KU LEUVEN MODEL UNITED NATIONS STUDENT ASSOCIATION

# KU Leuven Model United Nations 2019

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*A World Without Frontiers: Solutions beyond Borders for Regional Problems Going Global*

## World Health Organization

## Study Guide

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# Words of Welcome

Distinguished delegates,

Welcome to KU Leuven Model United Nations 2019. We are Ana Victoria and Hanne Pollet, and it is an honor for us to be chairing this prestigious committee. We will first introduce ourselves:

**Ana Victoria Martín Corral** is a Spanish student from the university town of Salamanca, now on her sixth –and final! - year of Medicine. She fell in love with MUNs when she participated in her home conference MUNUSAL at only 16 years old. While her medical studies clashed with her passion for MUNing in the first few years, the MUN virus came back with a vengeance and proved impossible to shake. KULMUN 2019 will be her 20th conference and she intends to celebrate it accordingly. This year she is also taking on the challenge of being President and Conference Manager of MUNUSAL 2019 (happening in April) and beginning to prepare for the ultimate medical exam to land herself a residency spot.

**Hanne** is a law student that was born and raised in Belgium but nowadays rather considers herself a global citizen. She studies law in Ghent and just came back from her Erasmus in Groningen (NL). A young Hanne discovered MUN at KULMUN's first edition and over the years she grew up to become a true devotee to every simulation that crosses her way. Being a firm believer that true understanding is the main part of a conflict solving process, she found her perfect tool in MUN and therefore made it her own personal mission to spread this addictive virus as much as possible.

The topics under discussion for the World Health Assembly are: *A) Tackling Maternal Health and Mortality in Sub-Saharan Africa* and *B) Mental Health in the Conflict Zones of Africa and the Middle East.* These two topics fall under the spectrum of the overarching KULMUN 2019 theme "A World Without Frontiers: Solutions beyond Borders for Regional Problems Going Global", since these regions are particularly vulnerable to health issues due to poverty, past or present conflicts, or a combination thereof. If we want to address global issues, it makes sense for us to focus on the root causes of inequality between regions, so the advances that have been achieved in some parts of the world can eventually reach every last corner.

We are certain that attending KULMUN 2019 is an opportunity for all of us to come together, debate global issues and experience the art of diplomacy. You can improve your academic skills and form strong friendships with likeminded peers. We sincerely hope that the sessions will provide you with an interesting look at the complex issues presented and that you will leave the conference with a more critical eye for the unique problems that are being faced by our modern-day world. We expect each of you to respect the platform you are becoming a part of. Use this chance to speak up and believe that you can make a change. Enjoy Leuven and seize the chance KULMUN offers to you. We are looking forward to fiery arguments, bizarre elucidations and bursting sessions of diplomatic spectacle to amaze us.

If you have questions concerning your preparation for the committee or the conference, please contact us at our email address. We wish you all the best for your preparation for the conference and look forward to seeing all of you at KULMUN.

Sincerely

*Ana Victoria Martín Coral and Hanne Pollet*

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# Committee Overview

## Introduction to the World Health Organization

The World Health Organization (WHO) is the supervising and coordinating authority on global health within the UN. Article 1 of the WHO Constitution[1] states that the objective of the WHO is "*the attainment by all peoples of the highest possible level of health*". Health is defined in the preamble as "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*". The WHO is a specialized agency of the UN and works with other specialized UN agencies through the coordination of the Economic and Social Council of the UN.[2] The WHO produces health guidelines and standards, supports countries in their public health issues as well as finances and promotes health research. Through the organizational framework of the WHO, governments, UN entities, professional groups and NGOs can jointly deal with global health and improve all people's well-being.[3]

The organization has quite comprehensive leadership priorities. Its current priorities are:

1. Advancing universal health coverage by empowering countries to sustain or expand access to health services, financial protection and effective, affordable medical products.
2. Combatting communicable diseases (CDs), like HIV/AIDS, ebola, malaria, tuberculosis.
3. Addressing non-communicable diseases (NCDs), mental health, injuries, and disabilities.
4. Promoting healthy lives through sexual and reproductive health, healthy aging, good nutrition, food security, healthy eating, occupational health, substance abuse prevention.
5. Addressing the socioeconomic and environmental determinants of health to reduce health inequalities within and between countries.
6. Making sure that all countries can detect and react to public health threats through the International Health Regulations.[4]

Moreover, the WHO is responsible for the World Health Reports, a series of worldwide World Health Surveys. They provide information for policymakers, donor agencies, international organizations and others to help them in deciding health policy and funding.[5] The WHO also organizes the World Health Days: global health awareness days celebrated every year which draw attention to important global health issues.[6]

## Origins and Achievements

The origins of the WHO can be traced back to the beginning of the 20th century, when its predecessor, the Health Organization of the League of Nations, was founded. The WHO was established on April 7th, 1948 and inherited the mandate and resources of its predecessor. [7] The First World Health Assembly met in 1948 and established early priorities for the organization: eradication of malaria, tuberculosis, venereal diseases, maternal and child health, sanitary

[1] World Health Organization. (2006, October). *Constitution of the World Health Organization.*
[2] United Nations. (n.d.). *About the UN: Funds, Programmes, Specialized Agencies and Others.*
[3] World Health Organization. (2007). *Working for Health – An Introduction to the World Health Organization*.
[4] World Health Organization. (2016). *The Global Guardian of Public Health*.
[5] World Health Organization. (n.d.). *Global Health Observatory (GHO) Data*.
[6] World Health Organization. (2017). *WHO Global Health Days.*
[7] World Health Organization. (n.d.). *About WHO: The role of WHO in public health.*

engineering, and nutrition.[8] The biggest success of the WHO so far is the eradication of smallpox in 1979.

In 1969 the International Health Regulations (IHR) were established as an international legal instrument that is binding on all countries across the globe, aimed at preventing and responding to public health risks that have the potential to transcend borders and threaten people in many other countries. The first list of essential medicines was created in 1977, registering all medicines that "*satisfy the priority health care needs of the population*"; according to the WHO, all people should have access to these medicines in sufficient amounts.[9]

In 1986, WHO started to fight against HIV/AIDS pandemic and ten years later UNAIDS was formed, a program for comprehensive and coordinated global action on HIV/AIDS.[10] The Global Polio Eradication Initiative was established in 1988. It is the largest public health initiative in history with the aim of eradicating one of the most worrying childhood diseases.[11] Currently, the WHO works together with other UN entities to realize the Sustainable Development Goals (SDGs), and specifically on SDG 3 "*Good Health and Well-being*".

## Membership of the WHO

Membership in the organization is open to all states according to article 3 of its Constitution. All UN member states and other countries may be admitted by signing the WHO Constitution or when their application has been approved by a simple majority of the World Health Assembly. As of 2017, the WHO member states list includes 194 member states, all of which are also Member States of the UN, except for the Cook Islands and Niue.[12] Additionally, the WHO has two associated members, Puerto Rico and Tokelau. Liechtenstein is currently the only UN Member state which is not part of the WHO. Several countries have observer status in the World Health Assembly: The Holy See, Order of Malta, the Palestinian Authority, the European Union, Taiwan (as Chinese Taipei) and the International Committee of the Red Cross.

## Structure of the WHO

According to article 9 of the WHO Constitution, the organization consists of three organs:

(a) The World Health Assembly (WHA) is the supreme decision-making body of the WHO. All 194 WHO member states appoint delegations, usually their health ministers, who meet once per year in Geneva, the location of the WHO Headquarters. The main functions of the World Health Assembly are to determine the policies of the Organization, appoint the Director-General, supervise financial policies, and review and approve the proposed programme budget. The focus on a specific health agenda set by the Executive Board.

(b) The Executive Board (EB) carries out the decisions and policies of the Assembly. They advise the WHA and facilitate its work. It is the executive organ of the WHA. Its 34 members are elected due to their qualification and reputation in the field of health but also according to their home country, thus creating an equal geographical representation. They meet twice a year.

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[8] McCarthy, M. (2002, October 12*). A brief history of the World Health Organization.* The Lancet, 360.
[9] World Health Organization. (2015, May). *Essential Medicines*.
[10] United Nations HIV/AIDS Programme. (2001, June). *Fact Sheet What is UNAIDS?*
[11] Global Polio Eradication Initiative (n.d.).
[12] World Health Organization. (2017*). WHO Member States*.

(c) The Secretariat comprises the Director-General and the technical or administrative staff of the WHO. The Director-General is the chief technical and administrative officer of the Organization but is subject to the authority of the Executive Board. According to the constitution, the Director-General is by the right of their office the Secretary of the WHA. On the regional level, the WHO has established regional offices to meet the special needs of an area. The regional divisions are: Africa (AFRO), Europe (EURO), Americas (AMRO), Eastern Mediterranean (EMRO), South-East Asia (SEARO) and Western Pacific (WPRO).[13]

Many decisions are pre-made at the regional level, including important discussions over WHO's policy and budget. The natural cooperation partners can therefore be found within the respective regional division of the WHO. Voting blocks in the WHA also usually form according to regional interests.

## Procedures and Voting

KULMUN will simulate the World Health Assembly (WHA), since it is the WHO's supreme decision-making body. Each delegation will have one vote in the WHA. In order to pass a resolution a simple majority (1/2 + 1 of votes) of the delegations present will be needed. The procedures and voting within the WHA are the MUN standard.

However, it must be noted that the IHR are, alongside UN Security Council Resolutions, legally binding internationally by their nature.[14] This enables delegates in the WHA to demand certain policy action (within the framework of the IHR) from the international community. Delegates can use this legal advantage in their health policy recommendations.

[13] World Health Organization. (n.d.). *Regions*.
[14] World Health Organization. (2016, June 20). *What are the International Health Regulations and Emergency Committees?*

# Topic A. Tackling Maternal Health and Mortality in Sub-Saharan Africa

## Introduction

If you are a woman of reproductive age (15 to 49 years) from a low-income country, you have a 1 in 180 chance of dying during pregnancy or childbirth. Your richer counterparts, on the other hand, have a 1 in 4900 chance of dying for the same cause.[15]

Maternal death is defined as the death of a woman while pregnant, or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management (from direct or indirect obstetric[16] death), but not from accidental or incidental causes.

Since the 42-day mark is arbitrary, the WHO introduced the concept of late maternal death to refer to the death of a woman from direct or indirect obstetric causes, more than 42 days but less than one year after the termination of pregnancy.[17]

The difference between a direct obstetric death and an indirect obstetric death[18] is that the former is caused by a complication of the pregnancy, childbirth or puerperium (the 6 weeks following the birth), while the latter is caused by an existing disease or one that developed during pregnancy but was not related to the pregnancy itself, only aggravated by it. An example of indirect obstetric death would be a woman with a heart condition[19] that worsens due to the pregnancy resulting in her death.

The main instruments to measure maternal deaths are the maternal mortality ratio and maternal mortality rate. Be careful when using the abbreviation "MMR", which refers to the ratio.

- Maternal mortality ratio (MMR): number of maternal deaths during a given time period *per 100,000 live births* during the same time-period.
- Maternal mortality rate: number of maternal deaths in a given period *per 100,000 women of reproductive age* during the same time-period.[20]

In the first sentence we have also made reference to the lifetime risk of maternal death: the probability of becoming pregnant and the probability of dying as a result of that pregnancy cumulated across a woman's reproductive years.

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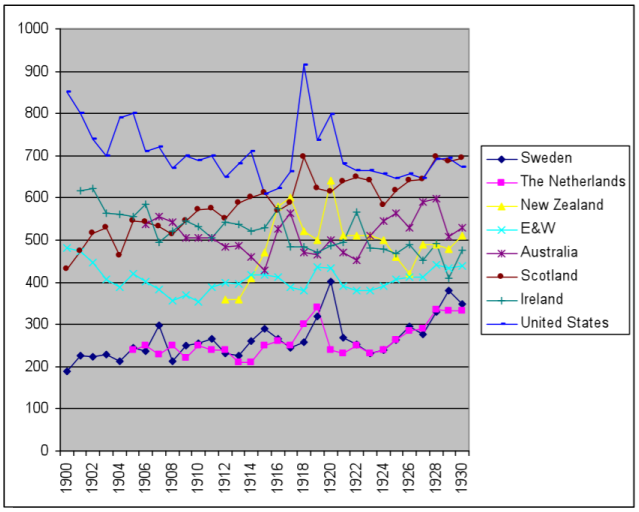
[15] World Health Organization (2014). *Fact Sheet: Maternal Mortality.*
[16] Obstetric: relating to pregnancy, childbirth, and the postpartum period.
[17] World Health Organization. Global Observatory (n. d.). *Indicator Metadata Registry*.
[18] Population Research Institute (2014). *Definitions of Maternal Mortality*.
[19] Franklin, W. J., Benton, M. K., & Parekh, D. R. (2011). *Cardiac disease in pregnancy*. Texas Heart Institute journal, 38(2), 151-3.
[20] *Maternal Mortality in 2005 (2005).* Estimates developed by WHO, UNICEF, UNFPA and The World Bank.

## Historical Background

At the start of the 19th century, 500 to 1000 mothers died out of every 100,000 live births.[21] It is difficult to properly track maternal mortality worldwide through the centuries, since most countries only established national death registration systems in the mid or late 20th century. It was not until the 1910s that the definition for maternal death was internationally adopted, so even those countries keeping records before then (Australia, Belgium, Finland, Ireland, the Netherlands, Sri Lanka, Sweden, the United Kingdom and the United States) might have had different criteria for inclusion of women in their records as a "maternal death".




**The influenza epidemic in the 1918 and maternal mortality**

Even after 1910, some countries differed in their inclusion of indirect obstetric deaths as maternal deaths. The 1918 influenza pandemic —the so-called Spanish flu— which killed 50 million people worldwide, made maternal mortality spike in Sweden, Scotland, the Netherlands and the United States of America, but not in England, Wales or Australia, for the sole reason that those countries did not count the death of a pregnant woman due to the pandemic as a maternal death.

Abortion was first legalized in 1920 in the Soviet Union, but in 2018 only 37% of the world's 1.64 billion women of reproductive age lived in a country where abortion was permitted without a medical reason[22] (but with requirements as to gestational age of the pregnancy). The fact that abortion was –or still is– illegal did not mean that women did not undergo it, only that is was done clandestinely and usually with very little regard for hygiene and performed by unskilled people, leading to many deaths. These deaths were usually hidden and did not count as maternal ones, meaning that our figures are flawed.

## Decline in Maternal Mortality

### *Semmelweis and the Germ Theory*

Dr. Ignaz Semmelweis was a Hungarian physician working at the Vienna Maternity Hospital in 1846, where he made an intriguing observation. The hospital was divided into two wards, one of which was managed by doctors and medical students, while the other was run by midwives. He noticed that maternal mortality was alarmingly higher in the first ward. Patients were allocated to either of the wards on alternate days, so there was no correlation between the difficulty of the cases doctors and midwives faced. In fact, most of the deaths were due to 'puerperal fever'. Semmelweis noticed that medical students and doctors started the day by performing autopsies on the women who had died from puerperal fever, and put forth a theory that they carried 'morbid matter' on their hands, which was transferred to the labouring women when they examined them. In 1847 he introduced a rule requiring all medical students and physicians to wash their hands in chloride of lime, and mortality fell in his ward to the same level as in the

[21] Gapminder Documentation (2010). *Data on Maternal Mortality*.
[22] World Economic Forum (2018). *These are the countries where it's still illegal to get an abortion*.

midwives' ward, and even further when he started washing the surgical instruments (such as forceps) in the same solution.

Even though the first microorganisms were observed under the microscope in the 1670s by Antonie van Leeuwenhoek, it was not until Louis Pasteur's and Robert Koch's experiments in the 1860s that these tiny beings were first linked to disease and death.[23] Until this moment, diseases were believed to be caused by 'foul odors' or 'miasmas'.

### *Asepsis and antisepsis*

Joseph Lister was inspired by Pasteur's studies to start using antiseptic substances to clean wounds, thus preventing infections. He is considered the father of modern surgery.[24] Antisepsis aims to arrest the growth of microorganisms, while asepsis seeks to fully eliminate them. Antisepsis is achieved nowadays in operating theatres worldwide through the use of alcoholic and other solutions on wounds, surgical scrubbing (surgeons must thoroughly wash their hands with an antiseptic agent before operating) and surgical masks. Asepsis goes hand in hand with antisepsis, and is achieved through the sterilization of surgical instruments and the use of sterile surgical drapes, gowns and gloves.[25] Consequently, caesarean sections –commonly known as c-sections- became a safe option for both mother and baby, and not just a desperate resort when the labouring woman was dead or dying.[26]

### *Antibiotics*

Alexander Fleming came back to his laboratory from his holiday in 1928 to discover the mold *Penicillum*, from which penicillin would be obtained, saving countless lives. Penicillin was then produced on a large scale during World War II to save the lives of wounded soldiers, and later became available to the general public.[27] Between the 1950s and 1970s many other antibiotics were developed, and infection, which once was the leading cause of death in the worlds, was staved off.[28]

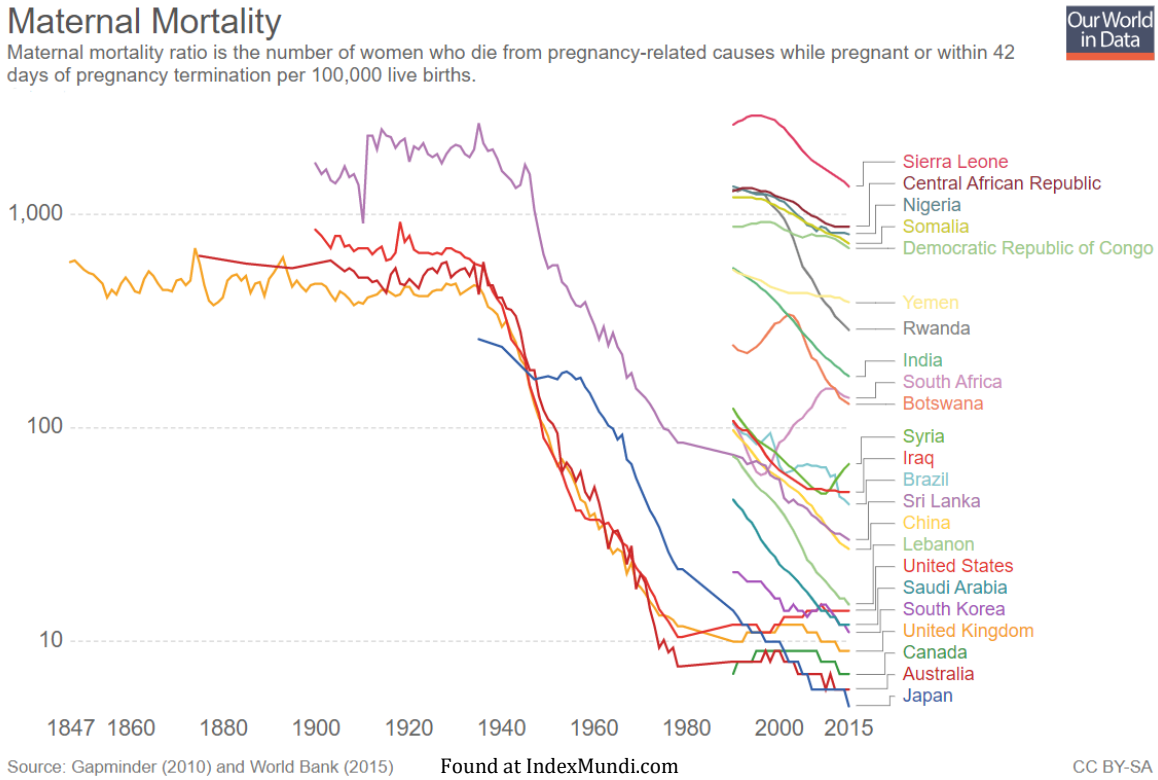
### *Anaesthesia*

A small mention must be made to anesthetics, which were first introduced in the 19th century. Dr. John Snow utilized chloroform on women to alleviate the pain of childbirth, his most famous patient being Queen Victoria of England, who used it for her eighth (1853) and ninth (1857) deliveries and made it popular. Modern epidurals (the administration of anesthetic through a catheter in the lower back, or lumbar area) were not in use until the 1970s.[29] While not a life-saving measure per se, it has greatly contributed to the comfort of women in labour. Having an epidural in place will also help in the event of an emergency c-section.

## Current Status of Maternal Mortality in the World

[23] Big Picture. *The History of Germ Theory.*
[24] Pitt, D., & Aubin, J. M. (2012). *Joseph Lister: father of modern surgery.*
[25] Infection Control Today (2009). *Maintaining Asepsis and Antisepsis Within a Sterile Field in Surgery*.
[26] U.S. National Library of Medicine. *Cesarean Section – A Brief History*.
[27] American Chemical Society. *Discovery and Development of Penicillin*.
[28] Aminov, R. I. (2010). *A brief history of the antibiotic era: lessons learned and challenges for the future.*
[29] Silva, M., & Halpern, S. H. (2010). *Epidural analgesia for labor: Current techniques*.

Maternal mortality began decreasing rapidly in developed countries in the 1940s, thanks to all the aforementioned advances.



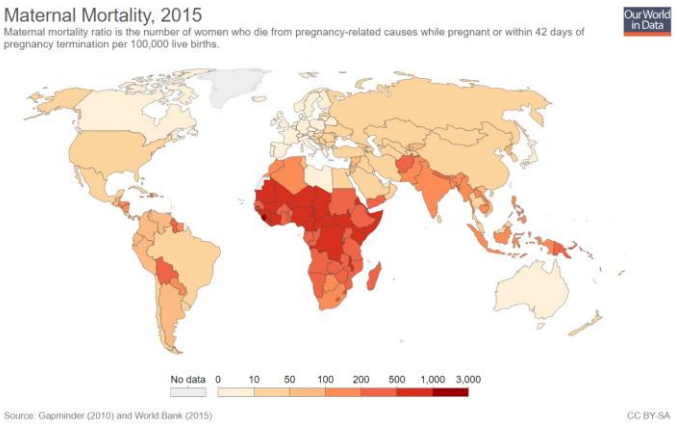
Found at IndexMundi.com

Between 1990 and 2015, it had descended 43% worldwide.[30] However, this still means that 303,000 women are losing their lives in childbirth every year, even now. 99% of those women come from developing countries, and roughly two thirds of those come from Sub-Saharan Africa.[31] There is a saying in many African countries that *"to be pregnant is to have one foot in the grave"*.[32] However, maternal deaths are preventable as there is clearly an immense gap between rich and poor, and between those from rural and urban areas, even within the same country.

As seen in the graph below, Sierra Leone is the worst country in the world for expectant mothers, with a MMR of 1360. Eighteen other countries, all in Sub-Saharan Africa, were estimated to have very high MMR in 2015, with estimates ranging from 999 down to 500 deaths per 100,000 live births, the regional average being at 546. There are only two countries in Sub-Saharan Africa with low MMR: Mauritius (53) and Cabo Verde (42). Three countries outside this region also have very high MMR: Afghanistan (396), Yemen (385) and Haiti (359).[33]

[30] Global Health Observatory (GHO). *Data - Maternal Mortality (2015).*
[31] Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division (2015). *Trends in maternal mortality: 1990 to 2015*.
[32] Women in the World (2016). *Pregnant Women "Have a Foot in the Grave": Four Women Reducing Maternal Mortality.*
[33] Index Mundi (n.d.). *Maternal Mortality Rate*.

| Rank | Country | Maternal mortality rate (deaths/100,000 live births) |
|---|---|---|
| 1 | Sierra Leone | 1,360 |
| 2 | Central African Republic | 882 |
| 3 | Chad | 856 |
| 4 | Nigeria | 814 |
| 5 | South Sudan | 789 |
| 6 | Somalia | 732 |
| 7 | Liberia | 725 |
| 8 | Burundi | 712 |
| 9 | Gambia, The | 706 |
| 10 | Congo, Democratic Republic of the | 693 |
| 11 | Guinea | 679 |
| 12 | Cote d'Ivoire | 645 |
| 13 | Malawi | 634 |
| 14 | Mauritania | 602 |
| 15 | Cameroon | 596 |




By contrast, the regional average in Europe is at 16 deaths per 100,000 live births, as this region boasts the countries with the lowest estimates when it comes to maternal mortality. Finland, Greece and Poland are the safest countries, with an MMR of just 3.[34]

Interestingly, the United States of America is the country with the highest MMR in the developed world (14 on average, but it differs greatly between states), and it is one of the few countries in the world whose figures are climbing.[35] This could be due to a higher number of non-communicable diseases affecting the expectant mothers, such as diabetes or cardiovascular disease, and leading to indirect obstetric deaths. The home-birth "all-natural" movement, though still marginal, also raises the risk of maternal death.

## Causes of Maternal Mortality in the Developing World and How to Prevent Them

### *Haemorrage*

Obstetric haemorrage (severe bleeding) accounts for 25% of all maternal deaths worldwide and occurs mostly in the postpartum period.[36] Most women do not have identifiable risks factors, so prevention is hard, but treatment should be swift and effective.

Uterine atony (when the uterus fails to contract after the birth, the placenta is partially or completely retained or there is a rupture) is the most common cause of postpartum haemorrage, and its primary treatment is uterine massage to help constrict the uterus and expel any blood clots or placental remains. Uterotonic agents (drugs that help the uterus to contract) will be required if bleeding continues.[37,38] If the bleeding continues, the help of a skilled professional might be the only thing that could save the woman's life. Lacerations, tears and the deadlier

[34] World Health Organization Regional Office for Europe (2015). *Maternal and Newborn Health Data and Statistics.*
[35] MacDorman, M. F., Declercq, E., Cabral, H., & Morton, C. (2016). *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues*.
[36] J Thromb Haemost (2011). *Obstetric haemorrhage*.
[37] Lancet (2001). *WHO multicentre randomised trial of misoprostol in the management of the third stage of labour.*
[38] Snelgrove J. W. (2009). *Postpartum haemorrhage in the developing world a review of clinical management strategies.* Medical sciences by students, 12(2), 61.

uterine rupture (when the uterine wall tears open) should be sutured or packed. If the bleeding continues, a hysterectomy (the removal of the uterus) will be the only option left.

*Hypertensive disorders*

16% of maternal mortality is owed to hypertensive disorders during pregnancy. Severe preeclampsia and eclampsia are the deadliest forms, leading to stroke, lung, kidney and liver damage and eventually death.[39] Preeclampsia encompasses hypertension and proteinuria (excessive amount of protein in the urine, which indicates a kidney malfunction) and when convulsions or coma occur it becomes eclampsia. It usually occurs after 20 weeks of gestation, and the only remedy is to induce labour or perform a c-section. In rare cases, however, it develops in the postpartum period.

The WHO recommends routine screening for preeclampsia based on measurement of blood pressure and testing of urine for proteinuria (and also for bacteriuria in the case of infections) in all pregnant women.[40]

*Infections*

Infections account for 10% of all maternal deaths, making it the third cause of maternal mortality in the world.[41] The fearsome "puerperal fever" of centuries past is what we now classify as maternal sepsis: a life-threatening condition defined as organ dysfunction resulting from infection during pregnancy, childbirth, post-abortion or postpartum period.[42]

Broad-spectrum antibiotics are usually the norm in developing countries, as there are no proper methods for bacterial culture and diagnosis of a specific pathogen, but this can lead to antimicrobial resistance. Instructing health professionals on the type of antibiotic regimens (what drug to take, when, and how often) would be the best way to comply with the *WHO Global Strategy for Containment of Antimicrobial Resistance*.[43] Prevention of malnutrition, anemia and overcrowding, and early recognition of signs and symptoms is also key to prevent infection and sepsis.

*Obstructed Labour*

Obstructed labour or dystocia occurs when the baby fails to make it out of the birth canal and is trapped inside despite strong uterine contractions. It is usually the result of a mismatch: the head of the baby is too big, the mother's pelvis too small.[44] This is known as cephalo-pelvic disproportion and could be one of the causes for higher maternal mortality among teenage girls, whose pelvis is smaller. Sub-Saharan Africa has the highest birth rate among adolescents, at around 101 births per 1000 adolescent women. Obstruction can sometimes be solved by

[39] Fokom-Domgue J, Noubiap JJ. *Diagnosis of hypertensive disorders of pregnancy in sub-Saharan Africa: a poorly assessed but increasingly important issue*.
[40] World Health Organization, UNICEF (2003). *Antenatal care in developing countries. Promises, achievements and missed opportunities: an analysis of trends, levels and differentials*.
[41] World Health Organization (2015). *Recommendations for prevention and treatment of maternal peripartum infections.*
[42] World Health Organization (2017). *Statement on maternal sepsis.*
[43] World Health Organization (2001). *Global Strategy for Containment of Antimicrobial Resistance.*
[44] World Health Organization (2003). *Global burden of obstructed labour in the year 2000*.

manipulation or instrumental delivery (with forceps or vacuum-extractor), but more often than not, a c-section will be needed.[45]

*Unsafe abortions*

Around 25 million unsafe abortions are estimated to have taken place worldwide each year, almost all in developing countries. While Africa accounts for 29% of all unsafe abortions, it sees 62% of unsafe abortion-related deaths.[46] An unsafe abortion occurs when the termination of a pregnancy is performed by people lacking the necessary skills or in an environment that does not conform to minimum medical standards, or both.

*HIV, Malaria, Tuberculosis*

In Sub-Saharan Africa, 2% of all maternal deaths were estimated to be AIDS-related indirect maternal deaths. In 2015, there were five countries where 10% or more of maternal deaths are estimated to be AIDS-related indirect maternal deaths: South Africa (32%), Swaziland (19%), Botswana (18%), Lesotho (13%) and Mozambique (11%).[47] Better testing, care, and access to antiretroviral treatment will reduce these numbers.[48]

Pregnant women infected with malaria are at a higher risk for severe anemia and maternal death.[49] Malaria can be prevented (and should be treated as a part of antenatal care) and treated with appropriate drugs, bed nets for mosquitoes treated with insecticide, and effective diagnosis and educational outreach programs.[50]

Tuberculosis has a major impact on maternal health in areas where it is endemic, such as Sub-Saharan Africa,[51] with HIV-infected mothers being particularly vulnerable (co-infection is exceedingly common and increases the risk of maternal mortality by almost 300%).[52] This could be prevented with the appropriate prophylactic drugs.

## Conclusion

The UN has set the goal of reducing the global maternal mortality ratio to less than 70 per 100,000 live births by 2030 (Sustainable Development Goal 3.1), and while this goal is still far, great advances are being made. Since 2000, the maternal mortality ratio in Sub-Saharan Africa has been reduced by 35% and it continues to fall. However, a global decline of three times the current annual rate (2.3%) is needed.[53]

The real killers of pregnant women are poverty, inadequate, inaccessible or unaffordable healthcare, illiteracy when it comes to sexual and reproductive education and lack of family

[45] World Health Organization (2008). Managing prolonged and obstructed labour.
[46] World Health Organization (2014). *Fact Sheet: Preventing Unsafe Abortion.*
[47] Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division (2015). *Trends in maternal mortality: 1990 to 2015.*
[48] Kendall, T., Danel, I., Cooper, D., et al. (2014). *Eliminating preventable HIV-related maternal mortality in sub-Saharan Africa: what do we need to know?*
[49] Schantz-Dunn, J., & Nour, N. M. (2009). *Malaria and pregnancy: a global health perspective*.
[50] World Health Organization (2017). *Malaria in pregnant women*.
[51] Marais B. J. (2011). *Impact of tuberculosis on maternal and child health.*
[52] World Health Organization (2015). *Tuberculosis in Women*.
[53] United Nations (2015). *Sustainable Development Goal 3.*

planning. The WHO needs to address the socio-economic aspects of the region and provide better healthcare access, comprising antenatal care and skilled birth attendance, access to family planning methods such as contraceptives (high fertility is linked to high maternal mortality), and better preventive strategies.

Questions an Outcome Document Should Answer

1. What cost-effective strategies could improve maternal health in Sub-Saharan Africa?
2. How can access to healthcare for pregnant women be achieved, especially for those living in rural areas?
3. How can the main causes of maternal mortality be prevented in the region, considering the challenges present (i.e. lack of resources)?
4. How can the WHO address the underlying socio-economic factors (poverty, illiteracy, cultural practices)?
5. Is SDG 3.1 a realistic goal considering the state of Sub-Saharan Africa?

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# Topic II: Mental Health in the Conflict Zones of the Middle East

## Introduction

80% of the population in the 22 countries of the Mediterranean WHO Region are in a conflict situation or have lived through such a situation in the last 50 years.[54] Psychiatric literature shows that conflict situations dramatically increase the prevalence of mental disease (the numbers depend on the severity of the conflict).[55] Especially in the Middle East, many people have been exposed to traumatic events and endured physical and psychological violence during on-going and past conflicts and wars. This puts them at high risk of developing mental disorders. In fact, there has been a sharp increase of mental health conditions such as post-traumatic stress disorder (PTSD), depression, anxiety, bipolar disorder, childhood behavioural problems and schizophrenia. Among these, depression and PTSD were the most common conditions. These mental disorders often end in violent acts against others or suicide, which are much more widespread in the Middle East than in any other region of the world.[56]

Mental health care in the Middle East is insufficient. The human resources and attention given to mental health issues is lower than the global average and mental health services countries are below accepted standards.[57] Without a proper mental health care system, meeting the mental health needs of people who have suffered due to war and violence is unlikely. In addition to that, regional statistics on mental health are likely not showing the whole picture. Various cultural and religious barriers, societal stigma and legal punishments create an environment that prevents victims, their families or governments from disclosing such information.[58] Accordingly, there is a lack of data that can serve as basis of Public Health policy interventions by the WHO. War compounds these problems, making it harder to obtain treatment. Moreover, the conflict zones are highly dangerous for foreign healthcare personnel. If the safety of the health workforce cannot be guaranteed, there will be a massive lack of both domestic and foreign healthcare personnel for labour-intensive mental health care.

Discussion of armed conflict is often centralised around the physical brutalities of war because death and physical disease are tangible ways to measure the effects of long-lasting conflicts in a way that mental health is not. As the impacts war has on mental health is less brazen and more abstract, it is often overlooked. However, mental health of the adult population is a potential obstacle for sustained peace in post-conflict societies. Through joint efforts, the WHO can make a significant improvement in the mental health of the general population and thus avert the figurative loss of the next generations due to the consequences of war and violence.

## Historical Background

The Middle East is the cradle of the three great religions and multiple civilizations, but its people have had to endure wars, upheavals and calamities for the past centuries. In order to gain an

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[54] Murthy, R. S., & Lakshminarayana, R. (2006). *Mental health consequences of war: a brief review of research findings.*
[55] Hoge CW, Castro CA, Messer SC et al (2004). *Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care.*
[56] Institute for Health Metrics and Evaluation (2017). *Mental illness, suicide, and 'intractable violence' creating 'lost generation' in Middle East*.
[57] Sewilam et al. (2015). *Roadmap to reduce the stigma of mental illness in the Middle East*.

understanding of the origins of the current burden of mental disease due to violence, it is necessary to adopt a historical perspective.

Mental health has a rich and complex history in the Islamic World. Ancient texts from the Pharaonic times describe mental disorders and how they were embedded and dealt with by ancient societies. Back then, mystical culture predominated. Healing for mental disorders was treated by mostly spiritual means, such as visiting temples, praying and advice from religious deities. In the early Islamic era, mentally ill people were not isolated, due to Muslim beliefs that they could be possessed by a good Muslim genie.[59] Starting with the Islamic Renaissance, the perception of mental disorders changed. Islamic scientists classified mental disorders, such as schizophrenia, depression, suicide and anxiety, and they were treated as a result.

After the Mongol invasions and the decline of the Islamic world, most achievements in mental health vanished. During this time, there was no meaningful mental healthcare system in the Middle East. Superstition and fatalistic attitudes replaced the scientific approach of the Islamic scientists. Isolating and chaining patients became more common. Back then, medical explanations of madness did not encourage compassion or tolerance. Instead, they implied that this impaired mental state was self-inflicted through an excess of piety. Mental illness was seen as a punishment from God, the result of the possession by evil spirits or the effects of evil objects that are transferred into the individual.[60] The era between the 17th and 19th centuries was a time of unprecedented ignorance and stigmatization of the mentally ill.

Modern medicine entered the Middle East and North Africa (MENA) region in the 19th Century. A few progressive leaders of the Middle East encouraged the introduction of modern medical science and practices through knowledge exchange with Western countries. A more humane and understanding way of dealing with mental illness emerged. However, superstition and stigmatization are still widespread in many societies. Modern psychiatric hospitals were modelled after European hospitals, yet most of them do not offer sufficient psychiatric care.[61] Although improvements in mental health care have been made in the Middle East in the past decade, the services for the population are still below globally accepted standards in many countries.[62]

Nowadays, there is a conflict between the ancient religious teachings as well as cultural norms and the modern approach to mental health. The dominant Islamic culture is a key element of solving mental health issues before and after crises. Thus, Islam can be both a hindrance and a guide to the practice of mental health in the Middle East.

## Recent developments

Over the past decades, a growing sense for mental health as a global issue has led to substantial WHO action on mental health. The WHO recognized that there is a lack of mental health care in developing countries (especially in the Middle East). Their mission has been to reduce the burden of disease associated with mental disorders, through the training of primary health workers for the recognition and management of mentally ill people and establishing mental health programs.[63] Civil society, government leaders, and UN representatives have made substantial progress to elevate the importance of mental health to the level of international law. The UN General Assembly adopted the *Declarations on the Rights of Mentally Retarded Persons*

[59] Mohit (2001). *Mental Health and Psychiatry in the Middle East: historical development.*
[60] Pridmore, Iqbal (2004). *Psychiatry and Islam.*
[61] Mohit (2001). *Mental Health and Psychiatry in the Middle East: historical development.*
[62] Sewilam et al. (2015). *Roadmap to reduce the stigma of mental illness in the Middle East.*
[63] Harding et al. (1983). *The WHO collaborative study on strategies for extending mental health care, II: The development of new research methods.*

(1971) and the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (1991).

The WHO has also played an important role in raising awareness. Especially the 2003 *Report on the Social Determinants of Health,* which highlighted the multisectorial social factors (lifestyle, environmental factors, impact of policies) that play into health and in particular mental health.[64] This is of particular relevance for the Middle East, because mental health issues there are largely caused by social factors, such as war, violence and displacement.

In 2008, the WHO published the *Mental Health Gap Action Program (mhGAP)*, which showed the discrepancy of services needed and available services, especially in developing countries. It was followed by the *mhGAP-Intervention guide*, which provides a framework for the treatment of mentally ill people.[65] This guide offers potential solutions on how to address the current mental health situation in the Middle East.

The WHO has also developed a Quality Rights Tool Kit. It provides mainly low- and middle-income countries with information and tools for assessing and improving human rights and quality standards in mental health care facilities. Additionally, due to its flexible design, the tool kit can be used by many different stakeholders. It could play an essential role in mental health care efforts in conflict zones, because it enables actors other than medical personnel to improve mental health care.[66]

The most important action on mental health to date is the *Comprehensive Mental Health Action plan 2013–2020*. It was adopted by the 66th World Health Assembly (May 2013) and calls for the end of stigma against and discrimination of mentally ill people and advocates for an expansion of services in order to promote greater efficiency in the use of resources for mental health.[67] The framework provided in this action plan can be adapted to the mental health needs in the Middle East.

In 2015, UN representatives established the 2005 *Sustainable Development Goals (SDGs)*. The importance of mental health is clearly stated in target 3.4. The UN commits to *"promote mental health and well- being".*[68] This also includes the mental health of people who have encountered war and violence.

During the past years, many books and documents by UN entities have addressed the relationship between the effects of violent conflict and mental health. Among the most notable is the World Bank report *Mental health and conflict –state of the world's children – Childhood under threat*. The UN itself has also published a book titled *Trauma interventions in war and peace: prevention, practice and policy*. The World Psychiatric Association provides a scientific basis for all these documents with their book *Disasters and Mental Health*.[69] Unfortunately, not a lot of action has followed these documents, books and reports. However, they are a valuable source that can be utilized when coming up with solutions for the mental health crisis in the Middle East.

### *Pattern of Health Seeking Behaviour*

[64] Wilkinson & Marmot (2003). *Social Determinants of Health: The Solid Facts.*
[65] WHO (2008). *Mental Health Gap Action Programme (mhGAP).*
[66] WHO (2012). *WHO QualityRights Tool Kit.*
[67] WHO (2013). *Mental health action plan 2013–2020.*
[68] Okpaku & Biswas (2014). *History of Global Mental Health.*
[69] Murthy et al. (2006). *Mental health consequences of war: a brief review of research.*

Most mentally ill people in the Middle East don't seek modern psychiatric treatment right away. Most patients see a general practitioner first, hoping to find biological evidence for their mental illness. This can be attributed to two factors: the lack of mental health care facilities and the stigma associated with having a mental disease.

Many patients also seek non-professional care. Traditional (faith) healers still play an important role in most health systems in the Middle East, due to a "spiritual connection to Islam" and earlier medical traditions from the region. Moreover, they offer a less expensive alternative to modern medicine, especially in rural areas.[70] Most Middle Eastern countries have not implemented universal health care yet, which makes mental health care very expensive for the individual. Cooperation could help, since traditional healers could encourage patients to seek help from health specialists, but this is not the case presently.[71]

### *Mental Health Care Systems and Financing*

A vast gap exists between the need for treatment and the services available in the Middle East. Mental health services are widely underfunded, especially in the poorest Middle Eastern countries. Only three countries have separate accounts of budget allocated to mental health (Qatar, Egypt and Palestine) and they amount to 1-2,5% of their total health budgets. Thus, there is a significant discrepancy between the burden of mental disorders and the resources dedicated to mental health services.[72]

In general, mental hospital systems have been less comprehensive in their coverage of populations than in developed countries. Some countries have been able to upgrade basic psychiatric hospital services and establish new psychiatric units in district general hospitals or to integrate basic mental health services with general health care by training primary care workers. A shortage of mental health care facilities could be substituted by community-based systems (instead of hospitalization in psychiatric institutions).[73] The WHO needs to find policies that address the burden of mental disease in the Middle East, with special attention regarding the shortage of both community-based care and hospital-based care.

### *Mental Health Services in Situations of Conflict*

The deterioration of social services and infrastructure in places of conflict is a common consequence of violence and political instability. One such service is mental health service, which gets even more inaccessible for those in need as a country descends into war.

Alongside this, exposure to war exacerbates the negative consequences of mental disorders such as depression and anxiety,[74] with evidence showing 15-20% of crisis-affected populations will develop these issues, with numerous more developing PTSD.[75] Simply put, conflict zones present the greatest need for mental health services, yet are the least equipped to provide them. The assistance of global institutions that have the capacity to help (e.g. WHO, the World Psychiatric Association) is needed.

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[70] Okasha et al. (2012). *Mental Health Services in the Arab World.*
[71] Sewilam et al. (2014). *Roadmap to reduce the stigma of mental illness in the Middle East.*
[72] Okasha et al. (2012). *Mental Health Services in the Arab World.*
[73] Shen et al. (2014). *Institutionalization and Deinstitutionalization: a cross-national analysis of mental health systems reform.*
[74] Hoge et al. (2004). *Combat Duty in Iraw and Afghanistan, Mental Health Problems.*
[75] World Bank (2016). *Mental health services in situations of conflict, fragility and violence.*

In the Middle East, the long-lasting effects of the Arab Spring have had a detrimental effect on services across the countries affected.[76] When it is recognised that a multi-pronged, multifaceted approach can help in all capacities, the task of creating a solution to mental health problems in the area becomes easier. In Syria, for example, the ongoing conflict has affected the provision of basic needs such as food, water and sanitation. As mental health is directly affected by these conditions, improving these services is a vital part of developing long-lasting and effective solutions to mental health problems.[77]

A multifaceted approach to designing mental health programmes in conflict-affected areas has to cover all bases. Programmes must incorporate preventative measures, alongside case finding and direct treatment of those affected. Monitoring the symptoms of those affected must also be at the forefront, as following-up on the effects of such programmes will show continued success in post-conflict areas.[78]

### *Mental Health of Children in Conflict Zones*

Up to one third of people exposed to traumatic war experiences exhibits signs of mental disorders in the aftermath of the conflict. For children, these disorders can be especially damaging.[79] A child's cognitive development is extremely important for their future growth, often determining general life satisfaction in the future. When this development is inhibited by the effects of war, children often see their school performance, peer relations and even physical health suffer.[80] In many post-war communities, the lasting effects left by violence and trauma can have negative consequences on families for generations to come. For example, mental health symptoms such as outbursts of anger in parents may contribute to higher levels of child abuse Similarly, the irritability and internalization of problems that are associated with the mental health effects of war can make a child more challenging for parents. All of these factors can lead to parents resorting to more violent parenting strategies.[81]

Understanding this risk allows healthcare professionals to design a protection strategy for exposed children, which is of utmost importance for breaking this cycle.[82] The importance to act is highlighted by a 2002 resolution of the World Health Assembly, which urged member states "to strengthen action to protect children from and in armed conflict".[83]

### *Stigmatisation*

The mental health problem in the Middle East is exacerbated by the widespread stigma attached to mental health, which is often still considered as a sign of weakness and personal failure.[84] Even though war and violence are mostly responsible for their trauma, individuals are blamed and considered to be responsible for their illness. These beliefs are deeply rooted in religion and culture. According to various scholars, Islam views mental illness as a result from an unbalanced lifestyle, lack of spiritual activities or a lack of remembrance of God. Cultural beliefs, such as

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[76] Amawi et al. (2014). *Overview of research on the mental health impact of violence in the Middle East in light of the Arab Spring.*
[77] WHO (2017). *Addressing the silent impact of War: WHO expands mental health care services around Syria.*
[78] World Bank (2016). *Mental health services in situations of conflict, fragility and violence.*
[79] Steel et al. (2009). *Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement.*
[80] Catani (2018). *Mental health of children living in war zones: a risk and protection perspective.*
[81] Sriskandarajah (2015). *Predictors of violence against children in Tamil families in northern Sri Lanka.*
[82] Catani (2018). *Mental health of children living in war zones: a risk and protection perspective.*
[83] World Health Assembly (2012). *WHA55.10 Mental health: responding to the call for action.*
[84] Sewilam et al. (2015). *Roadmap to reduce the stigma of mental illness in the Middle East.*

demonic possession, sorcery, evil eye and other negative beliefs create fear and social distance from the mentally ill.[85]

Stigmatization leads to isolation, status loss and negative discrimination of the mentally ill and disrupts social relationships, devalues families with mentally ill individuals and prevents people from obtaining employment. Even people who receive treatment experience stigma due to their condition. This creates a fear of stigmatization that prevents many affected individuals in the Middle East from seeking treatment.[86] Empowerment, advocacy and increased awareness are important tools to address the issue of stigmatization. Increasing awareness about the nature of mental illnesses seems to be one of the main solutions for stigma. Families must be educated so that they offer the support needed to overcome shame and to seek treatment. In general, increased knowledge is associated with lower social distance between mentally ill people and other individuals.[87]

## Questions a resolution should answer

1. How can PSTD, anxiety disorders and depression be treated most effectively in post-conflict or conflict areas of the Middle East?
2. Which strategies could reduce the stigma that comes with mental illness?
3. How can families be assisted when dealing with an affected family member?
4. How can the community be rebuilt in order to support individuals with a mental health issue?
5. What is the best way to expand existing health services to cover mental illness?
6. Can media be used in any way to promote help-seeking and acceptance?

[85] Okasha et al. (2012). *Mental Health Services in the Arab World.*
[86] Pocock, L. (2017). *Mental Health Issues in the Middle East – An Overview.*
[87] Sewilam et al. (2015). *Roadmap to reduce the stigma of mental illness in the Middle East.*

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## Further readings

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# Sample Outcome Document

SEVENTY-FIRST WORLD HEALTH ASSEMBLY WHA71.16

Agenda item 12.9 26 May 2018

## Poliomyelitis – containment of polioviruses

The Seventy-first World Health Assembly,

Having considered the report on eradication of poliomyelitis;[1]

Recalling resolution WHA65.5 (2012) on poliomyelitis: intensification of the global eradication initiative and WHA68.3 (2015) on poliomyelitis, and in which the Health Assembly urged all Member States inter alia to implement appropriate containment of all polioviruses starting with the serotype 2;

Noting the eradication of wild poliovirus type 2 globally, declared by the Global Commission for the Certification of the eradication of poliomyelitis in September 2015;

Acknowledging the continued progress in eradicating poliovirus types 1 and 3;

Recognizing the successful globally synchronized switch in April 2016 from the use of trivalent to bivalent oral polio vaccine, active only against poliovirus types 1 and 3;

Noting the development of the Polio Eradication and Endgame Strategic Plan 2013–2018, including objective 3 – containment and certification, considered by the Sixty-sixth World Health Assembly;[2]

Commending the work of WHO and the Global Commission for the Certification of the eradication of poliomyelitis in promoting the containment of all polioviruses, starting with type 2, the first serotype being eradicated;

Noting with alarm delays in implementation and certification of poliovirus containment for type 2 polioviruses planned for 2016, as well as the accidental release of wild poliovirus type 2 from a vaccine-production facility in 2017;

Underscoring the urgent need to accelerate globally activities to implement and certify containment of polioviruses;

Underlining that successful containment of all polioviruses will ensure the long-term sustainability of the eradication of poliomyelitis,

[1] Document A71/26.

[2] Document WHA66/2013/REC/3, summary records of the ninth meeting of Committee A, section 1.

A UN resolution can be divided into two parts:

-Preambulatory clauses: they start with a verb in gerund (–ing) and end in a comma (,). They highlight the importance of the issue and past actions that have been taken. They name past UN resolutions and strategies.

-Operative clauses: they start with a verb in present tense (urges, requests, supports…) and end in a semicolon (;). They say what you actually want to do to tackle the issue.



1. URGES all Member States:[1]

(1) to fully implement all strategic approaches outlined in the Polio Eradication and Endgame Strategic Plan 2013–2018;

(2) to intensify efforts to accelerate the progress of poliovirus containment certification as outlined in national requirements[2] as well as in the WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use (GAPIII);[3]

(3) to complete inventories for type 2 polioviruses, destroy unneeded type 2 materials and to begin inventories and destruction of unneeded type 1 and 3 materials in accordance with the latest available published WHO guidance;

(4) to ensure that any confirmed event associated with a breach in poliovirus containment is immediately reported to the National IHR Focal Point;

2. URGES all Member States retaining polioviruses:

(1) to reduce to a minimum the number of facilities designated for the retention of polioviruses, prioritizing facilities performing critical national or international functions;

(2) to appoint, as soon as possible and no later than the end of 2018, a competent National Authority for Containment[4] that will process containment certification applications submitted by the facilities designated to store and/or handle poliovirus post-eradication and communicate its contact details to WHO by 31 March 2019;

(3) to make available to the National Authority for Containment all necessary resources, including technical, personnel and financial, required for the full and successful certification of implementation of appropriate poliovirus containment measures;

(4) to request facilities designated to retain poliovirus type 2 to formally engage in the Containment Certification Scheme[5] by submitting to their National Authorities for Containment their applications for participation, which is the first step of the global certification process, as soon as possible and no later than 31 December 2019;[4]



(5) to initiate steps for the containment for wild type 1 and 3 materials so that, by the time of global certification of eradication, all facilities retaining poliovirus meet containment requirements;

(6) to prepare a national response framework for use in the event of a breach of poliovirus containment and risk of community exposure and to conduct a polio-outbreak simulation exercise that covers the risk of poliovirus release from a facility;

3. REQUESTS the Director-General:

(1) to provide technical support to Member States in their efforts to implement poliovirus containment safeguards and certify that facilities retaining poliovirus meet the requirements outlined in the WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use (GAPIII);

(2) to facilitate the harmonization of certification mechanisms for the long-term sustainability of the implementation of poliovirus containment in the post-eradication era;

(3) to update all WHO's recommendations and guidance on poliovirus containment, as and when needed;

(4) to report regularly to the Executive Board and the Health Assembly on progress and on the status of global poliovirus containment, aligned with other polio reporting requirements.

Seventh plenary meeting, 26 May 2018
A71/VR/7