The productivity and energy level of our committee depends on your efforts, and I know that you will make our committee the most exciting and interesting of this year's conference. I would like to thank you in advance for all of your hard work and dedication. I guarantee that you will enjoy this conference, and I look forward to meeting you in April.

Sincerely,

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HISTORY OF THE COMMITTEE

International cooperation in health initiatives can be traced back 150 years to the first International Sanitary Conference of 1851, whose purpose was to discuss the spread of plague in Europe. In 1902, the first permanent entity to address the goal of improving global health, the International Sanitary Bureau, was established in Washington, D.C., and was later renamed the Pan American Health Organization, and is still an active component of WHO today. Other similar landmark steps, such as the creation of the Office International d'Hygiene Publique in 1907 and the Health Organization of the League of Nations in 1919, paved the way toward the establishment in 1948 of a permanent, autonomous entity to “promote and protect the health of all peoples”, the World Health Organization.

Formally, WHO is a specialized agency existing within the charter of the United Nations with the main objective of “attainment by all peoples of the highest possible level of health.” In its official philosophy, the organization emphasizes that a healthy person is not only free of disease but also is in a state of “complete physical, mental, and social well-being”. In order to meet such a goal as defined, WHO serves as a mediator, which can often collaborate with governments and non-governmental organizations (NGOs) to administer and develop local, national and international health programs. It is also actively involved in the creation and distribution of new technologies, both directly and indirectly related to health care.

Given the prevalence of life-threatening disease, achieving the long-term goals of WHO requires a significant degree of decentralization. Accordingly, there are six regional offices of WHO responsible for their own geographical areas. These coordinate with the three main components of WHO, the World Health Assembly, the Executive Board, and the Secretariat, to establish and maintain their international initiatives.

Today, despite its impressive history of improving world health, WHO still has many problems that it must face. Recent WHO events focused on mental health as one of the world’s most pressing concerns. Other problems such as the eradication of polio also remain unsolved, despite numerous expenses and efforts. It is therefore largely up to the member states to contribute actively to discussion and to compromise in order for the organization to progress toward resolving these difficult questions.



TOPIC A: MENTAL HEALTH

STATEMENT OF THE PROBLEM

The prevalence of the global mental health crisis cannot be ignored. The importance of mental health in mainstream medical care is unfortunately, often underestimated. Nevertheless, a large proportion of debilitating illness worldwide can be categorized as mental health problems. Many of them striking with no discrimination to age, gender, or socioeconomic status, mental illnesses represent a problem, which faces a significant percentage of the world's population. Yet these diseases often have simple, developed treatments which are not applied due to social stigma, absence of accessible resources, and misdiagnosis.

Additionally, ignorance about these psychological ailments contributes to the victims' tendencies to not seek out help due to a lack of general awareness. Some UN member states do not even have mental health programs. Nevertheless, mental diseases are real, even if their outward appearances are not always so obvious. As expressed by a recent statement from WHO: "The existence of mental and brain disorders often remains hidden... Yet the underlying abnormal substructure of many disorders has been identified by images of the brain. Thus to ignore their existence is akin to denying that cancer exists because we are unable to see the abnormal cells without a microscope." All too often, mental disease also contributes to early death, often through seemingly unrelated causes such as heart disease, according to a June 2001 study by the United States Department of Health. In some cases, patients wrestle with such painful disorders that they even choose death as a form of relief from their suffering. It is evident that there are formidable obstacles to combating mental illnesses. However, we have come a long way since the last century and improving upon treatment programs is a very feasible task.

HISTORY OF THE PROBLEM

The history of treating mental illness is one of vast improvement. One hundred years ago, common treatments for schizophrenia included drilling holes into the patient's head and "beating the devil" out of the victim. Even worse, the famous St. Mary of Bethlehem Hospital in London, more commonly known as Bedlam, entertained visitors who would pay money to see patients in a matter similar to a freak show. What is now known as psychiatry did not emerge until the late 19th century, largely due to the efforts of French physician Philippe Pinel who advocated mental hospitals with more scientific approaches to treatment. Gradually, new methods of treatment emerged, ranging from biomedical therapies to Freudian psychotherapy to humanistic approaches. By the 1950's, community-based treatment programs, with more individual attention being their



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greatest advantage, became extremely popular in North America and Europe and displaced many mental health hospitals. Many of these large institutions were disbanded due to human rights violations. However, in most parts of the world, even today, these facilities still exist in great numbers.

BLOC POSITIONS

Central and South America

Countries in this bloc are generally not engaged in active research for new treatment methods. However, in several states, most notably Brazil, many consumer lobbyists have been successful in their de-institutionalization efforts. Past experiences of war and displaced persons for many nations in this bloc, have increased the need to place emphasis on mental health awareness.

Western Bloc (Excluding Europe)

Typically, the nations of the Western Bloc engage in a great deal of health research. However, it is not always the best way of solving mental health problems, since solutions are usually simply found in improving access to already existing treatment. Members of this bloc will promote community-based care and will push for drafting WHO recommendations that involve extensive facilities and resources to benefit nations in this bloc.

African Bloc

The most important concern by far for the African nations is the mental health of refugees. Many of the countries of the bloc have been in a state of war and insurrection which have resulted in large numbers of displaced persons and survivors of traumatic situations.

Europe and Russia

The trend of de-institutionalization in this bloc has been established since the 1970's. Community-based care has been a trend that will continue to grow as European nations disband existing large mental hospitals. Heavy emphasis is also placed on rehabilitation and the ability of patients to eventually return to society and lead normal, production lives. These nations will most likely seek the most economical methods of establishing local community mental health programs and raising general awareness about the problem.

Southern and Eastern Asian Nations

The biggest problem facing these member states is the stigma and discrimination associated with mental patients. This aspect of society makes it extremely difficult for governments to establish better programs, as afflicted individuals are hesitant to seek treatment. Furthermore, rehabilitated individuals who return to normal society are labeled and subject to discrimination. As a result the Asian nations will focus their efforts on education and awareness activities and seek WHO involvement to provide resources and campaigns.



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Middle Eastern Bloc

Several countries in the Middle East have been successful in integrating mental health into primary care programs. As a result many community care facilities exist in nations such as Iran. However, there is still much room for improvement. Rural areas, for example, often do not receive adequate resources, and discrimination and stigma issues remain unresolved. Thus, nations from this bloc will promote education and awareness actions while continuing to incorporate mental health into general health care.

PAST UN ACTION

As early as 1959, when WHO decided on mental health for its World Health Day theme, experts recognized the importance of the issue. Many of the same problems were addressed – treatment options, stigma, and burden on society. Today, while major advances have been made in terms of medications and treatment methods, accessibility to these resources is still greatly limited.

The fundamental ideas for the current campaign for mental health were laid down in 1991 when the UN General Assembly (GA) adopted resolution A/RES/46/119, “The Principle for the Protection of Persons with Mental Illnesses and for the Improvement of Mental Health Care.” This landmark declaration outlined the basic rights of the mentally disabled and condemned the discrimination and lack of care that often accompanies their ailments.

One of the most prominent ideas to solve the mental health crisis came out of discussion held at the Geneva World Health Assembly meeting in April 1999. In this meeting, experts from around the world discussed WHO’s potential collaboration with local science industries and institutions and non-governmental organizations (NGOs) – resulting in the establishment of WHO Collaborating Centers. These centers serve not only to promote awareness in mental health, but also to make significant advances in the field.

Alongside its efforts to establish collaboration, recently, over the course of 2001, WHO has stepped up its mental health education campaign. For example in April 2001, WHO launched Project ATLAS, which is an ongoing survey effort to assess mental health programs worldwide. The results of this initiative as well as others, including the discussion of the 54th WHA in May 2001, were published in the World Health Report 2001 entitled “Mental Health: New Understanding, New Hope.”



PROPOSED SOLUTIONS

Solving the problem of mental health is a complex question, but essentially can be broken down into its components: fighting discrimination and raising awareness, improving health care programs through de-institutionalization and other means, and finally creating legislation to address the mental health of refugees and those in crisis situations.

Mental health remains a topic often ignored by many countries, particularly lesser developed nations in the UN, 30 percent of which do not even have basic mental health care programs. Illnesses such as schizophrenia, depression, epilepsy, and alcohol dependence are, nevertheless, prevalent diseases, which are becoming increasingly common. Indeed, the World Health Organization (WHO) estimates that by the year 2020, such disorders will be responsible for 15% of DALY's (disability adjusted life years) lost.

As the global leader in health policy, WHO can make valuable recommendations and establish guidelines for countries that seek to improve their mental health programs. Our committee will then have to decide how best to approach the lack of attention to mental health worldwide. Is education the key? Or should we focus on de-institutionalization and more individualized care? On the other hand, the issue of available resources is also an important one, as developing nations often cannot afford to implement many of the recommendations deemed necessary for an effective mental health program. Are there ways to overcome this obstacle? By what means? Should governments be responsible for providing mental health care programs? How should NGO's be facilitated and solicited? By formulating carefully planned and executable guidelines, which answer these questions, WHO can play an important role in resolving the mental health problem.



TOPIC B: CHILDHOOD VACCINES

STATEMENT OF THE PROBLEM

Today, researchers continue to develop newer and better vaccines to protect us from progressively more dangerous infectious diseases. This ability to safeguard ourselves against “invisible killers” has proven to be one of the most promising and miraculous advancements in medicine. Undoubtedly, the practice of immunization has allowed millions of people of the past few decades to escape the terrible wrath of diphtheria, polio, measles, smallpox – just a few of the enemies which modern medicine has learned to combat. And although we now have the power to prevent these diseases from ever striking again, there are still many obstacles that stand in the way.

It has been two hundred years since doctors first discovered the process of immunization, yet some two million children still die each year from illnesses for which we have established vaccines. Hepatitis B, for example, is alarmingly prevalent in countries such as Benin and Cambodia, yet these countries cannot afford the US \$1 per dose price tag that comes with lifelong protection against the disease. The fact that we have the ability to stop this suffering is one of the greatest tragedies of our generation.

One quarter of the world’s children are not immunized. Every ten seconds a person somewhere in the world dies of a preventable disease. Solving the vaccination problem is not easy, as its roots span and intertwine across a multitude of disparate areas. Financial problems, delivery and service issues, and unchanging attitudes of governments are but a few of the points that our committee must address. Discussion and debate around these key issues will be instrumental in devising a comprehensive resolution.

HISTORY OF THE PROBLEM

In the late 1700’s, Edward Jenner’s discovery of the small pox vaccine sparked a flurry of scientific advancement leading to the age of immunization. The basic concept behind vaccination is this: by exposing the body to a weakened form of some pathogen such as an attenuated or sometimes even dead virus, a person’s natural immune response develops antibodies to counter the foreign agent. Since the pathogen is weakened, the immune system overcomes the outside threat but is subsequently prepared for any attack by the real virus.

In the early 20th century, use of vaccines was relatively haphazard and confined to local areas. Local outbreaks would be controlled, but since no consistent global or even national policies existed, the disease would still appear at various unpredictable times and places. By this time, most of the industrialized countries had in their possession vaccines against smallpox, tuberculosis, yellow fever, and a host of others. Some of these, such as



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the smallpox vaccine, were highly effective, while others had limited protective ability. Nonetheless, through child health services and efforts to increase coverage, more and more people were being protected from these historic scourges. It is important to note, however, that in the first half of the 20th century, there was no concerted effort in any nation to immunize *all* of its citizens.

During the 1950's, however, the increased number of vaccines available and their increased effectiveness prompted many officials worldwide to begin considering complete global immunization resulting in eradication of certain diseases. Development of the Oral Polio Vaccine (OPV), which could easily be administered, further demonstrated that lifelong protection was, in practical terms, not difficult to achieve on a large scale –even syringes and needles were not required in some cases.

In 1956, WHO took the next logical step and decided to begin its war on disease by selecting smallpox as “global enemy number one.” The intensive immunization program which followed was successful beyond expectation. Only twelve years after the first vaccinations in 1967, WHO declared total victory over smallpox – the last man to be naturally infected with the disease, a Somalian cook, was infected in 1977 and survived.

Unfortunately, the victory over smallpox has been the only one that any organization has achieved. Actually reaching out to those in high-risk areas is the hardest part, since we have vaccines for many killer illnesses. Today, most immunization efforts center on the “big six” six common infectious diseases for which we have developed vaccines. These preventable diseases are: measles, tetanus, pertussis (whooping cough), tuberculosis, polio, and diphtheria.

The most pressing issues concerning vaccination deal with access and delivery. Many times, vaccine stocks are spoiled as a result of inadequate infrastructure to store and maintain their efficacy. Usually, vaccines are delivered by airplane, stored in cold rooms and refrigerators until administrators can allocate them to various clinics and the field. Along this “cold chain” is where many flaws exist, resulting in incomplete or improper vaccination.

Many lesser developed nations requiring vaccines also possess little or no health infrastructure or central authority to govern the supply and delivery of vaccines. The common problems that accompany weak health infrastructures are insufficient refrigeration, lack of delivery vehicles, and lack of trained health staff. Unstable infrastructure often results in inefficient dissemination of critical information and resources. In fact, a WHO study reported that 43% of vaccines delivered to lesser developed nations are actually wasted for these reasons.



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BLOC POSITIONS

Central and Sub-Saharan Africa

The nations in this region will benefit most from outside assistance. Many the critical infrastructure required to implement large-scale immunization programs, although in the past thirty years there has been a dramatic improvement in childhood immunization rates. Typically, many of the countries in this region are also involved in war or insurrection. As a result, these states generally do not have the resources or the personnel and will subsequently call for educational and training programs alongside its requests for supplies and equipment.

Countries of the Former Soviet Union

Having recently suffered from the diphtheria epidemic, these nations know from experience the consequences of lacking immunization schedules. These countries will therefore be strong advocates of sustainability with an emphasis on commitment. They will likely support resolutions with a focus on awareness programs and education stressing the importance of commitment from industrialized nations.

Western Bloc (Excluding the Former Soviet Union Countries)

These nations will feel secure having well-established immunization programs. In fact, other countries will look towards this bloc for assistance and guidance as to how to form their own programs. Nonetheless, no nation is safe from infectious disease. And with the emerged threat of bioterrorism, the members of this bloc must also address vaccination strategies and re-examine their current infrastructure. Thus, the countries of this bloc will advocate assistance and aid, with a focus on pharmaceutical companies which are based in this region. They will work towards subsidizing prices for existing vaccines and encourage companies to do more research on new vaccines. At the same time, however, this bloc does not want developing nations to become dependent on their aid for an indefinite period of time, and will therefore emphasize the importance of long-term sustainability.

Central and South American Bloc

Although vaccination programs are not as well-established as those found in North America and Europe, they do exist and have prevented outbreaks over the course of the previous decade. Nevertheless, the nations of this bloc will not be anxious to be the source of aid, as they must first improve up on their own health programs and infrastructure. Thus, these countries will take a more neutral approach in advocating aid in the short-term from WHO and will support resolutions stressing sustainability.

Northern African, Southeast Asian, Middle Eastern Bloc

Although they have higher immunization rates than their Southern and Sub-Saharan counterpart, these nations still require a great deal of assistance in infrastructure and health programs. As a result, these countries will advocate aid and educational programs, preferably sponsored by an international organization such as WHO.



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East Asian Bloc

While the countries in this bloc usually have effective immunization programs, the biggest concern for the nations here is accessibility and delivery to rural areas. These countries will likely support resolutions that address the issue of improving immunization programs to include and sustain rural areas.

PAST UN ACTIONS

Encouraged by the success of its smallpox eradication campaign, WHO began to look towards other projects. In 1974, the Expanded Program on Immunization (EPI), which included protection against tuberculosis, polio, measles, pertussis, diphtheria, and tetanus, was launched. At this time, only 5% of children in the developing world were immunized against these “big six” diseases. In the years that followed, WHO, UNICEF, and other groups put together a large-scale immunization campaign, which included training, information dissemination, and infrastructure reform. By 1984, immunization coverage rates had risen dramatically. Average DPT (Diphtheria, Pertussis, Tetanus) and measles coverage, for example, went from 25 to 40 percent; polio protection went up by 70%.

WHO has also devoted some efforts to training programs designed to accompany the EPI. The Global Training Network on Vaccine Quality (GTN), for example, was established in 1996 as the answer to lack of qualified health workers in developing countries. The network has 12 centers worldwide and offers a number of training courses, each with accompanying documentation and certification. Workshops also complement normal curricula, which are available through application on a case-by-case basis.

In May 1988, WHO embarked on another ambitious journey: the eradication of polio. Acting in accordance with the WHA resolution to destroy polio by the year 2000, (which has now been expanded to 2005), WHO designed and executed a four-pronged approach modeled after the previously successful smallpox campaign. This included routine immunization, national immunization days, door-to-door vaccinations, and surveillance. Eradication efforts today are still based on this model. WHO estimates that the campaign is 99% complete, but funding (mostly delivery costs) and commitment problems pose challenging obstacles to the final goal.

PROPOSED SOLUTIONS

The solution to eliminating many diseases lies not in curing them after the fact, but in preventative measures, such as ensuring sanitary environments and providing vaccinations. Currently there exist preventative cures for countless diseases such as polio, diphtheria, and measles, yet people – mostly children – still die needlessly from these ailments. The problem is not so much the result of an inability to synthesize the



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materials needed, but rather a consequence of distribution issues, inadequate funding, and lack of political commitment. In particular, it is exceedingly difficult to get even basic vaccinations into rural, sparsely populated regions of the world. A lack of trained health staff in certain areas also contributes to the problem; as stated earlier, 43% of vaccines delivered to developing countries are spoiled due to improper storage practices.

An effective resolution for this topic must address all of the key components of the immunization problem: delivery and accessibility, commitment, and funding. Each of these main components encompasses a multitude of details and smaller problems which have to be addressed if we are to achieve global immunization.

How can we ensure that national governments have an adequate supply of vaccines? If the vaccines are available, then how can we strengthen local infrastructure so that timely delivery of the vaccines is possible and the “cold chain” is maintained? Furthermore, how can sustainability be achieved? Can we find a way for countries to sustain their own immunization programs independently? Can national governments continue to rely on international organizations such as WHO indefinitely – or, more importantly, what happens if nations do not seek out assistance at all? How can global immunization be achieved in these cases? Should NGO’s such as the Global Alliance for Vaccination and Immunization (GAVI) be used to intervene when national governments fail to establish their own local programs?

Our committee will have to debate these important concerns, keeping in mind the issue of sustainability, since member states cannot be dependent on outside resources indefinitely. Furthermore, we must also deal with financial constraints and cultural solidarity issues as we pursue resolutions. Only through thoughtful discussion of these key issues can WHO hope to save lives otherwise lost to preventable diseases.

CLOSING REMARKS

Although this is the end of my story, it is only the starting point for your research and model UN experience. I urge you to expand on these issues and investigate the topic areas on your own. Each is extremely broad, and you will at times feel overwhelmed with information. However, use this to your advantage and be sure to take note of interesting and new information that I have not covered in this study guide. I hope that you will find your research experience fun and enjoyable. I encourage you to contact us with any questions or concerns.

On behalf of the executive team of WHO of WASMUN 2003, I wish you the best of luck in your research, and I look forward to seeing you in April.



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