THE 2005 NATIONAL MODEL UNITED NATIONS

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Dear Delegates,

Welcome to the 2005 National Model United Nations (NMUN) Conference! My name is Jennifer Taylor and I will be serving as your Director of the World Health Organization (WHO). I am pleased to invite you all to our forum on global public health issues, an important Committee that promises to be very exciting. Please read the Committee History very carefully for full details on the running of this report writing Committee.

This is my fifth year affiliated with the NMUN Conference, and I am pleased to welcome you all. I live in Washington, D.C., and work for Chemonics International a government international development contractor. I have an MA from Yale University in international relations, and completed my undergraduate work at the University of North Carolina at Greensboro in music and international studies. Erik Fallis is our Assistant Director, a senior at California State University, San Bernardino, studying political science and economics. He will have the opportunity in further introduce himself during the update process. I would also like to note the hard work of Oliver Bladik who contributed greatly to the writing of the background guide.

Global health issues are the cornerstone to all other international concerns. Without sound health, education programs fail, security programs fail, and development fails. Therefore, the work of this body is very important for the well-being of the international community.

For the 2005 Session, the WHO will discuss the following topics:

1. Economies of Scale: The Problems of Polio Eradication
2. The Role of Generic Pharmaceuticals in Society
3. Resource Allocation for HIV/AIDS: Prevention Versus Treatment

As delegates to this Committee, you are responsible for reaching beyond the information provided here in this background guide on these topics. You will need to be well informed of the position you are representing, as we will be drafting a report on substantive solutions to the topics above. More details about report writing will be provided at the Conference, but delegates should anticipate a more narrative format than resolutions. For further information on report writing please see your Delegate Preparation Manual.

It is your responsibility to research the diverse interests of the State or NGO you represent. Those delegates representing NGOs will be considered a close link to the grassroots of these issues and should have a broad spectrum of knowledge regarding the topics.

Each delegation is required to submit a position paper. Similar to last year, NMUN is accepting papers via e-mail. All papers are due by **February 25, 2005**. An important message from the Director-General regarding where papers should be submitted, expectations for their content and format, and inquiring about alternatives to e-mail submission is included on **page nine** of this guide. It is vital that all delegates adhere closely to these instructions.

Good luck to you over the next few months of preparation. If Erik or I can help you or provide some insight or advice in anyway, please feel free to contact either one of us using the information provided below. You may also find the NMUN Web site, www.nmun.org, helpful as well. I look forward to meeting you at the Hilton in March!

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What to Expect at the Simulation

Opening session: After a brief introduction of the dais and some announcements, delegates will discuss the order in which the committee will address agenda topics while in formal and caucus sessions. The committee will then vote on a motion from the floor to set the agenda in a proposed order, and will continue to vote on such motions until one passes by a majority vote. If the committee fails to reach agreement on the agenda order by the conclusion of the first evening, the Director and Assistant Director reserve the right to set the agenda. After the agenda has been set, the chair will entertain motions for the opening of the speakers' list to address the first agenda topic.

Rules of procedure: The simulation is conducted through the use of the committee rules of procedure, which are included in this background guide. It is extremely important to develop a thorough working knowledge of the Rules, including when they should be introduced, and in what capacity. The rules of procedure are enforced to facilitate the efficient workings of the committee, not to hinder them. Therefore, the Director, Assistant Director and chair (with the approval of the Director), reserve the right to rule motions out of order which may be considered dilatory or disruptive to the committee. In this respect, one of the quickest ways for a delegate to alienate him/herself within a committee is to be labeled a "rules hound," or someone who attempts to disrupt committee proceedings with the introduction of redundant, inappropriate or time-consuming motions.

Decorum: Decorum is a *de facto* rule throughout the week of the simulation. In both large and small committees, the ability to conduct normal business while in formal session is an arduous task when decorum is not maintained; delegates will be asked for their assistance in this endeavor.

Caucusing: Caucusing is an important and logistically difficult component of the United Nations simulation. These informal meetings between voting blocs, as well as between States with positions that are diametrically opposed, often produce compromises acceptable to all parties. However, delegates are required to address issues within a week's time which, in many cases, the international community has failed resolve after years of debate and negotiation. Further, delegates to the NMUN do not have individual offices in which to convene informal meetings. As a result, the bulk of informal negotiation and the construction of working papers will occur within, or in the close proximity of, the committee chambers. In consideration for the other 3,100 Conference participants, delegates are asked to respect the formal proceedings occurring both within and between all committees participating at the Conference. Finally, given the importance of decorum within committee chambers, all caucusing should occur outside of the committee chambers while committee is in session.

Chairs and Rapporteurs: Delegates should also take note that the Director and Assistant Director (with the approval of the Director-General) will select a committee chair and rapporteur (committee administrative assistant) following the conclusion of interviews on the first evening of the Conference. For those interested in the opportunity to serve the committee as a chairperson or rapporteur, an application is available online at *www.nmun.org*. The application should be completed and submitted to the Director no later than the opening night of the Conference. The successful candidate for chair will demonstrate an excellent working-knowledge of the rules of procedure through a series of situations presented to her or him and exhibit qualities of leadership, patience and humility. The rapporteur will assist the chair, the Director and the Assistant Director with the abundance of paperwork and record keeping required in the efficient workings of the committee, as well as provide logistical support for the chair while in voting procedures.

Delegates selected to serve in these positions must forfeit their rights to participate in substantive debate within the committee. However, a co-delegate or substitute from another committee could still represent that country/NGO on the committee. Although the chair and rapporteur continue to serve as representatives of their assigned State, their primary duty is to assist the Director and Assistant Director in facilitating the professional operation of the committee. Additionally, delegates selected as committee chairs and rapporteurs do retain an equal eligibility for awards consideration. All delegates are encouraged to apply for these challenging and rewarding positions.

Attire: In keeping with the spirit of the simulation, delegates are ***required*** to wear professional business attire. Further, national symbols of any kind are forbidden in committee chambers, in accordance with practices of the UN. The complete dress code is available on line and in the conference program.

Your Role as a Delegate

The most important aspect of participating as a delegate to the NMUN is your assumption of the role of a foreign diplomat. In this role, you are acting as a representative of the government and the peoples of the Member State or NGO to which you have been assigned. While in preparation for and throughout the duration of the Conference, you may find personal disagreement with the foreign policy of the country you are representing or with the policy of the NGO you are representing. Your personal opinions are entirely inapplicable during the course of the simulation. Therefore, it is of the utmost importance for all delegates to arrive well-versed in the dynamics of their State's foreign policy or in that of their NGO, and anticipate possible obstacles their State or NGO may encounter during the simulation. The simulation's quality depends on the collective preparation of its participants.

As a delegate, you should be able to demonstrate thorough knowledge of your assigned country's policies, specific issues to be discussed, and the procedures, activities, and history of your committee. Delegates should also exhibit the ability to negotiate and compromise, demonstrate leadership, and the ability to influence by gaining the professional respect of fellow delegates. States and NGOs maintain specific and adaptive foreign policy methods and goals to allow delegates to function in the negotiation process. As a representative of the NGO or State to which you have been assigned, you will be expected to work within the historical confines of your NGO or country's foreign policy at the UN. Even though many Member States and Observer States do not assume strong leadership roles in the UN, the reality of the NMUN is that each delegation will be judged on its ability to provide leadership to other delegates throughout the Conference.

Delegates are reminded that professional diplomats conduct themselves, and regard one another, with the utmost dignity and respect, regardless of foreign policy affiliation or personal feelings. Even States and NGOs who observe severely conflicting ideological perspectives will work closely together, within the UN, on diplomatic matters of mutual concern. Likewise many delegates are forced to work together despite personal conflicts.

The Preparation and Introduction of Resolutions and Reports

Resolutions and reports adopted within respective committees represent Member States' decisions and recommended courses of action with respect to the topics under discussion. Clauses within the preamble of resolutions should provide a brief outline of historical and current perspectives and endeavors regarding the issues to be addressed within the operative clauses of the document. The operative clauses of resolutions provide the objectives and potential actions that Members designed to address the issues outlined within the preamble. More simply, the preamble states the problems before the committee in relation to the topic under deliberation and operative clauses outline the decisions of the committee for the solution of these problems.

Although delegates are encouraged to develop resolution and report writing skills, both in classroom scenarios and at regional MUN simulations, the NMUN will not accept any pre-written resolutions or reports, and which have not been developed by a plurality of the committee. This determination is at the sole discretion of the Secretariat. In addition, *any delegates found to be submitting plagiarized material within resolutions will be subject to dismissal from further participation within the Conference*. Although UN documents are within the public domain, the verbatim exploitation of these documents *will not be permitted* at the Conference.

Resolutions and reports are developed in three stages. In the initial stage, a resolution or report is referred to as a working paper and is generally developed by States or experts that share common perspectives on the issues to be addressed. The working paper is shared with other delegates in the committee for their input and support. Once the working paper gathers the required signatories, it is to be submitted to the Committee Director for approval. On the approval of the Director, the working paper will be copied by Delegate Resources and introduced by the chair to the committee as a draft resolution or report.

Once the working paper has been introduced as a draft resolution or report, it becomes the property of the committee and all references to sponsorship, with the exception of identifying the status of amendments while in voting procedure, are formally removed. The central contributors to the contents of the draft resolution or report will continue to enlist the advice and support of as many States or experts as possible to expand upon the substance of the draft and, thereby, gain as much input and support as possible prior to the closure of debate. Once the committee

moves to closure, all draft resolutions and reports will be voted upon and when adopted will thereafter be recognized as formal resolutions or reports.

Adopted resolutions and reports represent recommendations for States and the international community. The legal status of each document depends on which committee the resolution or report is coming from. For instance, the General Assembly's resolutions are not legally binding political treaties, but the decisions of the Security Council are binding on all Member States. Most countries avoid the embarrassing political position of failing to promote and implement the recommendations they publicly endorsed within the UN.

It is highly recommended that delegates introduce their ideas to the committee in the form of working papers as soon as possible in order to contribute to the potential development and adoption of resolutions and reports which characterize the united representative strength and will of regional blocs or, ultimately, the committee as a whole. Typically, a number of working papers before any committee will overlap in content, style, and substance. In this event, the Director will request delegates to integrate their individual endeavors into a single and, thus, more comprehensive and internationally representative document.

The Executive Bureau, the General Committee and Saturday Plenary Sessions

By the conclusion of Wednesday night sessions, the Economic and Social Council Plenary will select four vice-presidents to assist the president (chair) as members of the Council Executive Bureau. Likewise the General Assembly will select 21 of its Members to the General Committee by Wednesday evening. The members of the Bureau and the General Committee are to be selected with regard for equitable geographic representation from: African States, Asian and Pacific States, Eastern European States, Latin American States and Western European and other States. The Bureau will meet on Friday evening, following the conclusion of regular sessions. The General Committee will be composed somewhat differently than the Bureau. It will be comprised of each committee chair from the General Assembly department. They will also meet at the end of regular sessions on Friday evening.

On Friday the Bureau and General Committee will be briefed by a representative from each relevant committee regarding the work accomplished by their body throughout the week. After reviewing the reports and resolutions submitted by the committee representatives, the Bureau and General Committee will set the agenda for Saturday sessions to deliberate upon each committee's recommendations to the Plenary.

ECOSOC Executive Bureau: The Saturday ECOSOC Plenary Session will deliberate upon the work of all the committees within the ECOSOC Department, as well as other relevant bodies, including most of the specialized agencies. During the Friday evening meeting, the Bureau will set an agenda order for the review of these reports for deliberation and potential adoption during Saturday sessions. Additionally, the Saturday session of ECOSOC Plenary will be deliberating upon a fourth topic to be prepared and introduced by the Director and Assistant Director. This topic will be made available to delegates on Friday afternoon and will encompass a broad theme that relates, as much as is possible, to issues discussed by each of the committees within ECOSOC and the specialized agencies.

GA General Committee: On Saturday the General Assembly Plenary will deliberate upon the work submitted by each of the committees in the GA and Security Council department, as well as relevant inter-governmental organizations and other bodies. Following the conclusion of regular sessions on Friday, the General Committee will set the agenda order for the review of these reports and resolutions and for their potential adoption during Saturday sessions.

Saturday Sessions: On Saturday, the final day of the Conference, the ECOSOC Plenary, General Assembly Plenary, and Security Council will convene at United Nations Headquarters. Plenary deliberations will encompass the work of all Conference committees; and all delegates are advised to participate in the Saturday sessions in order to assist Plenary representatives with their broad scope of work. Minimally, Member State representatives to the Plenary should be briefed in regard to the work of the committees that report to their respective departments. Ideally, the representatives of the committee whose work is being considered will sit with Plenary representatives as expert advisors to the State. The agenda for Saturday sessions will be made available outside Delegate Resources by 11:00 p.m. on Friday.

The Role of Non-Governmental Organizations in the Simulation

Non-governmental organizations (NGOs) are recognized in Article 71 of the *UN Charter* as consultative bodies in relationship to ECOSOC. These organizations also maintain a close working relationship with almost all ECOSOC funds and programs, specialized agencies, General Assembly committees, and regional organizations. In this role, NGOs are an invaluable resource to the UN system because they provide information on political, economic, social, humanitarian, and cultural developments in all parts of the world. Their recommendations may address potential solutions to global problems, speak to specific country or regional needs, or call attention to an emerging crisis.

NGOs are a crucial link between policy-makers and the individuals directly affected by those policies. They represent civil society and its impact on the UN system. There are two primary advantages NGOs have over the UN in terms of information gathering and program implementation. First, NGOs are often locally based and have better knowledge of regional conditions, needs, and constraints. Second, NGOs may find it easier to gain the acceptance, trust and cooperation of the communities in which they work because they are more aware of the indigenous cultural climate than many intergovernmental organizations. If the UN attempted to gather independently all of the information available to NGOs, it would consume vast amounts of time and scarce financial resources that are better applied to actual programs.

The global summit process that characterizes much of the UN's work in the 1990s has brought new attention to NGOs. At the Earth Summit in Rio de Janeiro in 1992, participation in the NGO forum surpassed all previous records. Although they were not invited to formally participate in negotiations, the massive NGO presence indicated recognition of their importance by conference organizers. In 1993, at the World Conference on Human Rights in Vienna, the NGO forum took place in the same building as the official meetings. This increased access to the proceedings brought NGOs to a new level of integration in global summits. At later conferences, such as the Cairo Conference on Population and Development, the Copenhagen World Summit on Social Development, the Fourth World Conference on Women in Beijing, and Habitat II in Istanbul, NGO forums grew in numbers as well as in their abilities to contribute substantively. As the international community continues to review Conferences of the past ten years, it is apparent that the influence of NGOs will set a new precedent for the incorporation of civil society into UN activity at the global level.

NGOs at the National Model United Nations Conference

Over the past several years, the NMUN has integrated the presence of NGOs into committees at the conference. It is an ongoing project that improves the educational quality of the simulation and mirrors developments in the UN itself, where NGOs are gaining both visibility and respect as a resource for program design and implementation. A large number of delegates will take on the challenging task of representing NGO delegations this year.

NGO delegations maintain all of the privileges accorded to traditional country delegations, and are required to exhibit the same level of preparedness. NGO delegations are eligible for awards, based on the same criteria as country delegations, and may select head delegates to attend the Head Delegate Meetings each night. NGO representatives are also required to submit position papers reflecting the perspectives and priorities of their assigned NGO on the agenda topics at hand.

All delegates should take the role of NGOs very seriously. NGO representatives must be prepared to fully participate in all committee activities, including formal debate, caucusing and drafting working papers. In turn, Member State delegates must be prepared to engage NGO delegates in these activities. Mutual recognition and respect between NGO and country delegates is necessary to a successful conference experience.

NGO delegates maintain the following privileges in each committee to which they are assigned:

1. the right to make any procedural motion;
2. the right to vote on all procedural motions;
3. the right to speak before all assigned committees; and
4. the right to act as a signatory on working papers.

Please note that NGO delegates *do not* have substantive voting rights, and *may not* sponsor working papers.

In order to ensure a positive educational experience for all delegates, these rights and privileges may not exactly reflect those granted by ECOSOC. Any alterations made by the Director-General gave due consideration to existing realities and the need to provide a learning environment that encourages active participation.

Country delegates are fully expected to work with NGO delegates in the spirit of collaboration upon which the UN was founded. The exclusion of NGOs from committee work simply because they do not have substantive voting rights is both unrealistic and unprofessional. In almost all cases, actions denigrating the participation of NGOs will be considered extraordinarily out of character and be noted in awards consideration. NGOs are expert organizations in their respective fields that possess specialized knowledge of the subject matter at hand. The recommendations of NGO delegates maintain the same validity as those of Member States, and it is incumbent upon country delegates to ensure that those perspectives are recognized.

How to Prepare as an NGO Delegation

As an NGO delegation, your preparation should be structured in the same way as a typical country delegation. The most basic pieces of this process include fundamental knowledge of the organization and of the agenda topics. Based on your research, you will decide how your assigned NGO will approach each topic, and the recommendations you will make for potential solutions. This includes identifying blocs of countries and other NGOs that may share the same perspectives and priorities and collaborate with you in committee sessions.

NMUN Resources: In this background guide, each agenda topic contains a section specific to NGO action. This will provide you with basic information on the general role of NGOs in that topic area. These sections may not specifically address your assigned NGO, but will provide a broad discussion of relevant NGO activities. You should not hesitate to contact the main office of your assigned NGO during the course of your preparations. In addition, you should arrange a mission briefing with the UN Liaison Office in New York City of the NGO you are representing. If you need assistance in arranging this briefing, visit the NMUN Web site at *www.nmun.org* or contact Christine Richmond, Assistant Secretary-General for Internal Affairs at asg.internal@nmun.org.

Doing Research: Much of your research will likely rely on Internet resources. Because most NGOs do not have expansive budgets that allow for the widespread reproduction and dissemination of their written materials and reports, they choose to publish such documents on their Web sites. If you have difficulty obtaining materials from these electronic sources, please contact your Director, Assistant Director, departmental USG, or the Director-General for assistance. The UN Web site, as well as the sites for many of the specialized agencies, also contain valuable information about NGO activity. Finally, do not exclude traditional resources from your preparations. Newspapers, scholarly journals, and books will provide differing perspectives on your agenda topics, and may give interesting insight into the evolving role of NGOs.

Position Papers: NGO position papers should be constructed in the same fashion as traditional position papers. Each topic should be addressed briefly in a succinct policy statement representing the relevant views of your assigned NGO. You should also include recommendations for action to be taken by your committee. It will be judged using the same criteria as all country position papers, and is held to the same standard of timeliness.

The most critical part of a successful NGO delegate experience at the NMUN Conference is active participation in committee sessions. This includes utilizing the rules of procedure, speaking in formal debate and contributing during caucus sessions. Although you may not sponsor working papers or vote on draft resolutions, you have both the right and the obligation to participate in their composition and refinement. You may act as a signatory to any working paper on the floor of your committee if you wish to illustrate your support for continued development of the document. Getting involved in the simulation is the best way to enhance your own educational experience and that of your fellow delegates.

Sample Position Paper

The following position paper is designed to be a sample of the standard format that an NMUN position paper should follow. While delegates are encouraged to use the front and back of a single page in order to fully address all topics before the committee, please remember that only a maximum of one double-sided page (or two pages total in an electronic file) will be accepted. Only the first double-sided page of any submissions (or two pages of an electronic file) will be considered for awards. Visit the downloads section at *www.nmun.org* to find an example of an award-winning position paper. This paper was also included in the 2002-2003 National Collegiate Conference Association's Annual Report. When using these sources, please be mindful of the NMUN's policy against plagiarism.

Delegation from
The State of Tranquility

Represented by the
University of Bohemia

Position Paper for the General Assembly Plenary

The issues before the General Assembly Plenary are: The Situation in Sub-Saharan Africa; Racism and Racial Discrimination, and A Comprehensive Review of United Nations Peacekeeping Operations. The State of Tranquility a proud member of the Regional Alliance of Peaceful Countries and a fully supports other regional groups in their efforts to coordinated a regional plan for sustained and sustainable development. In that regard, the State of Tranquility recognizes the necessity of ensuring the full realization of the Right to Development as declared in the Declaration on the Right to Development and the Final Report of the Working Group on the Right to Development. Tranquility fully supports the implementation of national development plans with the cooperation of regional organizations, the United Nations, and the international community. Tranquility is firmly committed to addressing the underlying factors

I. The Situation in Sub-Saharan Africa

The State of Tranquility believes that the principles of sovereignty, territorial integrity and economic security lend themselves to the pacific settlement of disputes in Sub-Saharan Africa, the most ethnically diverse region in the world. The lack of development in the region constitutes the root cause of political instability and conflict. The report of the Secretary-General, *An Agenda for Peace: Recommendations,* if implemented, could enhance the work of the Organization in its efforts to bring about sustainable development in Africa. Tranquility also believes that the use of preventive development in Africa could ensure that conflicts such as those in Liberia, Rwanda, Angola, Somalia and the Democratic Republic of the Congo can be avoided before they erupt. While obstacles to be overcome are many, international support for effective national programs to ensure the relief to rehabilitation to development continuum through post-conflict peace-building, can enable Sub-Saharan Africa and the entire developing world to achieve the sustainable development which alone will guarantee regional peace and stability. The State of Tranquility fully supports the increased cooperation between the United Nations and regional organizations in all aspects of dispute settlement and peace-keeping. Increased support for such regional efforts, when combined with measures to eliminate the root causes of regional conflict, serves to further enhance the prospects for lasting peace, security and development in Sub-Saharan Africa and throughout the entire international community.

II. Racism and Racial Discrimination

The State of Tranquility believes that the World Conference against Racism, Racial Discrimination, Xenophobia, and Related Intolerance offers the global community an opportunity to establish an updated plan of action to completely eradicate racism and racial discrimination throughout the world. The necessity for all Member States to sign, accede to and ratify the International Convention on the Elimination of All Forms of Racial Discrimination is an integral part of this plan, as policies and practices based on racism and racial discrimination remain devastating to regional social, economic and infrastructure development. Tranquility encourage all States, international

organizations and non-governmental organizations to increase their efforts to combat racism, racial discrimination and xenophobia and to provide assistance to those affected by such practices. The lack of financial resources that prevented the international community from realizing its objectives in the three previous United Nations Decades to Combat Racism and Racial Discrimination must not continue to hinder the international community in guaranteeing the fundamental human rights of all peoples.

III. A Comprehensive Review of United Nations Peacekeeping Operations

The State of Tranquility remains firmly committed in support of the continued role of the United Nations Security Council as the primary agent for the maintenance of international peace and security, as mandated under Chapters IV and V of the UN Charter. We strongly recommend the authorization, determination, composition and financing of peacekeeping operations should be determined by the Council, as authorized by Articles 24, 25 and 26 of the Charter and in conjunction with the recommendations of the Special Committee on Peacekeeping Operations. Additionally, the State of Tranquility endorses the current role of the Secretary-General as administrator of the Operations established by the Council. The State of Tranquility remains a central contributor for both financial and logistical support of the United Nations Peacekeeping forces and will continue to contribute to the United Nations Peacekeeping Budget throughout the duration of the current year.

The State of Tranquility is firmly committed to addressing all threats to international peace and security through regional arrangements and multilateral forums. The international community must address the underlying causes of these conflicts and the destabilizing effects of such conflicts on entire regions. Tranquility is convinced that increased utilization of regional and sub-regional peacekeeping mechanisms can enhance the ability of peacekeeping missions to take into account historical, social, and cultural values and traditions within areas of conflict.

As operation costs continue to escalate, however, our nation strongly urges all Member States and the Secretary-General to devote greater attention to the monetary and management aspects of peacekeeping operations and provide serious consideration for the establishment of operation termination dates. The State of Tranquility further supports the proposal endorsed within A/Res/44/49, calling for Member States to develop and maintain an inventory of supplies and equipment to be made available for Operations on short-notice. In addition, the State of Tranquility calls upon Member States to recognize the need to maintain voluntary contributions for United Nations Peacekeeping Operations to reduce the continuing problems incurred by funding deficits.

Message from the Director-General Regarding Position Papers

Position papers are submitted for each committee in which a State/NGO participates at the NMUN Conference. Position papers should provide a concise review of each delegation's foreign policy regarding the topic areas under discussion and establish precise policies and recommendations in regard to the topics before the committee. International and regional conventions, treaties, declarations, resolutions, and programs of action of relevance to the policy of your State/NGO should be identified and addressed. Position papers also serve as a blueprint for individual delegates to remember their country's position throughout the course of the Conference.

Please be forewarned, delegates must turn in material that is entirely original. The NMUN Conference will not tolerate the occurrence of plagiarism. In this regard, the NMUN Secretariat would like to take this opportunity to remind delegates that although United Nations documentation is considered within the public domain, the Conference does not allow the verbatim recreation of these documents. This plagiarism policy also extends to the written work of the Secretariat contained within the committee background guides. Violation of this policy will be immediately reported to faculty advisors and may result in dismissal from Conference participation. Delegates should report any incident of plagiarism to the Secretariat as soon as possible.

An important component of the awards consideration process is the format of the position papers. Please refer to the sample paper on the previous page for a visual example of what your work should look like at its completion. The following format specifications are **required** for all papers:

- All papers must be typed and formatted according to the example in the background guides (following the specifications below will ensure this)
- Length must **not** exceed two single-sided pages
- Font **must** be Times New Roman sized between 10 pt. and 12 pt.
- Country/NGO name, School name and committee name clearly labeled on the first page
- Agenda topics clearly labeled in separate sections
- No binding, staples, paper clips, or cover sheets should be used on any of the papers

To be considered timely for awards one copy of the position paper must be e-mailed directly to the committee address, **who@nmun.org**, also provided in the cover letter of this guide, no later than **February 25, 2005.** *E-mailed files should be in Microsoft Word (.doc), Rich Text (.rtf), or Adobe (.pdf) formats*. Delegates should carbon copy (cc:) themselves as confirmation of receipt.

PLEASE TITLE EACH E-MAIL/DOCUMENT WITH THE NAME OF THE COUNTRY & COMMITTEE

Each delegation should send one set of **ALL** position papers to *positionpapers@nmun.org*

- This set (held by the Director-General) will serve as a back-up copy in case individual committee directors cannot open attachments. ***NOTE: This e-mail should only be used as a repository for position papers.***
- The head delegate or faculty member sending this message should carbon copy (cc:) him/herself as confirmation of receipt. *(Free programs like Adobe Acrobat or WinZip may need to be used to compress files if they are not plain text.)*
- **Important Note:** Because of the potential volume of e-mail, only one e-mail from the Head Delegate or Faculty Advisor containing all attached position papers will be accepted. ***Please put the school or delegation's name on the subject line.***

If you have any questions, please contact the Director-General at dirgen@nmun.org

If you need to make other arrangements for submission, please contact Jennifer 'JJ' Stewart, Director-General, at dirgen@nmun.org or at 937-269-5790.

Additionally, each delegation should submit a copy of their position paper to the permanent mission of the country you are representing along with an explanation of the Conference. Those delegations representing NGOs do not have to send their position paper to their NGO headquarters, although it is encouraged. This will assist them in preparing your mission briefing in New York.

Finally, please consider that over 1,000 papers will be handled and read by the Secretariat for the Conference. Your patience and cooperation in strictly adhering to the above guidelines will make this process more efficient and is greatly appreciated. Questions about the substantive nature of the position paper, research, or the committee should be directed to your Director or Assistant Director. Should you have any questions please feel free to contact the conference staff, though as we do not operate out of a central office or location your consideration for time zone differences is appreciated.

Sincerely,

Jennifer 'JJ' Stewart
Director-General

History of the World Health Organization

> *The world is living dangerously: either because it has little choice, or because it is making wrong choices. Let me put it another way. Six billion people co-exist on our fragile planet. On the one side are the millions who are dangerously short of the food, water and security they need to live. On the other side are the millions who suffer because they use too much. All of them face high risks of ill health.*[1]

The World Health Organization (WHO), a specialized agency of the United Nations, was established in 1948.[2] The first international organization related to health, was the Pan American Health Organization (PAHO).[3] Recognizing the importance of public health, in 1945, a United Nations Conference on International Organization in San Francisco unanimously approved a proposal by Brazil and China to establish a new, autonomous, international health organization.[4] In 1946, the International Health Conference held in New York approved the Constitution of WHO.[5] WHO is "the directing and coordinating authority on international health work" and is responsible for helping all peoples to attain "the highest possible levels of health."[6]

All countries that are members of the United Nations may become members of the WHO by adopting its Constitution. Other countries may be admitted as members when their application has been approved by a simple majority vote of the World Health Assembly.[7] Territories that are not responsible for the conduct of their international relations (such as protectorate States) may be admitted as Associate Members, upon application made on their behalf by the Members of WHO.[8] The current membership of the Organization is 192 Member States.[9]

The central structure of WHO includes: the policymaking body called the World Health Assembly, which consists of delegates from all Member States and meets yearly; an executive board of 32 qualified individuals elected by the Assembly; and a Secretariat, consisting of a Director-General and a technical and administrative staff.[10] The agency maintains regional organizations for Southeast Asia, the eastern Mediterranean area, Europe, Africa, the Americas, and the western Pacific area.[11]

Nearly 3,500 experts, from health and other necessary areas, in both professional and general service categories, who work at headquarters in Geneva and in the six regional country offices, staff the Secretariat.[12] The Secretariat is headed by the Director-General, who is appointed by the World Health Assembly on the nomination of the Executive Board.[13] The current Director-General is Dr. Lee Jong-wook, from Seoul, South Korea.[14] Most recently, the post of Director-General has been held by: Dr. G.H. Brundtland, Norway (1998-2003); Dr. Hiroshi Hakajima, Japan (1988-1998); Dr. Halfdan; Mahler, Denmark (1973-1988); Dr. Marcolino G. Candau, Brazil (1953-1973); and Dr. Brock Chisholm, Canada (1948-1953).[15]

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[1] Brundtland, Dr. Gro Harlem. (2002, May 13). *Address to the Fifty-fifth World Health Assembly*. Retrieved July 26, 2004, from http://www.who.int/director-general/speeches/2002/english/20020513_addresstothe55WHA.html

[2] Encarta On-line Encyclopedia. (1999, January). *History of the World Health Organization.* Retrieved July 26, 2004, from http://encarta.msn.com/encyclopedia_761579190/World_Health_Organization.html

[3] Pan-American Health Organization. (2004, August 11). *What is PAHO?* Retrieved August 11, 2004, from http://www.paho.org/english/paho/What-PAHO.htm

[4] World Health Organization. (n.d.). *History of WHO and International Cooperation in Public Health.* Retrieved July 26, 2004, from http://www.who.int/about/overview/en/

[5] Encarta On-line Encyclopedia, *supra*, note 2.

[6] World Health Organization. (1948). *Constitution of the World Health Organization.* Retrieved July 26, 2004, from http://policy.who.int/cgi-bin/om_isapi.dll?infobase=Basicdoc&softpage=Browse_Frame_Pg42.

[7] *Ibid.*

[8] *Ibid.*

[9] For the purposes of the 2005 National Model United Nations Conference, membership consists of 190 Member States. The Cook Islands and Niue will not be simulated.; World Health Organization. (n.d.). *Governance.* Retrieved July 26, 2004, from http://www.who.int/governance/en/

[10] *Ibid.*

[11] *Ibid.*

[12] *Ibid.*

[13] *Ibid.*

[14] World Health Organization. (n.d.). *Director General.* Retrieved July 26, 2004, from http://www.who.int/dg/lee/en/

[15] *Ibid.*

WHO exists for the "attainment by all peoples of the highest possible level of health."[16] Health, as defined in the WHO Constitution, "is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[17] In support of its main objective, the Organization has a wide range of functions, including the following: to act as the directing and coordinating authority on international health work; to promote technical co-operation; to assist Governments, upon request, in strengthening health services; to furnish appropriate technical assistance and, in emergencies, necessary aid, upon the request or acceptance of Governments; to stimulate and advance work on the prevention and control of epidemic, endemic and other diseases; to promote, in cooperation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene; to promote and coordinate biomedical and health services research; to promote improved standards of teaching and training in the health, medical and related professions; to establish and stimulate the establishment of international standards for biological, pharmaceutical and similar products, and to standardize diagnostic procedures; and to foster activities in the field of mental health, especially those activities affecting the harmony of human relations.[18]

In addition to its other objectives, WHO also proposes conventions, agreements, and regulations, as well as makes recommendations about the international nomenclature of diseases, causes of death and public health practices.[19] Furthermore, the Organization also develops, establishes, and promotes international standards concerning foods and biological, pharmaceutical, and similar substances.[20] The World Health Organization is responsible for setting universal health standards: WHO sets the standards to ensure the highest quality of biological and pharmaceutical preparations; WHO helps developing countries establish a list of essential pharmaceuticals from those currently available on the market; and, WHO cooperates with the pharmaceutical industry to make medicines more available either free of charge or at low cost to poor communities.[21]

The services of WHO may be either advisory or technical. Advisory services include aid in training medical personnel and in disseminating knowledge of diseases such as influenza, malaria, smallpox, tuberculosis, venereal diseases, and acquired immunodeficiency syndrome (AIDS); maternal and child health; nutrition; population planning; and environmental sanitation.[22] The agency maintains health-demonstration areas for sustained application of modern techniques to improve general health conditions and to combat specific diseases interfering with agricultural productivity and overall economic development.[23] The technical services include biological standardization and unification of pharmacopoeias, collection and dissemination of epidemiological information, special international research projects on parasitic and viral diseases, and publication of a series of technical and scientific works.[24]

A new global health policy to meet future health challenges has been developed by the World Health Organization in consultation with all its national and international partners.[25] Health for All (HFA) seeks to create the conditions where people have, as a fundamental human right, the opportunity to reach and maintain the highest attainable level of health.[26] The vision of a renewed HFA policy builds on the WHO Constitution, the experience of the past and the needs of the future.[27] For the past two centuries, it was known that smallpox could be prevented, but only in the 20th century was a coalition organized by the World Health Organization able to do something definitive about it.[28] With

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[16] *Ibid.*
[17] *Ibid.*
[18] World Health Organization. (n.d.). *Mission Statement*. Retrieved July 26, 2004, from http://www.euro.who.int/observatory/About/20020521_6
[19] *Ibid.*
[20] *Ibid.*
[21] World Health Organization. (n.d.). *Rapid Overview.* Retrieved July 26, 2004, from http://www.who.int/whr/2003/overview/en/print.html
[22] World Health Organization, *Mission Statement*, *supra,* note 18.
[23] *Ibid.*
[24] World Health Organization, *History of WHO and International Cooperation in Public Health*, *supra,* note 4.
[25] World Health Organization, *Rapid Overview*, *supra,* note 21.
[26] *Ibid.*
[27] *Ibid.*
[28] *Ibid.*

political will, commitment and a willingness to work together there is no reason why this success cannot be continued.[29]

190 Member States will be represented at the 2005 NMUN World Health Organization. The non-governmental organizations (NGOs) that will participate are:

Action Aid
B'nai B'rith International
CARE International
Counterpart International
Global Alliance for Women's Heath
Human Rights Watch
International Council of Women
International Federation of Red Cross and Red Crescent Societies
Médecins sans Frontières
OXFAM International
Rotary International
The Population Council
Third World Network
World Assembly of Youth
World Council of Churches

NGOs, from time to time, have been invited to participate in the Organizations activities. They are "invited to attend plenary meetings…and to participate…in accordance with [the rules of procedure]."[30] They are not afforded substantive voting rights.

I. Economies of Scale: The Problems of Polio Eradication

There is no question that the virus is spreading at an alarming pace.[31]

Polio is one of the gravest scourges faced by humanity. Striking those most vulnerable (children), the disease forces them to a lead a largely debilitated life without the use of their lower limbs. Though vaccination efforts have been successful in eradicating 99% of occurrences of the disease, the remaining 1% poses a huge health risk. However, it is largely a problem for developing countries, which may not have the resources for the expense of final eradication. This situation elicits several questions about the circumstances. What are these "economies of scale?"[32] Furthermore, what about the economies of scale of polio eradication? Is it possible to weigh the cost of eradication against the benefits of a polio free society? Will the monies spent on polio eradication be better spent on other diseases? Do we pull together to eradicate the disease completely, or are the benefits of having some naturally occurring instances of the disease enough to outweigh the risk of large-scale epidemic.

The World Health Organization (WHO) has made great efforts to support polio eradication and has spearheaded the endeavor in the polio eradication initiative. As the Director General, Dr. Lee Jong-wook, recently stated, "The world has a one-time chance to finish this job once and for all – to protect our collective investment."[33] In January 2004, WHO hosted the ministers of health from the remaining six polio pandemic countries who pledged their unending support of polio eradication.[34]

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[29] *Ibid.*

[30] World Health Organization. (n.d.). *Rules of Procedure.* Retrieved October 2, 2004, from http://policy.who.int/cgi-bin/om_isapi.dll?hitsperheading=on&infobase=basicdoc&record={127E}&softpage=Document42

[31] Statement made by Dr. David Heymann, Executive Director, Communicable Diseases, World Health Organization.; Located in: Fowler, Jonathan. (2004). Polio re-emerges in Sudan, Africa on the brink of massive outbreak. *Associate Press Wire.* Retrieved June 22, 2004, from http://www.irinnews.org/report.asp?ReportID=41819&SelectRegion=West_Africa&SelectCountry=WEST_AFRICA

[32] "Economies of scale" can be defined one way as "situations where the cost of producing one unit of a good or service decreases as the volume of production increases. Economies of scale tend to occur in industries with high capital costs [for instance, as pharmeucital production] in which those costs can be distributed across a large number of units of production [for example, the number of unites produced by the pharmeucital company]."; Wikipedia. (2004). *Economies of Scale.* Retrieved September 30, 2004, from http://en.wikipedia.org/wiki/Economies_of_scale

[33] World Health Organization. (2004). *Polio Eradication: Now More Than Ever.* Retrieved September 8, 2004, from http://www.who.int/features/2004/polio/en/

[34] *Ibid.*

Polio eradication is easy to accept as beneficial, but there are negative aspects tied to completely removing the disease. Suddenly it becomes viable as a bioterrorist threat, where entire populations will be left vulnerable. Ministries of health are having a difficult time meeting their needs in prevention of other diseases. In evaluating the positives and negatives of polio eradication, this committee should consider where those scarce resources gain the most benefit. Therefore the question before this committee is do the benefits of eradicating a specific disease, polio, warrant the use of resources that might be better used to fight diseases in general. The purpose will be to defend, or not defend, the eradication efforts while imagining the unforeseen consequences.

History of the Disease and its Vaccine

Polio is one disease that did not benefit from increased standards of sanitation over the 19th and 20th centuries. Rather, the disease benefited greatly, while its victims did not, as exposure to the virus through poor sanitation actually creates immunity. Discovered to be a virus in 1909, immunization is achieved through exposure to the virus.[35] However, polio, or *paralytic poliomyelitis*, has been present since ancient times, frequent exposure and its subsequential immunity to the virus would prevent further outbreaks. With improvements in sanitation and the dumping of sewage away from the drinking water supply in the 20th century, the same technology that prevented the outbreaks of diseases such as cholera and dysentery became the cause of polio epidemics in the developed world. This is because the children, who are most affected by the virus, were no longer exposed to the virus in small doses, which builds the antibodies.[36] As the children grew older and began interacting with others, swimming in public pools, and going to school, they were more likely to be exposed to the virus, which was then more likely to cause *paralytic poliomyelitis*.[37]

Before the great depression, polio was one of the most feared diseases. It came on fast, there was no cure, and if you were lucky to survive, you would be bound to crutches, wheelchairs, or an iron lung for life. Little was known in the first half of the 20th century about methods of transmission, and fear ran rampant similar in fashion to that of the HIV/AIDS epidemic in the last three decades.[38] It was known that transmission rates soared in the summer, largely due to exposure at swimming pools and increased interaction between children.[39] Kathryn Black, a memoirist who accounts her mother's battle with polio, states about the disease that, "Fear hung like heat in the summer. No one knew how you got it. Did you breathe it in, swallow it in contaminated milk, drink it down at a public fountain, or get it from flies on your picnic lunch?"[40]

Polio transmission in such a manner occurs because it is a fecal-oral infection, a common route for microbes. In areas where raw sewage enters a watershed without treatment, polio can be found in rivers, lakes, and streams. When a susceptible person drinks water from one of these sources, the virus enters his digestive tract.[41]

> *After surviving the harsh, acidic conditions of the stomach, the virus infects the cells lining the intestine (the "gut mucosa"). Each round of replication produces thousands of new virus particles, or virions, which are then carried through the intestine and released into the sewage system to start the cycle over again. In addition to untreated drinking water, the virus appears to spread through contact, especially among children, whose hands are often contaminated.*[42]

Polio is caused by three stable strains of virus that do not change, and can live for quite some time in food and water. In most cases (90% of them), the antibodies created by the body's natural immune system fights the progression of the virus and that immunity lasts a lifetime. Of those who are not so lucky, 10% develop symptoms and 1%

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[35] Polio Information Center On-line. (2004). *A Brief History of Polio.* Retrieved July 28, 2004, from http://microbiology.columbia.edu/pico/Chapters/History.html
[36] *Ibid.*
[37] *Ibid.*
[38] *Ibid.*
[39] *Ibid.*
[40] Black, Kathryn. (1996). In the Shadow of Polio: A Personal and Social History. Indianapolis: Perseus Publishing, p. 22.
[41] Polio Information Center On-line. (2004). *Polio Epidemiology*. Retrieved July 28, 2004, from http://www.cumicro2.cpmc.columbia.edu/PICO/Chapters/Epidemiology.html
[42] *Ibid.*

develops the paralytic form of polio.[43] The good news is that a vaccine can prevent a virus that replicates in such a manner, but the vaccine must provide immunity against all three strains to be effective.[44] Both vaccines developed are effective against these strains, but the come with their weaknesses, which are described below.[45]

Because of the massive amounts of interest in the disease, a non-governmental organization (NGO) named the March of Dimes was founded to assist in the development of the vaccine. This organization enlisted the assistance of renowned researchers to accelerate the development of the vaccine. They would not be disappointed. In 1952, Dr. Jonas Salk was able to grow a vaccine based on a weakened virus in monkey's kidneys, using formalin, a chemical that inactivated the virus.[46] Soon after, the first human trials began in the United States and Canada with dramatic reduction in polio cases. In 1955, the U.S. Government granted permission for the vaccine to be distributed to children.[47] It was distributed to a million individuals including Salk's own family, and was virtually 100% effective with booster shots.[48]

Salk's vaccine, the injected polio vaccine (IPV), however had a downside in that it had the potential to cause cases of polio if the virus was not completely inactivated.[49] In the United States, through the 1960s, 260 cases of polio were caused in such a manner including ten deaths. This prompted Albert Bruce Sabin, from 1955 to 1957, to develop a live oral form of the virus for vaccination, with the infectious part of the virus inactivated.[50] Sabin's vaccine eliminates the risk of contracting polio from the vaccine itself.

There are some advantages to the orally administered version of the vaccine. Unlike the "dead" virus, which must be injected into the arm, and requires booster shots every five years, Sabin's oral polio vaccine (OPV) does not require shots.[51] It is administered in three doses in the first three years of life with a booster when the child starts school.[52] Thus, it is more convenient in developing countries due to lower cost of administering the vaccine, as sanitary needles are not required. The live vaccine also gives bodily and digestive tract immunity, meaning the individual cannot become a carrier of the virus.[53] Salk's vaccine provides only bodily immunity. This means an individual might carry the virus. IPV also costs approximately five times that of the OPV.[54]

At the same time, Sabin's virus cannot be administered to immuno-suppressed individuals or those that may be in contact with immuno-suppressed individuals as the live virus can be shed and passed on. Furthermore, individuals with an enterovirus infection of the gastrointestinal tract when taking the oral vaccine may not develop the immune response.[55] There is a recognized, though rare risk, of vaccine associate polio (VAPP), which is generally accepted by the healthcare community; but without it, community immunity would not be as efficient, and naturally occurring cases of wild-virus polio would still be a problem.[56] However, in general, OPV is the preferred method of vaccination, though some countries have begun to use a combined program to mitigate all risks.

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[43] Okonek, Bonnie A., & Morganstein, Maybury and Linda. (Eds.). (2004). *Development of Polio Vaccines*. Access Excellence Classics Collection. Washington, DC: National Health Museum. Retrieved July 30, 2004, from http://www.accessexcellence.org/AE/AEC/CC/polio.html

[44] *Ibid.*

[45] Polio Information Center On-line, A *Brief History of Polio*, supra, note 35.

[46] *Ibid.*

[47] *Ibid.*

[48] Brody, Seymour. (1996). Drs. Jonas E. Salk and Albert Sabin Conquer Polio. *Jewish Heroes and Heroines in America.* Hollywood, FL: Florida Atlantic University Libraries. Retrieved September 8, 2004, from http://www.fau.edu/library/br118.htm

[49] *Ibid.*

[50] *Ibid.*

[51] Okonek & Morganstein, *supra,* note 43.

[52] *Ibid.*

[53] Cincinnati Children's Hospital Medical Center. (2004). *Dr. Albert Sabin's Discovery of the Oral Polio Vaccine*. Retrieved July 30, 2004, from http://www.cincinnatichildrens.org/about/history/sabin.htm

[54] Polio Eradication Initiative. (2004). *Polio Vaccines.* Retrieved July 30, 2004, from http://www.polioeradication.org/vaccines.asp

[55] Okonek & Morganstein, s*upra,* note 43.

[56] Black, *supra,* note 40.

Polio Eradication Efforts

The discovery and use of the polio vaccine has virtually succeeded in eliminating occurrences of the disease. Because of the success of smallpox eradication, in 1988, the WHO, and the United Nations Children's Education Fund (UNICEF) launched the Global Polio Eradication Initiative.[57] "Back when the Global Polio Eradication Initiative was launched, wild poliovirus was endemic in more than 125 countries on five continents, paralyzing more than 1000 children every day. Today, polio is endemic in Nigeria, India, Pakistan, Niger, Afghanistan and Egypt."[58] Its purpose is to eradicate the last vestiges of polio on the planet. It has succeeded in eliminating 99% of the naturally occurring cases of polio.[59] One cannot underestimate the impact of the polio vaccine. For example; "In 1960, there were 2,525 cases of paralytic polio in the United States. By 1965, there were 61."[60] However, "between 1980 and 1990, cases averaged eight per year, and most of those were induced by vaccination! There has not been a single case of polio caused by the wild virus since 1979, with a rare case reported each year from persons coming into the country carrying the virus."[61] Because of the vaccine, the direct effect was that polio was considered eradicated in all of the Americas in 1994.[62]

Currently just six countries still have naturally occurring cases of polio: Nigeria, India, Pakistan, Niger, Afghanistan, and Egypt.[63] Nigeria, India, and Pakistan account for over 95% of polio cases and 65% of the Eradication initiative's financial resources.[64] Rates in these areas continue to be high not because of poor eradication strategies, but also because of costs and political support. There are a number of high-risk States as well mostly in Africa, in neighboring countries to those that are still actively pursuing eradication.

Generally, it takes three to five years of National Immunization Days (NIDs) to eradicate polio in a country. NIDs are normally conducted during the cool, dry season because logistics are simplified, immunological response to OPV is improved, and the potential damage to heat-sensitive OPV is reduced.[65] As part of the eradication strategy, the Global Polio Eradication Initiative is sponsoring NIDs to administer the OPV in mass quantities.[66] In 2003, 415 million children under five years of age were immunized during NIDs in 55 countries using over 2.2 billion doses of OPVs.[67] Before the eradication campaigns began, most vaccinations took place in clinics on a more ad hoc basis. This meant the disease could continue to spread to those who did not participate.[68]

Even when eradication has been achieved in one country, there is potential for the virus to be transmitted across borders. This has prompted some regions to sponsor region-wide NIDs. One such NID occurred on February 23, 2004. On this date, "10 countries across west and central Africa held simultaneous polio immunization campaigns, targeting 63 million children in Benin, Burkina Faso, Cameroon (20 February), Central African Republic, Chad (joined in March), Ghana, Niger, Nigeria, Ivory Coast and Togo. Political, religious, and traditional leaders teamed up to launch the activities, and tens of thousands of vaccinators went house-to-house over three days to administer the vaccine directly to every child."[69]

Such cross-bordered vaccination efforts mitigate the risk, but must be coordinated by a global agency requiring a number of resources. The consequences of cross-border transmission can be seen most recently in Nigeria. Last year, rumors of the vaccines imported from the United States causing infertility were spread by some Muslim clerics

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[57] *Ibid.*
[58] Polio Eradication Initiative. (2004). *The History*. Retrieved October 2, 2004, from http://www.polioeradication.org/history.asp
[59] BBC News. (2001, April 3). *Polio Eradication Draws Closer.* Retrieved July 30, 2004, from http://news.bbc.co.uk/2/hi/health/1257691.stm
[60] Black, *supra,* note 40.
[61] *Ibid.*
[62] *Ibid.*
[63] Global Polio Eradication Initiative. (2003). *Estimated External Financial Resources Required, 2004-2008.* Geneva, Switzerland: World Health Organization.
[64] *Ibid.*
[65] Global Polio Eradication Initiative. (2004). *National Immunization Days.* Retrieved July 30, 2004, from http://www.polioeradication.org/content/fixed/national.shtml
[66] *Ibid.*
[67] *Ibid.*
[68] *Ibid.*
[69] *Ibid.*

in Nigeria's Kano region, essentially halting the project in its tracks.[70] The halting of the eradication efforts caused reinfection in neighboring States, an estimated U.S. $10 million in cost.[71] The government of Nigeria has recently decided to import the polio vaccine from Indonesian sources.[72] On the day vaccinations resumed, it was reported, "Nigeria has had nearly 400 cases of polio as of this week, -- 85 percent of the global total and four times the number recorded in the same period in 2003. One quarter of Nigeria's cases are in Kano,"[73] thus, proving that eradication efforts limit the spread of polio.

In the final stages of eradication, countries may conduct "mopping-up" activities in targeted geographical regions in order to administer OPVs to children in their homes. This serves to reach any that may have been missed in the NIDs, and solidifies eradication.[74]

For all the successes of the polio eradication campaigns, there are hindrances as well, particularly in developing countries. From 1988-2003, polio eradication efforts required U.S. $2.5 billion in expenditures to achieve 99% eradication.[75] From 2004-2005, U.S. $760 million is required to maintain the current level of effort of polio eradication.[76] Unfortunately, there is only U.S. $635 million available from a combination of donors, ministries of health, and private funds.[77] Furthermore, it is estimated that for complete eradication another U.S. $380 million will be required through 2008.[78] The Ministries of Health in the nations that require them cannot sustain funding for these programs. If donor funds are required, there is an issue of cost-effectiveness for them.[79]

WHO works with many partners in the polio eradication effort. For example, the World Bank is attempting to alleviate the cost of eradication through buy-down programs where once a State has successfully eliminated polio within its border, the bank will buy bank the loan, effectively turning it into a grant.[80] The donor benefits as for every dollar invested, there is up to a three-dollar return in real development assistance. They also ensure their investment results in measurable performance.[81] The Pan American Health Organization sponsors many vaccination days in a number of countries in Latin America.[82]

The Eradication Debate

The cost of complete eradication of polio is immense. As stated earlier U.S. $760 million is used to complete the eradication of polio. The attempt at complete eradication has become one of the most controversial public health issues of the late 20th and early 21st centuries. Many argue that eradication is blatantly obvious and beneficial. While others say that polio eradication does more harm than good, and that the cost is not worth the benefits. For WHO, they have based the polio eradication project on its successful smallpox eradication program of the 1960s and 1970s.[83] The two diseases, however, are different in various ways that make this analogy impractical.

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[70] *Ibid.*
[71] Lichtarowicz, Ania. (2004). 'Final push' against polio agreed. *BBC News: World Edition.* Retrieved August 2, 2004, from http://news.bbc.co.uk/2/hi/africa/3398503.stm
[72] No Author. (2004, August 1). Polio Vaccines Resume in Nigeria After a State's 11-Month Boycott. *The Washington Post,* p. A20.
[73] *Ibid.*
[74] Partnerships for Health Reform. (2004). *Cost-Effective Strategies for Achieving Polio Eradication.* Washington, DC: Abt Associates, p. 3.
[75] *Ibid.*
[76] *Ibid.*
[77] *Ibid.*
[78] *Ibid.*
[79] Brody, *supra,* note 48.
[80] World Bank. (2003). *Financial Innovation Will Buy Polio Vaccine To Help Eradicate Polio Worldwide.* Retrieved August 2, 2004, from http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,contentMDK:20107918~menuPK:34463~pagePK:34370~piPK:34424~theSitePK:4607,00.html
[81] *Ibid.*
[82] Reuters News Wire. (2004). *Photo Album: Red Cross helps fight polio in Haiti.* Retrieved September 21, 2004, from http://www.alertnet.org/thenews/memphotoalbum/108333127690.htm
[83] *Ibid.*

As explained by Allen Dove, the difference between the vaccines is vital.

> *The smallpox vaccine consists of a preparation of Vaccinia virus, a relative of the virus, which causes smallpox. Since the vaccine is not directly derived from the wild virus, there is no way it can mutate back into a pathogenic form and cause an outbreak. There are potential complications of smallpox vaccination, but it cannot cause smallpox. OPV, on the other hand, is a preparation of three mutant strains of wild poliovirus, representing the three serotypes of the virus. IPV is the wild-type virus itself, inactivated in the laboratory before injection into the patient. These distinctions are crucial in understanding the difficulties presented by stopping vaccination.*[84]

This affects the global eradication strategy, which is based on the strategy implemented in the polio campaign. According to the *Global Action Plan for laboratory Containment of Wild Polio Viruses*, global eradication will be achieved when every region is certified as polio free for three consecutive years.[85] As with smallpox, the plan is to contain small amounts of the virus in protected biohazard laboratories.[86] This will serve as an emergency stockpile. The downside of maintaining that is in the fact that there have been approximately 20 cases of laboratory transmission documented, most recently in 1992.[87]

Therefore, unlike the smallpox virus, which can be contained, a contained poliovirus is still a risk. The poliovirus itself is durable and can exist for many months in the environment, unlike smallpox which exists today only in small amounts in protected areas. This means that natural occurrences of the virus are possible even after eradication (the poliovirus can survive at freezing temperatures for many years).[88] If vaccination stops because eradication has been achieved because, "the number of unvaccinated individuals in the world population will increase every hour of every day. In ten years, there will be a huge number of potential hosts available to support a new outbreak, and virus persistence would represent a major threat to public health."[89]

Vaccine stocks would also be at risk. Should some sort of release, whether accidental or in the form of bioterrorism, occur, emergency vaccines would be unavailable as laboratories would not be able to provide at the level required:

> *Workers responsible for preparing and testing these stocks, ideally, would be vaccinated against the virus. Unfortunately, vaccination with OPV would cause them to secrete live poliovirus, possibly causing an epidemic. Using IPV would avoid this problem, but would not provide the same type of immunity as OPV; individuals vaccinated in this way would still be able to act as carriers, negating the benefit of vaccinating them. To date, nobody has proposed a solution to this problem.*[90]

The potential consequences of eradicating polio and stopping vaccination in the public at large are heavy. It is estimated that each case of polio will cost U.S. $3.2 million to treat.[91]

The counter to these arguments is that polio is only transmitted via humans. Though higher primates may carry the disease, their populations are too small to maintain any transmission to humans. The recent results of immunization efforts lead experts to believe that continued immunizations will remove the virus of its human host. Thus, the virus will also cease to occur naturally. If the virus cannot be transmitted from animal to human, and proper vaccination using both OPV and IPV occurs, naturally occurring instances of polio will end. "The continued decrease of

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[84] Dove, Allen. (1997, August). *When Polio is Gone, Should We Still Vaccinate?* Retrieved June, 29, 2004, from http://cumicro2.cpmc.columbia.edu/PICO/Chapters/News897.html

[85] World Health Organization. (2004, January). *Global Action Plan for laboratory Containment of Wild Polio Viruses.* (WHO/V&B/03.11). Geneva: Author, p. 52.

[86] *Ibid.*

[87] *Ibid.*

[88] *Ibid.*

[89] Dove, *supra*, note 84.

[90] *Ibid.*

[91] Brown University. (2004). *Vaccine Strategies.* Retrieved August 2, 2004, from http://www.brown.edu/Courses/Bio_160/Projects1999/polio/vac.html

incidents of polio in many countries and the progressive disappearance of poliovirus genetic lineages suggest that the interruption of human-to-human transmission is achievable."[92]

What Others Might Benefit?

Should we compare health related interventions, we may see that cost-benefit is not where we anticipate.[93] WHO has begun to implement the CHOosing Interventions that are Cost Effective, or CHOICE, program to determine where resources are most wisely spent. Cost Effective Analysis is becoming a popular way for developing nations to tap into the same information about health interventions that have been available to richer countries for years.[94]

This type of analysis can assist policy makers in deciding if the remaining balance currently being devoted to polio, U.S. $760 million would be more wisely spent; for example, building sanitation facilities for the same expense. The same amount of money will defer the costs of fighting a 99.9% curable disease, Tuberculosis, a major concern in fighting the HIV/AIDS pandemic.[95] Delegates should contemplate the other areas where funding used for polio might be better spent.

The Role of Non-Governmental Organizations

Many non-governmental organizations are responsible for the day-to-day vaccination concerns; with their resources largely come from donor States and working with the ministries of health. For example, the International Federation of Red Cross and Red Crescent Societies recently assisted the Pan American Health organization in administering OPV to thousands in Haiti.[96] They are also active in the fights for the other diseases that might benefit fro freed up resources of polio. Other NGOs, such as Rotary International, sponsor extensive fundraising campaigns to provide the resources for eradication.[97] Other NGOs in this committee may participate to a varying degree.

In this committee delegates will be working with Action Aid, B'nai B'rith International, CARE International, Counterpart International, Global Alliance for Women's Heath, Human Rights Watch, International Council of Women, International Federation of Red Cross and Red Crescent Societies, Médecins sans Frontières, OXFAM International, Rotary International, The Population Council, Third World Network, World Assembly of Youth, World Council of Churches. Whether or not these organizations are active in the polio eradication programs, each has a unique perspective to add to this debate.

Weighing the Costs and Benefits

With polio 99% eradicated from the globe, the last 1% of immunizations is more than many nations can afford. Ministries of health are reliant on donor programs to complete eradication, which may even do more harm than good when completed. Thus, the costs are more than financial. Polio eradication, though largely helpful, may not be. Creative financing along the lines of the World Bank program will assist in funding the effort to eradicate polio. However, other communicable diseases require funding as well, and many ministries of health are taxed beyond capacity. Even eradication does not completely alleviate the funding crisis as emergency funding and continued vaccinations should be maintained. This is a conundrum of the worse sorts, two benevolent ends that must be chosen between. Polio eradication is in its hardest part, the final countdown. It is now a question of political will to remove the remaining threat, but even then, the threat polio presents remains. Where are the limited resources most wisely spent? Is the expense of the last 1% of eradication worth the expense, if that money can be used to help the

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[92] BBC News, *supra*, note 59.

[93] World Health Organization. (2004). *Global Programme On Evidence for Health Policy Improving Health System Performance.* Retrieved September 27, 2004, from, http://www3.who.int/whosis/cea/guide/guide.cfm?path=evidence,cea,cea_guide&language=english

[94] Edejer, Tan-Torres, Baltussen, R., Adam, T., Hutubessy, R., Acharya, A., Evans, D. B. & Murray., C. J. L. (Eds.). (2003). *Making Choices in Health: WHO Guide to Cost-Effectiveness Analysis.* Retrieved September 28, 2004, from http://www3.who.int/whosis/cea/background_documents/pdf/guidelines.pdf, Introduction.

[95] Carter, Joanne. (2004). *Tuberculosis: Action Needed Now.* Retrieved September 27, 2004, from http://www.massiveeffort.org/html/cartereditorial.html

[96] Reuters News Wire, *supra,* note 82.

[97] Rotary International. (2004). *Polio Eradication Fundraising Campaign Information*. Retrieved October 2, 2004, from, http://www.rotary.org/foundation/polioplus/donate/information.html

fight against more devastating diseases? Delegates might look at the potential for eradication not as the end goal, but a starting point for additional vaccination programs.

II. The Role of Generic Pharmaceuticals in Society

> *Weakening international patent rules would not help AIDS victims. Erosion of the patent system will only lead to lessened innovation of the new drugs needed to treat diseases. Criticisms of drug patents deflect attention from the real barriers to health care, poverty, inadequate infrastructure, flawed health systems, cultural barriers, and lack of political will.*[98]

Generic pharmaceutical manufacturers, with their reduced research and development (R&D) costs are able to price essential medicines far below the cost of their brand-name equivalents.[99] Without allowing research-based pharmaceutical companies to capture their substantial investment into R&D by giving them time-limited market exclusivity, the drive for further pharmaceutical innovation subsides. Therefore, the principal question placed before the World Health Organization under this topic is: how can the World Health Organization improve access to necessary medicines by using generic equivalents without eliminating incentives for further research in the pharmaceutical industry?

Regardless of the rhetoric of the manufacturers of drugs, WHO is primarily concerned with availability of essential medicines of which one-third of the globe still does not have access.[100] In the poorer parts of Africa and Asia, 50% of the population does not have access to even the most basic essential medicines.[101] In fact, WHO quantifies the number of deaths that could have been prevented by having access to said essential drugs to be approximately 10 million.[102] However, one must also remember that of the approximately 300 drugs on WHO's list, 95% are not under patent, suggesting that distribution, regulatory, and other non-patent issues inhibit drugs from reaching the people who need it most.[103] For example, it is not enough just to take one pill to relieve the ailment in question; often these drugs require the patient to follow a regime of varying complexity. As such, this example reaffirms that simply providing the medication is not enough to help cure the sick; it is merely one piece in the jigsaw puzzle of an individual's medical treatment.

Generic vs. Brand name: What is the Difference?

When considering the issue of generic versus brand name, it is important to note the difference between companies that produce brand-name pharmaceuticals and their associated generic equivalents. While both types of firms perform some element of research, the magnitude and focus of the research are what distinguishes the two. More specifically, the research of generic firms focuses on copying a known substance, whereas research-based firms focus on finding new molecules that can have a therapeutic effect. The difference in cost between their research and that of generics exceeds, on average, U.S. $1 billion, with the R&D cost for "innovative medicine" approaching U.S. $1.3 billion and R&D for generics hovering in the U.S. $1 million range.[104] As such, generic drugs are able to price

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[98] Pharmaceutical Research and Manufacturers of America. (n.d.). Intellectual property and access to AIDS drugs. *Health Care in the Developing World.* Retrieved September 1, 2004, from http://www.world.phrma.org/ip.access.aids.drugs.html

[99] Canada's Research-Based Pharmaceutical Companies. (2002). *The difference between brand-name medicines and generic drugs*. Retrieved July 4, 2004, from http://www.canadapharma.org/Industry_Publications/Fact_Sheets/RxdCompAd_e.pdf, p. 1.

[100] World Health Organization. (2004). *The rationale of essential medicines*. Retrieved July 13, 2004, from http://www.who.int/medicines/rationale.shtml

[101] World Health Organization. (2000). *WHO medicines strategy: framework for action in essential drugs and medicines policy 2000-2003.* Geneva: Author.

[102] World Health Organization, *The rationale of essential medicines. supra*, note 100.

[103] International Federation of Pharmaceutical Manufacturers Associations. (2002). *IFPMA issues: access to quality healthcare*. Retrieved July 14, 2004, from http://www.ifpma.org/Issues/issues_access.aspx

[104] Canada's Research-Based Pharmaceutical Companies, *The difference between brand-name medicines and generic drugs, supra*, note 99.

as much as 90% lower than their brand name counterparts, largely attributed by the lack of necessity to recapture research costs.[105]

The cost of bringing a pharmaceutical to market is not the sole determinant of price in a market system. The difference in prices between generic and brand name drugs is explained through a deeper understanding of the principles of economics, primarily microeconomics of competitive and monopolistic systems. In an extreme version of what is referred to as the "congestion problem," if generic drugs could be instantaneously developed and marketed then competition would ensure a low equilibrium price, which would render little or no return to the R&D of the initial manufacturer.[106] Patents "provide the inventor with a certain degree of certainty" of return (or rent) to an investment in "innovative medicine," provided through a limited monopoly mechanism.[107] It is the market forces of a patent generated monopoly that, for the term that the innovator and patent proprietor holds significant rights of exclusivity, allow innovative "brand names" to set and maintain higher prices that would be unattainable in the competitive market of generics, through "price-discrimination" and other moves considered rational for "profit-maximizing firms."[108]

Patent Law

It is important to understand the law surrounding pharmaceutical patents before deciding the role of generic drugs in our society. A patent is a legal instrument that gives the proprietor the ability to hold a time-limited monopoly on the rights to the invention in exchange for full disclosure of the invention to the public.[109] In order to qualify for a patent, the product and/or process must meet three criteria – that it is new, non-obvious to a worker of average skill in the industry, and useful.[110] The basis for international patent law comes from the World Trade Organization's *Trade-Related Aspects of Intellectual Property Rights* (TRIPS).[111] The agreement as written in 1994 proposes a standard of 20 years for said market exclusivity by the holder to be initiated on the date of filing for the protection.[112] One must also file for a patent for each country in which it seeks protection.[113]

While not specific to pharmaceutical products, it is important to note that one could patent the process to make a molecule, the product itself, or both as the case may be.[114] In other words, one can patent the finished good, and/or the process of taking starting materials and turning them into said finished good.[115] Regardless of what element of a pharmaceutical is being patented, significant lag time exists between when proprietors begin the patent application process, and when a new pharmaceutical is ready for full-scale manufacturing.[116] For example, the Association of the British Pharmaceutical Industry showed that the requirements of preparing a drug could take up to 12 years.[117] During that term, the drug must go through both pre-clinical and clinical development, subject to the approval of regulatory bodies.[118] Given the 20-year grant of market exclusivity on a patent, and assuming a 12-year lag in development, a patent proprietor's term to recapture R&D costs is reduced from 20 years to 8 years.[119] The reduced

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[105] Kong, Ying. (2004). The price premium of generic to brand-names and pharmaceutical price index. *Applied Economics*, 36, p. 7.; Quick, Jonathan D. (1999). *The worldwide role of generic pharmaceuticals.* Retrieved July 7, 2004, from http://www.who.int/medicines/library/pptpres/generics/1

[106] Cohen, Jillian C., & Illingworth, Patricia. (2003, May). The dilemma of intellectual property rights for pharmaceuticals. *Developing World Bioethics*, 3, p. 30.

[107] *Ibid.*

[108] *Ibid.*, p. 32.

[109] Wiles, John A., & Wiles, John H. (2004). *Contemporary Canadian Business Law* (7th ed.). Toronto, Ontario; McGraw-Hill, p. 593.

[110] *Ibid.*

[111] *Ibid*.

[112] Agreement on Trade-Related Aspects of Intellectual Property Rights, (opened for signature April 15, 1994), Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, 1869 U.N.T.S. 299.

[113] Wiles & Wiles, *supra*, note 109.

[114] *Ibid*.

[115] *Ibid.*

[116] The Association of the British Pharmaceutical Industry. (n.d.). *The development of medicines*. London, England: Author, p. 1.

[117] *Ibid.*

[118] *Ibid.*

[119] Agreement on Trade-Related Aspects of Intellectual Property Rights, *supra*, note 112.; *Ibid.*

window of opportunity entices companies to recapture its costs, and achieve profits, more aggressively. Aggressive pricing is a key reason provisions for the public health needed to be considered in TRIPS.

The initial wording of TRIPS was vague in the circumstances allowing for an exemption of patent law due to public health issues, initially starting that "members may… adopt measures necessary to protect public health."[120] In 2001, the *Doha Declaration* on TRIPS and Public Health clarified this section by encouraging Member States to grant compulsory licenses – giving permission for a company to breach a patent for the purposes of access to essential medicines.[121] Paragraph 6 of the aforementioned Declaration required the WTO to undertake further work, namely to solve the problem that granting a compulsory license does not benefit States that do not have the ability to manufacture pharmaceutical products within their jurisdiction.[122] The Organization clarified this in 2003 by allowing the granting of a compulsory license in order to import the product into a State; if said State has both notified the WTO that it is doing so, and that the recipient country does not currently possess the capacity to produce said medicine of its own volition.[123] To date, no country has used this provision.[124] As with any multi-national agreement like the WTO, member nations must ensure that their nation's policies and practices are in concert with that of the signed and ratified agreement. Further examples will be provided which show countries bringing their policies in line with TRIPS.

One must remember that the focus of this committee is not on the patent law itself, but the way in which the WHO can utilize said law to improve public health. The WHO worked with the WTO on ensuring that TRIPS balances meeting the health needs of the public with the ability to provide sufficient motivation for future progress in the pharmaceutical industry.[125]

The Innovative Pharmaceutical Argument

The CEO of Pfizer, Hank McKinnell, sums up the need for patents by examining what would happen without intellectual property protection.[126] He suggests that in a marketplace without Intellectual Property rights (IP) "you would have exactly the same number of drugs that have been discovered in the Soviet Union in the past 50 years, which I think is about one."[127] In other words, in order to drive research and development of pharmaceutical products, the company must then have sufficient protection to exploit the findings of the research without any competition. Inherent in this argument is the notion that if society did not protect the intellectual property of newly discovered medicines, research and development into those drugs would not occur.[128]

In order to ensure their viability, pharmaceutical companies in sixty countries unite in order to lobby effectively their respective governments, as well as internationally to ensure the protection of their intellectual property, among other issues.[129] As such, their compendium of statistics strongly supports the need to encourage research and development by allowing for a time-limited monopoly in sales of said product.[130] The Association of the British Pharmaceutical Industry (ABPI) notes that the £3.5 billion that went into pharmaceutical research in 2003 comprises 20% of the pharmaceutical's expenditures, and 25% of the total industrial research and development expenditure in Britain.[131] Canada's Research Based Pharmaceutical Companies (CRBPC) identifies that for every 10 thousand

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[120] *Ibid.,* Agreement on Trade-Related Aspects of Intellectual Property Rights, Article 8.
[121] World Trade Organization. (2001). *The Doha Declaration on the TRIPS Agreement*. (WT/MIN(01)/DEC/2). Geneva: Author.
[122] *Ibid*.
[123] World Trade Organization. (2003). *Implementation of paragraph 6 of the Doha Declaration on the TRIPS agreement and public health*. (WT/L/540). Geneva: Author.
[124] World Trade Organization. (2004). *TRIPS and public health: dedicated webpage for notifications.* Retrieved July 14, 2004, from http://www.wto.int/english/tratop_e/trips_e/public_health_e.htm
[125] World Health Organization & World Trade Organization. (2002). *WTO agreements and public health – A joint study by the WHO and WTO Secretariat*. Geneva: Authors.
[126] Mader, Ian. (2004, July 13). WHO Says World Has 'Failed' in AIDS Fight. *The Associated Press*.
[127] *Ibid.*
[128] *Ibid.*
[129] International Federation of Pharmaceutical Manufacturers Associations. (2004). *IFPMA Member Associations.* Retrieved August 9, 2004, from http://www.ifpma.org/About_Us/about_mem_americas.aspx
[130] *Ibid.*
[131] The Association of the British Pharmaceutical Industry. (2003). *ABPI Annual Review.* London, England: Author.

molecules discovered, only one makes it to market.[132] They further highlight that the average cost to develop a drug in Canada is Can$1.3 billion, whereas a generic only costs Can$1 million to bring to market.[133]

Academic research also supports some of these claims. The Pharmaceutical Research and Manufacturers of America (PhRMA) highlights a study that suggests that for every U.S. $1 saved when a brand-name drug has a generic alternative, there is a U.S. $3 loss due to a reduction in research and development (all figures are in present value).[134] This emphasizes the key cost-benefit issue in this debate: on one hand, consumers win directly when generic pharmaceuticals enter the market due to a marked reduction in the cost for medicine via lower manufacturing costs leading to excess supply. On the other hand, consumers lose indirectly by decreasing the number of new drugs to come to market, caused by a decreased incentive to discover, and seek approval of, new drugs.

It is important to note that in order to receive market exclusivity in a particular country; one must apply for, and receive patent protection with that country's Intellectual Property office, or its equivalent.[135] One study showed that there was nothing in terms of patent protection preventing the distribution of anti-retrovirals in Africa (a principal type of drug used to ameliorate the effects of HIV/AIDS) as less than 25% of the total patents available had been filed.[136] PhRMA took this further when surveying its members, finding that for drugs used in tuberculosis, malaria, trypanosomiasis, and enteric diseases also have poor, or no, patent coverage in Africa.[137]

The Generic Pharmaceutical Argument

The dilemma of awarding profits to proprietors of patents is the cost to immediate public health.[138] More specifically, within the scope of the generic production argument is the case that "intellectual property protection for pharmaceuticals may maintain the uneven direction of product research and development, by limiting the type of drug therapies available to treat disease among the poor."[139] The price inflation mechanism of patented pharmaceuticals is the most obvious of these challenges, yet the generic drug (anti-patent) argument extends deeper:

> *Patents impede the progress in technology by precluding other firms from cross-learning and building on the original innovation. Patents produce a loss or 'dead-weight burden' insofar as the benefits of the new knowledge to society would have been greater in the absence a patent regime, and thus reduce the capacity for other firms to exploit the knowledge on a competitive basis.*[140]

Who profits from such a constriction of market competition? Very clearly the pharmaceutical corporation involved in R&D with responsibility to its shareholders, benefit.[141] On deeper inspection "the benefits of IPR [Intellectual Property Rights] tend to go to the rich rather than the poor countries, the latter being net importers of technology."[142] In relative terms of profits "the country with the most to gain from TRIPS is the biggest (economy) of them all-the United States, as the net incomes earned from [United States'] patents in foreign markets is considerable."[143] Countries receiving significant return from patents often seek to expand patent protection through international policy bodies as well as national trade policies such as the United States' "'Special 301' provisions of the 1974

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[132] Canada's Research Based Pharmaceutical Companies. (2002). *Fact Sheet: The Difference Between Brand-Name Medicines and Generic Drugs.* Toronto, Ontario: Author.
[133] *Ibid*.
[134] Hughes, James W., Moore, Michael J., & Snyder, Edward A. (2002). *"Napsterizing" pharmaceuticals: access, innovation, and consumer welfare*. Cambridge, MA: National Bureau of Economic Research.
[135] Wiles & Wiles, *supra*, note 109.
[136] Attaran, Amir, & Gillespie-White, Lee. (2001, October). Do patents for antiretroviral drugs constrain access to AIDS treatment in Africa? *Journal of the American Medical Association*, 286, 1886-92.
[137] Pharmaceutical Research and Manufacturers of America, *supra*, note 98.
[138] Cohen & Illingworth, *supra*, note 106, p. 31.
[139] *Ibid.*
[140] *Ibid.*, p. 32.
[141] *Ibid.*, p. 28.
[142] Kobori, Shinzo. (May 2002). TRIPS and the primacy of public health. *Asia-Pacific Review*, 9, p. 12.
[143] *Ibid.*

Trade Act, as amended" threatening "to close its domestic market to countries who did not comply with minimum intellectual property standards."[144]

That certain groups or countries derive benefits from patent harmonization does not discredit the claims that patents are cumulatively a positive for innovation. In fact, among patent benefactors and supporters the recovery of profits from R&D is openly admitted and celebrated. Countering the economics based conclusion that deriving monopolistic profits provided "incentive for research and development," those in the generics camp posit "that the entrenched patent monopolist has weaker incentives than a 'would-be' entry firm to initiate an R&D programme that would produce substitutes, even superior quality ones, than for goods, which were already profit-generating."[145] If this is the case, patents in pharmaceuticals are responsible for "sub-optimal outcomes for social welfare."[146]

National Action

Various countries around the world have attempted to balance the arguments of both those lobbying for patent protection and generic access. The Organization for Economic Co-operation and Development (OECD), composed almost exclusively of advanced industrial nations, conducted a policy review entitled *Patents and Innovation: Trends and Policy Challenges*.[147] The report shows "strengthening of the patent systems in the European Union, Japan, and the United States" in "ability of the patent holders to protect and enforce their rights."[148] In the extraterritorial approach, the previously noted "Special 301" of the United States, domestic legislation extends the power to enforce rights internationally.[149]

Not all OECD members agree with this approach. Bolar provisions adopted in Canada, one of the original members of the OECD, allow a generic manufacturer to begin its process of research and development on a brand-name before the patent expires.[150] The EU challenged these provisions, suggesting that they violated current international law, but lost its case in 2000.[151] Although the research needed to copy a drug is less rigorous than the process to create one, the time period before expiry when a generic manufacturer can develop its own brand-name equivalent could take up to twelve years – over half of the length of the patent.[152] The inconsistency of each country's application of these provisions was a potential source of conflict in the expansion of the European Union this past year.[153]

Outside of the OECD, the public health concerns will promote great tension between countries facing epidemics, and those possessing the patents of viable drug treatments. While this tension is unfortunately expected among least-developed counties, two prime cases involve Brazil and South Africa.[154] These nations are considered by most standards to be newly developed and both nations face a rising AIDS epidemic.[155] In response, Brazil attempted to enact provisions in its laws, with threats "to compulsory license Nelfinavir, the cocktail drug used by over 25 percent of AIDS patients in Brazil."[156] South Africa went further and allowed "the abrogation of all patent rights for

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[144] *Ibid.*
[145] Cohen & Illingworth, *supra*, note 106, p. 32.
[146] *Ibid.*
[147] The Organization for Economic Co-operation and Development. (2004). *Patents and innovation: trends and policy challenges*. Paris: Author, p. 7-8.
[148] *Ibid.,* p. 7.
[149] Kobori, *supra*, note 142, p. 32.
[150] The Organization for Economic Co-operation and Development, *supra*, note 147.; The Canadian Generic Pharmaceutical Association. (2004). *Canada's bolar provisions*. Retrieved July 12, 2004, from http://www.cdma-acfpp.org/en/issues_international/bolar_provisions.html
[151] Milmo, Sean. (2000, February). EU to adopt bolar provisions in a victory for generic makers. *Chemical Market Reporter*, 257, p. 6-7.
[152] The Association of the British Pharmaceutical Industry, *ABPI Annual Review, supra*, note 131.
[153] Stolate, Nigel. (2003). EU enlargement, the Bolar exemption, and parallel imports: The consequences for market exclusivity. *International Journal of Medical Marketing,* 3, p. 241.
[154] Kobori, *supra*, note 142, p. 17.
[155] *Ibid.*
[156] *Ibid.*

pharmaceutical products."[157] In both cases, the companies involved first sought injunction and international action to stop the infringements only to relax the absolute hold on patent rights.[158]

International Action

Prima facie, the finger pointing between research-based and generic drug manufacturers will continue for some time. Other individuals and groups have found ways to attempt to appease both parties, while executing the goal of all – using pharmaceutical products to heal and/or relieve the sick. These ideas most definitely find the "third way" – a task that many countries are attempting to discover currently.

Again, the basis for the rationale behind patent protection of pharmaceuticals is to ensure that companies are able to recoup all of the expensive research and development costs paid for up-front. One professor suggests an increase in government intervention – not through additional patent regulations, but rather tying incentives to useful research and development.[159] One difficulty in this proposal, however, is the lack of motivation to perform research in unknown areas that may have the potential to provide a significant area of further study.

While it is clear that the price differentiation of pharmaceuticals allow generic drugs, in the immediate, to be more affordable, this matters little to those without even the most basic purchasing power. In the least developed areas of the globe, efforts to distribute medications fall to donor States, joint efforts through IGOs such as the WHO and the ever-expanding numbers of NGOs. As an example, Rotary International has been lauded for its efforts combating polio through the purchase and distribution of vaccinations in poor regions of the world, activities that have aggressively resumed in Nigeria.[160] Indeed a vast array of NGOs including Médecins sans Frontières, OXFAM International, CARE International and International Federation of Red Cross and Red Crescent Societies, have aligned to counter not only polio, but HIV/AIDS and other infectious disease by treatment, involving pharmaceuticals, and prevention whenever possible. Other NGOs have served as advocates and watch dogs for international health care issues, seeking to aid and direct better treatment.

Pharmaceutical companies have attempted to put products into the hands of those who need it by collaborating with these NGOs and charitable organizations to help distribute brand-name drugs.[161] For example, Merck works with the Bill Gates Foundation in donating medication to fight river blindness.[162] In regards to HIV/AIDS drugs, Pfizer, donated drugs to the least-developed nations in Africa.[163] However, members of Médecins sans Frontières express concern that while the donation mechanism helps some patients, it inhibits the ability to form a long-term strategy to deal with these epidemics because of the nature of the donations involving numerous covenants and tax incentives.[164]

A number of international resolutions have been proposed to conclude the conflict between the need and desire for innovation with the role of generic drugs in providing affordability. Two scholars in the field of bioethics, Jillian Clare Cohen and Patricia Illingworth, considered four such options:

> *(1) intensified loans or grants to client states for the purchase of patented medicines; (2) the cancellation of debt and the use of these 'extra' financial resources for pharmaceuticals currently under patent; (3) the purchase of patents from the research-based pharmaceutical industry and*

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[157] *Ibid.*
[158] *Ibid.*
[159] Hollis, Aidan. (2004). *An efficient reward system for pharmaceutical innovation.* Retrieved July 10, 2004, from http://econ.ucalgary.ca/hollis.htm
[160] Rotary International. (2004). *Vaccinators target 13 million children in northern Nigeria*. Retrieved September 20, 2004, from http://www.rotary.org/newsroom/main/news03.html
[161] The Association of the British Pharmaceutical Industry. (2002). *Providing the developing world medicines*. Whitehall: Author.
[162] *Ibid.*
[163] Pfizer. (2004). *The Diflucan® Partnership Programme.* Retrieved August 10, 2004, from http://www.diflucanpartnership.org/en/welcome/
[164] Guillioux, Alain, & Moon, Suerie. (2000). *Hidden price tags: disease-specific drug donations: costs and alternatives.* Geneva: Médecins sans Frontières.

the licensing of production of the patented drugs to generic drug firms in client states (a split-TRIPS model); (4) the promotion of a tiered pharmaceutical pricing (equity-pricing) system.[165]

By their own admission, the options are "imperfect, entailing trade-offs, either for the local and international pharmaceutical industry or for developing States."[166] The challenge for any solution put forward this year will be the trade-offs, and it is exactly to face this challenge that bodies like WHO exist.

Conclusion

The topic of generic drugs yields some unavoidably simple conclusions. With almost absolute certainty, benefit maximizing human beings, faced with two drugs of identical properties, where one drug is cheaper than the other, will choose the cheaper drug. Innovative research is expensive and will continue to be. Generic research is less expensive, and will continue to be. Generic drugs will always be produced at a lower cost, and firms producing generics will be able to make a profit while driving the innovative firms from the market. In order to avoid this scenario, nations and respective IGOs erect barriers known as patents. Patents inflate the price on "new" drugs by creating a temporary monopoly for a given product.

The topic of generic drugs also yields some unavoidably complex questions. Without a panacea answer, the debate between innovative and generic pharmaceutical production is one of opportunity costs. Is the immediate concern of society, to provide all the sick with medicine, outweighed by the promise of innovation? Opportunity costs involve a complex assessment of future potentialities, as compared to often-unknown returns in the present. In this case, however, a single individual or even a single State does not make the decision over costs. Every State must assess the demands of its population, and for some, the demand of pharmaceutical producers.

As an international body the WHO serves as a forum to raise, discuss and where possible resolve concerns of States looking at very different domestic circumstances. Is a change to patent law the only viable solution? Perhaps not; and most certainly a change in patent law is not satisfactory alone. The WHO is not called upon to be preoccupied with the augmentation or diminution of intellectual property protections, rather to consider the range of options that exist to better match present and future demands for pharmaceuticals.

In the end, the goal of the WHO must be to take a high-cost, research-intensive medicine, and use it to treat the sick in least-developed countries while at the same time allowing innovation to continue by rewarding successful research. As mentioned previously, countries and trade agreements attempt to allow for special exemptions for generic producers to supply essential medicines to those who cannot afford brand-name pharmaceuticals under patent protection, yet of the WHO's essential medicine list, very few of these are under patent exclusivity. This area is one that can utilize our world's increase in globalization to help those in need. As stewards for your country, we look forward to your leadership and vision in creating WHO policy and direction on the role of generic drugs in society.

Therefore, there are several questions you should consider when you begin your research. To what extent should the WHO aid in the distribution of generic pharmaceuticals? How can the WHO influence the WTO and NGOs in improving the access of the needy to essential medicines? Has your country passed legislation to bring its policies in line with TRIPS? If this is so, are the ideas suitable for global implementation via the WHO?

[165] Cohen & Illingworth, *supra*, note 106, p. 34.
[166] *Ibid.*

III. Resource Allocation for HIV/AIDS: Prevention Versus Treatment

> *On current trends, AIDS will kill tens of millions of people over the next 20 years. But this need not happen. We know prevention works. We know that HIV treatment and care work. The global AIDS response is poised to enter a new era: where leadership and commitment are at long last matched with the resources needed to get on with the job. Investment in AIDS will be repaid a thousand-fold in lives saved and communities held together.*[167]

When HIV/AIDS first emerged as a disease over 20 years ago, few people could have predicted how the epidemic would evolve, and fewer still could have described with any certainty the best ways of combating it. Now, in the year 2004, it is known from experience that AIDS can devastate whole regions, knock decades off national development, widen the gulf between rich and poor nations and push already-stigmatized groups closer to the margins of society. HIV/AIDS shows no discrimination, either geographically or demographically.

Today, over 40 million people live with HIV, the virus that causes AIDS, most of whom will die in the next ten years.[168] Over 30 million already have, including, around 5 million children.[169] It is well known that the disease hits countries in sub-Saharan Africa particularly hard, with over two-thirds of the people living with the disease residing there.[170] The epidemic in Africa is a generalized one, meaning, it effects the general population, rather than specific groups f population.[171] In Botswana alone, 37.5% of adults carry the virus.[172] South Africa has the highest number of adults living with HIV/AIDS.[173] Their infection rates have been dropping in recent years due to prevention programs implemented by the government.[174] The same is true in Uganda where infection rates dropped from 14% to 5%.[175] At the same time, though, the consequences of the disease are still felt.

However, in Eastern Europe and Central Asia, they have not been so lucky. The infection rates in those areas are on the rise.[176] It is worth pointing out that, in countries that do not exercise proper syringe sterilization and disposal protocols, the promulgation of infection will continue. This is especially true of the countries in Eastern Europe where the HIV epidemics are still developing and have so far spared some cities and sub-populations. In the Russian Federation, a new outbreak of HIV among injecting drug users in the Moscow region in 1999, resulted in the reporting of more than three times as many new cases in that year as in all the previous years combined.[177] Eastern Europe and Central Asia have not been so lucky. The infection rates in those areas are on the rise. In Europe, syringe drug use accounted for 10% of the HIV/AIDS cases, while in North America it was responsible for 25% of the cases.[178] It is worth pointing out that,

> *In any country with unsafe drug-injecting practices, a fresh outbreak of HIV is liable to occur at any time. This is especially true of the countries in Eastern Europe where the HIV epidemics are still young and have so far spared some cities and sub-populations. In the Russian Federation, a new outbreak of HIV among injecting drug users in the Moscow region in 1999, resulted in the reporting of more than three times as many new cases in that year as in all the previous years combined.*[179]

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[167] Piot, Dr. Peter. (2003). *One on one with Dr. Peter Piot.* Retrieved July 17, 2004, from http://www.tpan.com/publications/positively_aware/mar_apr_03/one_on_one_piot.html
[168] UNAIDS. (2004). *2004 Report on the Global AIDS Epidemic.* UNAIDS. New York: UNAIDS, p. 10.
[169] *Ibid.*
[170] *Ibid.*
[171] *Ibid.*
[172] Avert.org. (2004). *AIDS around the world.* Retrieved August 10, 2004, from http://www.avert.org/aroundworld.htm
[173] *Ibid.*
[174] *Ibid.*
[175] *Ibid.*
[176] *Ibid.*
[177] *Ibid.*
[178] UNAIDS, *supra,* note 168.
[179] *Ibid.*

Asia's cases result primarily from syringe drug users, men who have sex with men, and sex workers.[180] National adult prevalence is still under 1% in the majority of this region's countries.[181] That figure, however, can be misleading. Several countries in the region are so large and populous that the attention is only drawn to major urban areas, which may obscure serious epidemics in some smaller provinces and States. More importantly, total population is so large, that percentages mean little. Although national adult HIV prevalence in India, for example, is below 1%, five States have an estimated prevalence of over 1% among adults.[182] In real terms, India has an HIV infected population is the largest outside of South Africa.[183]

In Oceania, transmission rates remain relatively low. Australia has recently seen a rise after a long-term decline. More that 80% of those are through homosexual contact, and 3.4% through injection drug use, and 8.5% through heterosexual contact.[184] Papua New Guinea has the highest prevalence in the region. In the islands, though the rate of HIV/AIDS is relatively low, transmission rates for other sexually transmitted diseases (STDs) remains relatively high. "In Vanuatu, pregnant women have chronically high levels of some sexually transmitted infections: 28% have *Chlamydia* and 22% have *Trichomonas* infection. Some 6% of pregnant women are infected with gonorrhea, and 13% with syphilis. About 40% of the women had more than one sexually transmitted infection. Similarly, in Samoa, 31% of pregnant women had *Chlamydia* and 21% had *Trichomonas* infection. Overall, 43% of pregnant women had at least one sexually transmitted infection."[185] This proves that the potential for high HIV/AIDS transmission rates matches those for other STDs.

Latin America sees high prevalence rates in high-risk groups, injection drug users, and men who have sex with men. However, low national rates disguise some high population rates. As the global epidemic report states, For example, in Brazil—the most populous country in the region, and home to more than one in four of all those living with HIV—national prevalence is well below 1%. However, infection levels above 60% have been reported among injecting drug users in some cities.[186]

The Caribbean rates are high largely due to prostitution. The Bahamas, Haiti, and Trinidad and Tobago all have prevalence rates well above 3% of the total population. To demonstrate the effectiveness of prevention campaigns,

> *Haiti shares the island of Hispaniola with the Dominican Republic, which also has a serious HIV epidemic. However, in the Dominican Republic, previously high prevalence has declined, due to effective prevention efforts that encouraged people to reduce the number of sexual partners and increase condom use. Over 50% of males aged 15–29 used a condom with a non-cohabiting partner. In the capital, Santo Domingo, prevalence among pregnant women declined from around 3% in 1995 to below 1% at the end of 2003. But high levels are still reported elsewhere, and range from under 1% to nearly 5%. In 2000, HIV prevalence among female sex workers ranged from 4.5% in the eastern province tourist centre of La Romana, to 12.4% in the southern province of Bani.*[187]

In the wealthier nations of North America and Western Europe, an estimated 1.6 million people live with HIV/AIDS. However, they have access to the antiretroviral drugs that mean they can live relatively healthy lives. In the United States, deaths due to AIDS have continued to decline because people have broad access to antiretroviral therapy. There were 16,371 reported deaths in 2002, down from 19,005 in 1998, whereas in Western Europe, the number of reported deaths among AIDS patients also continued to decline, from 3,373 in 2001 to 3,101 in 2002.[188]

More frightening figures come from Pakistan. They are not in the form of transmission rates though, but rather in public knowledge. A 2001 study reported very low transmission rates, and an estimated adult HIV prevalence of

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[180] *Ibid.*
[181] *Ibid.*
[182] Avert.org, *supra,* note 172.
[183] *Ibid.*
[184] *Ibid.*
[185] *Ibid.*
[186] *Ibid.*
[187] *Ibid.*
[188] *Ibid.*

0.1%. However, a behavioral survey in the region of Quetta found a high proportion of respondents used un-sterile injecting equipment, many had sex with sex workers, few had heard of HIV or AIDS, and even fewer used a condom.[189]

With HIV/AIDS the fastest growing threat to development today, this also brings about the possibility that there will be national and regional insecurity.[190] "This was recognized by the United Nations Security Council in January 2000."[191] "What sets the disease apart form other epidemics is the speed of its spread and the extent of its devastation."[192] The number of people living with AIDS is equally important to the potential number that may become infected. Specifically, this topic is meant to discuss the allocation of financial, human, and physical resources to prevent HIV/AIDS. The committee is not meant to discuss treatment options for those already stricken by the disease. Ability to track efforts of treatment and their effectiveness are integral to future planning to treat the disease. The purpose here is a comprehensive discussion on where money is most wisely spent, on prevention or treatment.

The problem with the accessing prevention or treatment programs can be generally classified into six areas: financial hurdles; physical infrastructure barriers; military, social and political issues; damaging economic policies; and informational gaps.[193] However, the most important of these aspects is the issue of the financial difficulties in Least Developing Countries. Because the epidemic is worst felt in the poorer developing countries where accessing medicines, health care and prevention programs are most difficult to access, the poorest of LDCs (some of which have a per capita income of less than $1 per day), are barely able to provide health care that can support their population.[194] "As a result, it is vital that international and bilateral donors boost their support to LDCs in order to provide for the improvement of either their prevention or their treatment program."[195] "Experts in the field have estimated that over $10 billion annually is needed in addition to the [current level of pharmaceutical resources to] fight AIDS alone."[196] "Furthermore, the new Global Fund for AIDS, Tuberculosis, and Malaria could become an important facilitator in building up the national healthcare capacities of poor countries if used effectively and run efficiently."[197] Many countries do not have resources available to provide even rudimentary health care.[198]

Economic policy options constitute additional elements of difficulty. "Overall, economic policy implementation can cause serious short-term and long-term barriers to accessing health care and pharmaceuticals."[199] Economic protectionism is one such barrier that can be considered damaging to the access of healthcare, since a State may create networks of non-competitive distribution that cannot handle the supply needed to support the population.[200]

The Debate

The number of people living with AIDS is equal in import to the potential number that may become infected. Specifically, this topic is meant to discuss the allocation of financial, human, and physical resources to prevent HIV/AIDS, and compare it to resources available for treatment. The committee is not meant to discuss treatment options for those already stricken by the disease. Antiretroviral access will keep those stricken by the disease alive longer with a better quality of life. Ability to track efforts of treatment and their effectiveness are integral to future planning to treat the disease.

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[189] UNAIDS, *supra,* note 168.
[190] World Health Organization. (2003). *WHO and HIV/AIDS.* Retrieved October 1, 2004, from http://www.who.int/hiv/aboutdept/en/
[191] *Ibid.*
[192] *Ibid.*
[193] European Federation of Pharmaceutical Industries and Associations. (2003). *Access to Medicines: The Right Policy Prescriptions.* Retrieved July 12, 2003, from http://www.efpia.org/4_pos/access/policyprescriptions.pdf, p. 0.
[194] *Ibid.*; UN Chronicle. (2003). *Pharmaceuticals: Improving Equity of Access to Medicines.* Retrieved July 8, 2003, from http://www.un.org/Pubs/chronicle/2003/issue2/0203p12.html
[195] *Ibid.*
[196] *Ibid.*
[197] *Ibid.*
[198] Kuesters, Gabriele. (1999). *The Problem of Access to Pharmaceuticals.* Retrieved June 23, 2003, from http://www.washington.edu/wto/issues/pharmaceuticals.html
[199] *Ibid.*
[200] Network. (2002). *The Durban AIDS Conference & Beyond: The Challenge of Partnership in the Global Fight against AIDS.* Retrieved July 11, 2003, from http://www.earthsummit2002.org/es/newsletter/Issue%204.rtf

Here, however, the WHO is asking the hard question of prevent the disease or treat those that already have it. Ideally, both would have precisely the amount of resources needed. How can those needs be met? The purpose here is a comprehensive discussion on where money is most wisely spent, on prevention or treatment, and the distribution between the two. The purpose of this debate is to address the unintended consequences of seeming benevolent actions.

Creating Successful Prevention Campaigns

Some States have already begun successful prevention campaigns. The United Nations Joint Campaign, UNAIDS, has identified several key aspects of successful prevention campaigns. These include national and community leadership, cross-sector approaches, mass media packets of targeted information to influence behavior change, reduction of stigma and discrimination of those living with HIV/AIDS, and focused energy on prevention behaviors.

We know how HIV/AIDS is spread.[201] There remains a possibility to receive the virus through blood transfusion. Though the odds of this are slim with blood supply testing, it remains a real risk.[202] There remains a possibility when improper procedures are followed of accidental exposure. Mother to child transmission remains very high without proper antiretroviral treatment (a combination of treatment versus prevention concern).[203] The most common transmission method as stated earlier, is intravenous drug use and unprotected sexual contact, both heterosexual and homosexual.[204]

Prevention programs focus on changing the behaviors of all these methods of transmission. The UNAIDS working group on HIV/AIDS prevention has suggested a number of programs. A number of broad-based community programs have been effective through Behavior Change Programs , which change habits including visiting professional sex workers, delaying the onset of sexual activity, encouraging mutual monogamy, and consistent and correct condom use.[205] STD control is also vital as the presence of other STDs increases the risk of HIV transmission by two to five times. Controlling other STDs assist in both the prevention and treatment of HIV/AIDS. Voluntary Counseling and Testing (VCT) is also a successful method as those who are aware are less likely to infect others. A recent study in Kenya, Tanzania, and Trinidad demonstrated that knowledge of infection was more effective in reducing risk factors than simply passing out pamphlets.

Targeting at risk groups is another method of prevention. For example, harm reduction programs for intravenous drug users like needle and syringe exchange programs have been useful in limiting outbreaks amongst those populations. Reducing substance addiction through peer outreach has proven successful in reducing the spread of infection. Reducing mother-to child transmission helps two people, the mother, and the child. By using anti-retroviral medications on both the mother and newborn, through VCT, and counseling for breastfeeding alternatives mother to child transmission can be reduced by 50%.[206]

Simple practices such as blood safety can have a huge impact. By implementing basic policies of creating a national blood supply, using low risk donors, routine screening of donations, and reduction of unnecessary transfusions, transmission via blood transfusion can be essentially eliminated. Infection control in heath care settings and adherence to universals precautions, such as proper disposal of biohazard material, and use of gloves, can significantly reduce transmission.[207]

Policy makers have a responsibility as well. Structural interventions such as policy reforms that change the environment, such as universal primary and secondary education, mandating use of condoms in brothels, and legalization of the sale of syringes without a prescription, all reduce risk. The socio-economic power of women and young children also needs to be considered in these types of programs. Programs for people with HIV/AIDS, who

[201] Global HIV Prevention Working Group. (2003, May). *Access to HIV Prevention: Closing the Gap.* New York: UNAIDS, p. 1-6.
[202] *Ibid.*
[203] *Ibid.*
[204] *Ibid.*
[205] *Ibid.*
[206] *Ibid.*
[207] *Ibid.*

are often the forgotten population, prevention programs should include them in order to avoid inadvertent exposure to the virus.[208]

The ABC slogan — abstain, be faithful, and consistently use a condom — is a consistent theme in many HIV/AIDS prevention campaigns.[209] ABC becomes an easy way for individuals to remember the key components for HIV/AIDS prevention. Abstinence is self-explanatory. Do not have sex outside of committed relationships. The "be faithful" aim is only successful if it incorporates both partners, a difficult situation to control in certain cultures. In many programs, condom use is taught and condoms are provided. However, certain groups, particularly women, are not empowered to control the abstinence and condom use.[210]

Women are culturally and physiologically more susceptible to HIV transmission. A woman who contracts HIV/AIDS and is the head of her household puts the entire family at a higher risk. The loss of income could potentially force children, primarily girls, to leave what available schooling there is to care for those at home.[211] Children may end up caring for relatives, without basic precautions, which creates another potential method of transmission through exposure to bodily fluids.[212] Community stigma further aggravates the situation.

The most successful prevention campaigns target both men and women, are equally available across socio-economic boundaries, and incorporate the items listed above.[213] WHO has the goal of integrating gender into all of its programs. They recognize there is a technical/substantive and a structural aspect to integrating gender into HIV/AIDS programs. The technical/substantive will be inadequate without structural change.[214] Some technical aspects that might be used include addressing a continuum of behaviors from risky to empowering, which may be helpful for women to recognize what behaviors they might change. In these programs, however, it is all too easy to slip into stereotypes where women appear as victims, and men as sexual predators. There is far more to the story and that should be integrated into these programs.[215] There is a variety of appropriate interventions based on the circumstances of the program.

Creating Successful Treatment Programs

Prevention is part of the equation. Equally important is the creation of treatment campaigns for those individuals already infected. Anti-retroviral (ARV) drugs have the potential to dramatically improve the health and extend the lives of some people with HIV/AIDS. Yet the high cost and demanding clinical requirements of these drugs put them out of reach of the vast majority of people with HIV.

This problem is especially acute in developing countries, where HIV infection levels are high and public resources are extremely scarce.[216] In *Cost and Financing Aspects of Providing Anti-Retroviral Therapy,* Katherine Floyd and Charles Gilks conclude that in most developing countries, ARVs are at present neither affordable nor cost-effective. For example, providing triple combination therapy to all people with HIV in sub-Saharan Africa could consume between 9% and 67% of total GDP.[217] The objectives of treatment programs include:

- Scaling up of antiretroviral treatment programs, with the objective of 'universal access', i.e. that all those who need it will have access to it;

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[208] *Ibid.*
[209] World AIDS Campaign. (2004). *Women, Girls, HIV and AIDS: Strategy Notes.* New York: UNAIDS, p. 7.
[210] *Ibid.*
[211] Kristofferesson, Ulf. (2000). *HIV/AIDS as a human security issue: a gender perspective*. (EGM/HIV-AIDS/2000/WP 2). New York: UNAIDS.
[212] Obaso, Milicent. (2001, May 8). Plague upon Plague: AIDS and Violent Conflict in Africa. [Transcript of speech]. United States Institute of Peace.
[213] Shaw, Amelia. (2004, July 14). Personal Communication.
[214] Department of Gender and Women's Health. (2003). *Integrating Gender into HIV/AIDS programs.* New York: World Health Organization, p. 28.
[215] *Ibid.*
[216] World Bank. (2004). *Anti-Retroviral (ARV) Treatment in Developing Countries: Questions of Economics, Equity and Ethic.* Retrieved September 3, 2004, from http://www.worldbank.org/aids-econ/arv/
[217] *Ibid.*

- Standardization and simplification of ARV regimens to support the efficient implementation of treatment programs in resource-limited settings;
- Ensuring that ARV treatment programs are based on scientific evidence, in order to avoid the use of substandard treatment protocols, which compromise the treatment outcome of individual clients and create the potential for emergence of drug resistant virus. However, it is also important to consider the realities in terms of availability of human resources, health system infrastructure, and the socio-economic context, in order to elaborate clear and realistic recommendations.[218]

WHO has developed the 3 by 5 initiative. This program works to assist 3 million individuals living with HIV/AIDS using antiretroviral drugs by 2005. Estimated costs of the program range between 4-5 billion. They advocate this being done through five pillars. The first pillar is to develop global leadership, alliances, and advocacy. First to advocate for funding, together with UNAIDS and other partners, raising money for drugs, training and strengthening country health services, commit hundreds of personnel at the country level to the 3 by 5, and publish, with UNAIDS, ethical guidelines promoting equity and human rights in ART. The second pillar is to provide urgent, sustained country support.[219] The goal is to provide emergency response teams for high burden countries, as requested by the country, to assess need and help define 3 by 5 targets, build political will for the 3 by 5 initiative, and work with national governments to strengthen health systems to respond to the crisis. In real terms this means to start the emergency expansion of training with a goal to train 100 thousand professional and lay staff and to strengthen physical resources like laboratories and testing equipment.[220]

The third pillar, simplify standardized tools and assure quality, will establish uniform standards and simplified tools to track ARV. It will work to identify multiple entry points for treatment, including TB and reproductive health programs, NGO's, faith-based organizations and other potential providers of antiretroviral therapy, and simplify Treatment Regimes and Guidelines for antiretroviral therapy.[221] Information on regulatory issues prices and sources can be better disseminated by creating an effective, reliable supply of medicines and diagnostics, and establishing an AIDS Medicines and Diagnostics Service to assist countries to secure uninterrupted access to appropriately priced, quality, antiretrovirals and diagnostics. This is the fourth pillar. This will also assist in disseminating information on legal and regulatory issues, prices, and sources, developing, and distributing technical tools for supply and demand forecasting, procurement, quantification, and supply-chain management. Additionally, the 3 by 5 initiative will continue the pre-qualification of manufacturers and products assist buyers to obtain best prices for individual or pooled demand, and arrange for targeted technical and operational support to countries.[222]

The fifth and final pillar is to rapidly identify and reapply new knowledge and successes. New networks are created through establishing global communication systems to share progress and experience. By documenting early successes, partners can receive up to date information on what is working elsewhere, to see if it will work for them. This fifth pillar will also help to develop and carry out an appropriate operational research agenda.[223]

These pillars will help to distribute appropriate treatment where it is needed most. However, simply paying, or assisting, in treatment may have unintended consequences. One World Bank publication, *Confronting AIDS: Public Priorities in a Global Epidemic* details the impact of HIV/AIDS on the health sector, mostly from a public economics perspective. The publication points out that providing increased public funding for health care and/or providing special subsidies for the treatment of HIV/AIDS may have unintended consequences that exacerbate the impact of the epidemic on the health sector, making if more difficult for everybody to obtain care. "Furthermore, it argues that larger public subsidies for ARV than for other serious adult illnesses, such as cancer and heart disease, are difficult to justify as (1) reducing the infectiousness of treated individuals, (2) insurance against catastrophic health events or (3) 'merit' goods for the poor. As an alternative, the chapter calls for increased efforts to eliminate

[218] World Health Organization. (2004). *Scaling up antiretroviral therapy in resource-limited settings: Treatment guidelines for a public health approach.* Retrieved September 3, 2004, from http://www.who.int/3by5/publications/documents/arv_guidelines/en/
[219] World Health Organization. (2004). *About 3 by 5 Strategy.* Retrieved September 3, 2004, from http://www.who.int/3by5/about/strategy/en/index.html
[220] *Ibid.*
[221] *Ibid.*
[222] *Ibid.*
[223] *Ibid.*

barriers to access of other, less expensive types of treatment that have the potential to greatly ease the suffering and extend the lives of people in developing countries with HIV/AIDS."[224] Should valuable resources be spent solely on less than effective methods of treatment?

Monitoring and Evaluation

Any successful program must come equipped with some monitoring and evaluation systems (M&E). Evaluation is a toolbox consisting of different tools meeting different needs. According to feedback from the UNAIDS-World Bank Workshop, Building a Sustainable M&E Technical Resource Network in Southern, and East Africa, evaluations do not present the ultimate truth about projects, but represent important opportunities for learning. The first challenge in evaluation is to identify the problems, which the evaluation should answer. Evaluation involves assessing the value of programs. It is more than description and requires a systematic approach - different from impressions. It is based on specific evaluation criteria and the application of social research standards.[225]

M&E should be considered integral from the beginning. What standards is the project to be held? What would the program like to achieve? This committee should also consider in its reporting what basic standards of M&E are important and achievable in projects related to HIV/AIDS, as it will determine the effective deployment of resources.

The Role of NGOs in the Fight Against HIV/AIDS

Civil society has taken on a major role in the fight against HIV/AIDS. However, there is no blueprint being enacted. Many see the agencies of the United Nations, and the World AIDS campaign, as potential mechanisms to ensure global participation in HIV/AIDS prevention and treatment.[226] However, the pendulum may swing too far into the global bracket, leaving local and national programs out to dry. This is the area where NGOs must take greater roles, using the tools provided by the international community.

Human Rights Watch runs a project linking HIV/AIDS prevention to human rights violations. The links between human rights and HIV/AIDS prevention are important to make. These include sexual violence and coercion faced by women and girls, stigmatization of men who have sex with men, abuses against sex workers and injecting drug users, and violations of right of young persons to information on HIV transmission.[227]

Additionally, Médecins sans Frontières is working on providing ARV treatment to those that would not have access to it. Their program in Uganda recently celebrated 2 years of providing free ARV. As Dr. Olaro, Medical Superintendent of Arua Regional Referral Hospital and the Arua Hospital AIDS Program, stated, "Although our program has improved the lives of more than a thousand patients and their families, we must be modest regarding our achievements, be aware of the important challenges that we face, and remind ourselves that over one million people have died in Uganda since the epidemic first appeared."[228]

In this committee delegates will be working with Action Aid, B'nai B'rith International, CARE International, Counterpart International, Global Alliance for Women's Heath, Human Rights Watch, International Council of Women, International Federation of Red Cross and Red Crescent Societies, Médecins sans Frontières, OXFAM International, Rotary International, The Population Council, Third World Network, World Assembly of Youth, and the World Council of Churches. Whether or not these organizations have active HIV/AIDS programs, each has a unique perspective to add to this debate.

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[224] Global HIV Prevention Working Group, *supra*, note 201.

[225] UNAIDS & World Bank. (2002). *UNAIDS-World Bank Workshop, Building a Sustainable M&E Technical Resource Network in Southern and East Africa*. Retrieved August 19, 2004, from http://www.unaids.org/html/pub/Topics/M-E/Technical_Resource_Network-Africa_en_doc.htm

[226] UNAIDS, *supra,* note 168.

[227] Human Rights Watch. (2004). *Program Overview.* Retrieved October 3, 2004, from http://www.hrw.org/doc/?t=hivaids&document_limit=0,2

[228] Médecins sans Frontières. (2004). 2 *Pills a Day: Treat HIV/AIDS Now!* Retrieved October 2, 2004, from http://www.doctorswithoutborders.org/pr/2004/07-29-2004.shtml

Conclusion

Everyday the battle is being fought against HIV/AIDS. Real results are being seen through valuable prevention and treatment campaigns. No one should question the importance of the public health debate. It is however necessary to evaluate resources allocation. The purpose of this topic is to explore where funding can most wisely be spent with finite resources, particularly in terms of donor relationships. What resources are available for prevention and treatment campaigns? How are those resources most efficiently allocated? How does this vary from State to State, region to region? How can equitable distribution be ensured? Does an ounce of prevention equals a pound of cure when lives are at stake?

Annotated Bibliography

General Sources

Brundtland, Dr. Gro Harlem. (2002, May 13). *Address to the Fifty-fifth World Health Assembly*. Retrieved July 26, 2004, from http://www.who.int/director-general/speeches/2002/english/20020513_addresstothe55WHA.html
Speeches made by leaders of organizations are instrumental tools for laying out policies of the organization. Dr. Harlem's speech in 2002 is an excellent example of how this mechanism is used to describe the directions in which the World Health Organization would head. This speech in particular reflects the importance of the organization.

Encarta On-line Encyclopedia. (1999, January). *History of the World Health Organization.* Retrieved July 26, 2004, from http://encarta.msn.com/encyclopedia_761579190/World_Health_Organization.html
The basics of the organization are outlined in this on-line encyclopedia. While useful for general information, such resources will not be able to provide the bulk of information for research. However, to receive a broad overview, encyclopedias serve as excellent starting points.

Pan-American Health Organization. (2004, August 11). *What is PAHO?* Retrieved August 11, 2004, from http://www.paho.org/english/paho/What-PAHO.htm
The Pan-American Health Organization is the oldest international organization. They have been focused on public health issues since its founding, and cooperate actively with the World Health Organization. PAHO will be an excellent alternative source of information.

World Health Organization. (1948). *Constitution of the World Health Organization.* Retrieved July 26, 2004, from http://policy.who.int/cgi-bin/om_isapi.dll?infobase=Basicdoc&softpage=Browse_Frame_Pg42
The Constitution is the basic document providing guidance for the mandate of the organization. It is the integral document of the organization and should be read prior to the conference. Delegates will want to have a copy with them at the conference.

World Health Organization. (n.d.). *Director General.* Retrieved July 26, 2004, from http://www.who.int/dg/lee/en/
The Director General's biographical information is provided on this Web site. The most important information has been provided for you here.

World Health Organization. (n.d.). *Governance.* Retrieved July 26, 2004, from http://www.who.int/governance/en/
The Web site here provides information on the general structure of how the organization is governed. It outlines the general structures of the organization and WHO's framework for operations.

World Health Organization. (n.d.). *History of WHO and International Cooperation in Public Health.* Retrieved July 26, 2004, from http://www.who.int/about/overview/en/
Cooperation in public health is one of the most important mechanisms in global institutions. Because of the importance of cross-border control and cooperation of disease transmission, which do not understand the political boundaries man has made, WHO has become a leader in that cooperation. This Web site details the history of cooperation in the field.

World Health Organization. (n.d.). *Mission Statement*. Retrieved July 26, 2004, from http://www.euro.who.int/observatory/About/20020521_6
The mission statement of any organization gives it the guidance towards its goals. It is essential to familiarize yourself with the mission statement. These are integral documents to the organization.

World Health Organization. (n.d.). *Rapid Overview.* Retrieved July 26, 2004, from http://www.who.int/whr/2003/overview/en/print.html
The rapid overview is a general Web site, which provides extensive information in a compact method. It is a good general starting point for WHO resources. However, general overviews should not be used as main sources of topic research.

World Health Organization. (n.d.). *Rules of Procedure.* Retrieved October 2, 2004, from http://policy.who.int/cgi-bin/om_isapi.dll?hitsperheading=on&infobase=basicdoc&record={127E}&softpage=Document42
These are the official rules of procedure for the WHO. These help set the ground rules for the conduct of business in Organization. These are not the rules that will be used at the simulation. Those are provided at the end of the background guide.

I. Economies of Scale: The Problems of Polio Eradication

Black, Kathryn. (1996). In the Shadow of Polio: A Personal and Social History. Indianapolis: Perseus Publishing.
This book is a memoir about a young girl's experience with her mother's polio. Ms. Black speaks eloquently of the real life concerns of living with and around polio. Her descriptions of the daily hardships provide a human face to this otherwise largely unknown.

Brody, Seymour. (1996). Drs. Jonas E. Salk and Albert Sabin Conquer Polio. *Jewish Heroes and Heroines in America.* Hollywood, FL: Florida Atlantic University Libraries. Retrieved September 8, 2004, from http://www.fau.edu/library/br118.htm
Mr. Brody explores the connection between Drs. Salk and Sabin. He explores their history and connections as major contributors to vaccine research. The connection of their religion is explored.

Brown University. (2004). *Vaccine Strategies.* Retrieved August 2, 2004, from http://www.brown.edu/Courses/Bio_160/Projects1999/polio/vac.html
The variance of IPV and OPV is great. The strongest vaccine is the combination of the two. However, it simply is not cost effective enough to use both simultaneously. This article explores those costing issues.

BBC News. (2001, April 3). *Polio Eradication Draws Closer.* Retrieved July 30, 2004, from http://news.bbc.co.uk/2/hi/health/1257691.stm
By describing the early efforts of the polio eradication campaign, the major hurdles of eliminating the remaining 1% of the poliovirus are outlined. The countries that still foster the virus are poverty stricken, suffering under the plight of famine and war.

Carter, Joanne. (2004). *Tuberculosis: Action Needed Now.* Retrieved September 27, 2004, from http://www.massiveeffort.org/html/cartereditorial.html
Ms. Carter explores the importance of the link between Tuberculosis (TB) and HIV/AIDS. It is usually not HIV/AIDS that kills an individual, but the weakening of the immune system makes them more susceptible to other diseases. The argument goes that fighting one disease does nothing without fighting the other.

Cincinnati Children's Hospital Medical Center. (2004). *Dr. Albert Sabin's Discovery of the Oral Polio Vaccine*. Retrieved July 30, 2004, from http://www.cincinnatichildrens.org/about/history/sabin.htm
Dr. Sabin developed the oral polio vaccine while at this hospital. This web site explains the history of the vaccines development. It is specifically used to endorse Sabin's role in the polio vaccine.

Dove, Allen. (1997, August). When Polio is Gone, Should We Still Vaccinate? Retrieved June 29, 2004, from http://cumicro2.cpmc.columbia.edu/PICO/Chapters/News897.html
Mr. Dove explores the all too important reasons of continuing the vaccination even after eradication of the disease. These include bioterrorism, accidental release, and vaccine stocks. He raises some interesting points for continued expenses.

Edejer, Tan-Torres, Baltussen, R., Adam, T., Hutubessy, R., Acharya, A., Evans, D. B., & Murray, C. J. L. (Eds.). (2003). *Making Choices in Health: WHO Guide to Cost-Effectiveness Analysis.* Retrieved September 28, 2004, from http://www3.who.int/whosis/cea/background_documents/pdf/guidelines.pdf
This report of the World Health Organization goes into in-depth analysis of appropriate cost-effectiveness analysis. It explores the methodology WHO uses to develop health intervention policies. It is an extremely technical, econometric resource, and should be used sparingly.

Fowler, Jonathan. (2004). Polio re-emerges in Sudan, Africa on the brink of massive outbreak. *Associate Press Wire.* Retrieved June 22, 2004, from URL http://www.irinnews.org/report.asp?ReportID=41819&SelectRegion=West_Africa&SelectCountry=WEST_AFRICA
This document written by Fowler gives an overview of the polio situation in Sudan.

Global Polio Eradication Initiative. (2003). *Estimated External Financial Resources Required, 2004-2008.* Geneva, Switzerland: World Health Organization.
The Estimated External Financial Resources Required report describes the potential resources necessary to eradicate fully polio by 2008. It is an invaluable resource for this particular topic

Global Polio Eradication Initiative. (2004). *National Immunization Days.* Retrieved July 30, 2004, from http://www.polioeradication.org/content/fixed/national.shtml
This web-site explains the finer points of the National Immunization Days. It explores their successes and failures. The piece describes their usefulness to the polio eradication efforts.

Lichtarowicz, Ania. (2004). 'Final push' against polio agreed. *BBC News: World Edition.* Retrieved August 2, 2004, from http://news.bbc.co.uk/2/hi/africa/3398503.stm
BBC News explores the recent reinvigoration of global efforts to eradicate polio. The six remaining States have built up the political will for the final push against the 1% of the disease. The BBC offers a unique analysis into what it will take in the remaining years.

No Author. (2004, August 1). Polio Vaccines Resume in Nigeria After a State's 11-Month Boycott. *The Washington Post.*
This news brief outlines the reinstatement of Nigeria's vaccination program in the Kano region where it had been stopped due to rumors of vaccine quality. The Nigerian government had stopped vaccinating due to rumors of contaminated vaccines. The rumors were disproved by independent laboratory investigation.

Okonek, Bonnie A. & Morganstein, Maybury and Linda. (Eds.). (2004). *Development of Polio Vaccines*. Access Excellence Classics Collection. Washington, DC: National Health Museum. Retrieved July 30, 2004, from http://www.accessexcellence.org/AE/AEC/CC/polio.html
As a series of articles, the Access Excellence Classics Collection provides a vast array of information on a variety of topics. This particular article delves into the development of the polio vaccine by Salk and Sabin. It thoroughly describes how the two scientists found the paths to the vaccine that they followed.

Partnerships for Health Reform. (2004). *Cost-Effective Strategies for Achieving Polio Eradication.* Washington, DC: Abt Associates.
The report created by the USAID funded Partners for Health Reform explores two case studies in Turkey and Cambodia for polio eradication. It serves as a useful document for placing strategy into context. The development community plays an important role in implementing donor programs.

Polio Eradication Initiative. (2004). *The History*. Retrieved October 2, 2004, from http://www.polioeradication.org/history.asp
The Global Polio Eradication Initiative traces the history of the initiative. This source includes a timeline of the disease, and eradication efforts. It provides even the earliest references to the disease.

Polio Eradication Initiative. (2004). *Polio Vaccines.* Retrieved July 30, 2004, from http://www.polioeradication.org/vaccines.asp
This webpage describes the various types of Polio vaccines. It talks about the OPV and IPV, as well as some facts about each. It also provides links to other webpages that discuss the advantages and disadvantages of each.

Polio Information Center On-line. (2004). *A Brief History of Polio*. Retrieved July 28, 2004, from http://microbiology.columbia.edu/pico/Chapters/History.html
This webpage give a chronological history of polio. It starts from the ancient times to modern day. It also provides various historical illustrations and links that can further discuss Polio.

Polio Information Center On-line. (2004). *Polio Epidemiology*. Retrieved July 28, 2004, from http://www.cumicro2.cpmc.columbia.edu/PICO/Chapters/Epidemiology.html
A brief, though, worthwhile, description of the transmission of the disease is presented in this article. You will also find the mechanisms for transmission and potential preventions.

Rotary International. (2004). *Polio Eradication Fundraising Campaign Information*. Retrieved October 2, 2004, from, http://www.rotary.org/foundation/polioplus/donate/information.html
Rotary International sponsors a major fundraising campaign with an amazing U.S. $80 million by June 2005. They have already surpassed this goal by U.S. $40 million. Clearly political will for providing resources is built.

Reuters News Wire. (2004). *Photo Album: Red Cross helps fight polio in Haiti.* Retrieved September 21, 2004, from http://www.alertnet.org/thenews/memphotoalbum/108333127690.htm
This article in the Reuters News Wire explores many different programs of polio eradication in Haiti. It is a good source for beginning to link the programs of international organizations together. The programs specifically listed were PAHO programs completed in conjunction with WHO.

Wikipedia. (2004). *Economies of Scale.* Retrieved September 30, 2004, from http://en.wikipedia.org/wiki/Economies_of_scale
Wikipedia, like all on-line encyclopedias, are a good source for general information. This particular page states some basic principles of economics that concern our topic here. Economies of scale in this topic refer to the use of resources to benefit the few rather than the many.

World Bank. (2003). *Financial Innovation Will Buy Polio Vaccine To Help Eradicate Polio Worldwide.* Retrieved August 2, 2004, from http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,contentMDK:20107918~menuPK:34463~pagePK:34370~piPK:34424~theSitePK:4607,00.html
The World Bank, in cooperation with the Bill and Melinda Gates Foundation and the United Nations Foundation has established a buy-down program for polio related loans. These innovative methods of financing will assist in filling the gap in funding required to eradicate polio. There are many ways to continue the eradication programs.

World Health Organization. (2004, January). *Global Action Plan for laboratory Containment of Wild Polio Viruses.* (WHO/V&B/03.11). Geneva: Author.
The Global Action Plan provides the necessary plan of action to prevent retransmission of the wild poliovirus from laboratory to community. This plan will prove integral to your research, as delegates explore the consequences of polio eradication. It describes the reality of the containment situation.

World Health Organization. (2004). *Global Programme On Evidence for Health Policy Improving Health System Performance.* Retrieved September 27, 2004, from, http://www3.who.int/whosis/cea/guide/guide.cfm?path=evidence,cea,cea_guide&language=english
As this source states, "Health systems have multiple goals, but the fundamental reason they exist is to improve health. Yet health systems with very similar levels of health expenditure per capita show wide variations in population health outcomes." The CHOICE program of the World Health Organization ensures that policy makers are making the best choice for the resources by providing cost-benefit analyses of disease related programs.

World Health Organization. (2004). *Polio Eradication: Now More Than Ever*. Retrieved September 8, 2004, from http://www.who.int/features/2004/polio/en/
The Polio Eradication Initiative is sponsored by the World Health Organization and is the primary proponent of polio eradication today. This web site effectively outlines the basics of polio eradication. It goes into the details of the programs, which mainly surrounds polio eradication days. There is a historic, one-time only opportunity to stop transmission of poliovirus. If the world seizes this opportunity and acts immediately, no child will ever again know the crippling effects of this devastating disease. The WHO espouses the importance of polio eradication.

II. The Role of Generic Pharmaceuticals in Society

Agreement on Trade-Related Aspects of Intellectual Property Rights, (opened for signature April 15, 1994), Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, 1869 U.N.T.S. 299.
The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement came into effect in concert with the World Trade Organization in 1995. It sets out a minimum standard of 20 years for patent protection. Of note, it vaguely describes the ability for countries to set guidelines as to the issuance of compulsory licenses (those in which a company may exploit a patent without consent of the patent holder).

The Association of the British Pharmaceutical Industry. (2003). *ABPI Annual Review.* London, England: Author.
A product of the collaboration of pharmaceutical firms in the UK, this source provides costs, statistics, and other information favorable to pharmaceutical innovation. Specifically reinforced is the position that recovered costs are returned to future research. This document will provide a good resource for the overall information on pharmaceutical information for comparisons.

The Association of the British Pharmaceutical Industry. (n.d.). *The development of medicines*. London, England: Author.
This source is a valuable source on the intense costs. It also includes timeframes (or lag) involved in the development of an innovative pharmaceutical. Of particular note is a chart on page 1 detailing the evolution of the drug from concept to market, and the costs involved in each step.

The Association of the British Pharmaceutical Industry. (2002). *Providing the developing world medicines*. Whitehall: Author.
As a collaboration of pharmaceutical firms in the UK, seeks to address the concerns of the developing world. This is in regards to access to vital medicine, without compromising the patent system. It also articulates, among other considerations, cooperation between pharmaceutical firms and NGOs in charitable distribution

Attaran, Amir, & Gillespie-White, Lee. (2001, October). Do patents for antiretroviral drugs constrain access to AIDS treatment in Africa? *Journal of the American Medical Association*, 286.
The authors ascertain, through a broad study of African nations and key pharmaceuticals that the scarcity of antiretroviral medication in Africa is not due to patent constraints. The authors attempt to discuss other likely causes of medicine scarcity. This includes issues such as poverty.

Canada's Research-Based Pharmaceutical Companies. (2002). *The difference between brand-name medicines and generic drugs*. Retrieved July 4, 2004, from http://www.canadapharma.org/Industry_Publications/Fact_Sheets/RxdCompAd_e.pdf
As a rather simple chart, this source shows the step-by-step comparison in cost and risk for innovative and generic drugs. The chart suggests the innovation to be significantly more costly, with higher associated risk.

Canada's Research Based Pharmaceutical Companies. (2002). *Fact Sheet: The Difference Between Brand-Name Medicines and Generic Drugs.* Toronto, Ontario: Author.
This is a basic one page sheet describing the difference between brand-name medicines and generic drugs. This can be useful in determining the different types of medicines that are being described in the paper above. It will also clarify further the terminology used in the paper.

The Canadian Generic Pharmaceutical Association. (2004). *Canada's Bolar provisions*. Retrieved July 12, 2004, from http://www.cdma-acfpp.org/en/issues_international/bolar_provisions.html
A unique pushback from generic producers allowing access to patented information in anticipation of the expiration of patents. This is so that generics can come to market sooner after the proprietary patent expires. This site discusses some of the justifications and advantages of the Bolar provisions.

Cohen, Jillian C., & Illingworth, Patricia. (2003, May). The dilemma of intellectual property rights for pharmaceuticals. *Developing World Bioethics*, 3.
A strong example of why peer reviewed sources should be included in your research. This article clearly lays out the terms of the TRIPS agreement, the agreement's impact on pharmaceuticals and how it can be applied be developing States. The article also looks at solutions for continuing challenges faced by developing nations and evaluates each of those probable solutions.

Guillioux, Alain, & Moon, Suerie. (2000). *Hidden price tags: disease-specific drug donations: costs and alternatives.* Geneva: Médecins Sans Frontières.
Report submitted to the NGO Medécins Sans Frontières. This report shows the long-term deficit to having specific donation methods supplement medicine in developing regions. The primary concerns, for the authors, revolve around long-term planning, and responsiveness.

Hollis, Aidan. (2004). *An efficient reward system for pharmaceutical innovation.* Retrieved July 10, 2004, from http://econ.ucalgary.ca/hollis.htm
This article attempts to reconcile the monopoly period of profits for an innovative firm with the corollary benefits to society. The purpose of this article would be to determine if a more "just" system of award could be worked out for the pharmaceutical industry. Also address why the patent system functions poorly.

Hughes, James W., Moore, Michael J., & Snyder, Edward A. (2002). *"Napsterizing" pharmaceuticals: access, innovation, and consumer welfare*. Cambridge, MA: National Bureau of Economic Research.
The article attempts to address the trade-offs between extending and reducing patent privileges. The authors do so by modeling a world without any patent protection. The paper can be access at: http://www.ftc.gov/os/comments/intelpropertycomments/snydermoorehughes.pdf

International Federation of Pharmaceutical Manufacturers Associations. (2002). *IFPMA issues: access to quality healthcare*. Retrieved July 14, 2004, from http://www.ifpma.org/Issues/issues_access.aspx
The associated body, the IFPMA, is clearly a source for the innovative pharmaceutical argument. As such this web page attempts to show how medical advances. The webpage also addresses the efforts of pharmaceutical companies, in collaboration with the public sector, advance access to quality healthcare.

International Federation of Pharmaceutical Manufacturers Associations. (2004). *IFPMA Member Associations.* Retrieved August 9, 2004, from http://www.ifpma.org/About_Us/about_mem_americas.aspx
This webpage describes the IFPMA Member Associations. It provides links to the various State level associations throughout the world. The page also provides links to other areas on the IFPMA Web site.

Kobori, Shinzo. (2002. May). TRIPS and the primacy of public health. *Asia-Pacific Review*, 9.
This is another good peer-reviewed article. It is a deep examination of the impact of intellectual property rights, through TRIPS, and the cost-benefit of TRIPS. This source provides ample research though a paradigm clearly oriented to the ultimate good of society, not individual firms.

Kong, Ying. (2004). The price premium of generic to brand-names and pharmaceutical price index. *Applied Economics*, 36.
Based in an advanced economics framework, this article is a comprehensive study of the comparatives for numerous name brand/ generic pairs. This article attempts to identify a coherent explanation of the idiosyncrasies of price premiums.

Mader, Ian. (2004, July 13). WHO Says World Has 'Failed' in AIDS Fight. *The Associated Press*.
Associated press reporting on the dire WHO status report on AIDS. Also including comments of CEO of Pfizer, Hank McKinnel, regarding patent rights and drug discoveries. This article is very helpful in gaining perspective on patent rights from the drug company perspective.

Milmo, Sean. (2000, February). EU to adopt Bolar provisions in a victory for generic makers. *Chemical Market Reporter*, 257.
This article defines basically defines and expounds upon the Bolar provisions. It also reports on the actions of the EU resulting in adoption of the new provisions. This source is significant, because it shows the EU participating in a rare relaxation of patent law.

The Organization for Economic Co-operation and Development. (2004). *Patents and innovation: trends and policy challenges*. Paris: Author.
The OECD is an excellent source for worldwide issue knowledge and economic/social cost assessments. This particular source is a broad assessment of intellectual property policies and ramifications, both on the national and international level, among developed States. The treatment of IP policies is far more reaching than the objectives this committee, so use with discretion.

Pfizer. (2004). *The Diflucan® Partnership Programme.* Retrieved August 10, 2004, from http://www.diflucanpartnership.org/en/welcome/
The Web site details Pfizer's efforts to address world needs by donations of medicines and funds for health related crisis. This site is indicative of the efforts of drug companies to address pressures to provide medicines without compromising trade regimes. This Web site focuses on African disease.

Pharmaceutical Research and Manufacturers of America. (n.d.). Intellectual property and access to AIDS drugs. *Health Care in the Developing World.* Retrieved September 1, 2004, from http://www.world.phrma.org/ip.access.aids.drugs.html
This issue site, sponsored by drug innovators, seeks to dispel the perception that patents and intellectual property laws are a cause for the difficulty in treating AIDS epidemics worldwide. The site reviews the actual extent of patent protections in these States. It also reviews the other exigent breakdowns in combating AIDS.

Quick, Jonathan D. (1999). *The worldwide role of generic pharmaceuticals.* Retrieved July 7, 2004, from http://www.who.int/medicines/library/pptpres/generics/1
This is a webpage that provides links to three PowerPoint presentations. They all deal with the generic pharmaceuticals and various themes. They vary from needs for generic pharmaceutical to national price disparity.

Rotary International. (2004). *Vaccinators target 13 million children in northern Nigeria*. Retrieved September 20, 2004, from http://www.rotary.org/newsroom/main/news03.html
This news item on the Rotary Web site is a valuable case in point of NGO involvement and challenges. Detailing the renewed efforts to vaccinate for polio in Nigeria, Rotary faced local fears that vaccinations were actually causing illnesses. Also discussed Nigeria's intention to combat Polio.

Stolate, Nigel. (2003). EU enlargement, the Bolar exemption, and parallel imports: The consequences for market exclusivity. *International Journal of Medical Marketing,* 3.
This is a peer-reviewed article. It is a deep examination of the legal entanglements and harmonization problems indicative of a system with competing sovereign State interests. One topic, not addressed in this background guide, is that of parallel imports and other circumventions of intellectual property standards.

Wiles, John A., & Wiles, John H. (2004). *Contemporary Canadian Business Law* (7th ed.). Toronto, Ontario; McGraw-Hill.
This source provides textbook treatment of the very specific realm of intellectual property in Canada. Useful for definitions for patents and law. It also describes the basic analysis of law in a State active in finding a "third-way" for patents.

World Health Organization. (2004). *The rationale of essential medicines*. Retrieved July 13, 2004, from http://www.who.int/medicines/rationale.shtml
The WHO provides lists of drugs considered primary to public health in developed and developing regions. This Web site explains the means by which these drugs come to be included on the list. It also will discuss the background behind the issue of essential medicines.

World Health Organization. (2000). *WHO medicines strategy: framework for action in essential drugs and medicines policy 2000-2003.* Geneva: Author.
This report provides detailed WHO strategy, and strategy proposals for ensuring that medicines are delivered to regions most in need. This is a critical starting point for all research into what the WHO should do next. This is also available on-line at: http://www.who.int/medicines/strategy/strategy.pdf.

World Health Organization & World Trade Organization. (2002). *WTO agreements and public health – A joint study by the WHO and WTO Secretariat*. Geneva: Authors.
A comprehensive look at the overlap between trade and health. This is a good study to review for identifying prior works of the WHO and WTO. This is due to the fact that this was published before the update on paragraph 6 of the Doha Declaration on TRIPS.

World Trade Organization. (2001). *The Doha Declaration on the TRIPS Agreement*. (WT/MIN(01)/DEC/2). Geneva: Author.
This document presents a revised position on TRIPS by the WTO. This is done by emphasizing the ability for member nations to grant compulsory licenses on matters of public and international health. It acts as the current yard-stick to which all member countries of the WTO must ensure that their national laws adhere to.

World Trade Organization. (2003). *Implementation of paragraph 6 of the Doha Declaration on the TRIPS agreement and public health*. (WT/L/540). Geneva: Author.
This document provides clarification of provisions in the TRIPS agreement that would allow compulsory licensing to be granted by one State to a firm in another. The provisions have numerous requirement and restrictions detailed. This document does provide a more detailed analysis of the provisions of TRIPS.

World Trade Organization. (2004). *TRIPS and public health: dedicated webpage for notifications*. Retrieved July 14, 2004, from http://www.wto.int/english/tratop_e/trips_e/public_health_e.htm.
This webpage is set up through TRIPS for Member States to publicly announce actions provided under paragraph 6 of the Doha Declaration on the TRIPS agreement. To date it has not been used for that purpose; however, this site does contain links to agreements and clarifications.

Additional Sources

Abboud, Leila. (2004, May 13). Abbott's pricing on AIDS drug prompts call for an early generic. *Wall Street Journal*. D7.
A case of where a brand-name pharmaceutical company's supposed unnecessarily high street-price may be overruled by the Bayh-Dole Act; giving other drug-makers the ability to exploit the patent without the owner's consent. Abbott's rationale as to the price increase is due to the drug's importance and efficacy in HIV therapy.

Canada: House of Commons. (2004, May 4). *An Act to Amend the Patent Act and the Food and Drugs Act (The Jean Chrétien Pledge to Africa)*. Ottawa: Author.
Canadian legislation passed May 4, 2004 allowing Canadian pharmaceutical manufacturers to supply certain medications to developing nations in a generic, low-cost manner, even if said medication is under current patent protection. The impetus for the legislation rests primarily with supplying Africa with inexpensive AIDS drugs. An example of the 'read-in' expanded provisions of the Doha Declaration on the Trips Agreement.

Frank, Richard, &Salkever, David. (1995). *Generic entry and the pricing of pharmaceuticals*. Cambridge: National Bureau of Economic Research.
This paper provides an attempt at a quantitative analysis of the effect that generic drug makers have on the price of pharmaceutical products. More specifically, it suggests that there is a lost opportunity cost when generics bring down the price of current medication.

Sun, Haochen. (2003). Reshaping the TRIPs agreement concerning public health: two critical issues. *Journal of World Trade*, 37.
Despite the Doha round of the WTO talks clarified the ability for compulsory licenses to help distribute generic pharmaceuticals to least developed nations, the author identifies two main flaws with TRIPS as it is currently interpreted; first, the inability for countries who do not have the ability to produce drugs to use the compulsory license provision, and second, the lack of flexibility of countries to interpret issues surrounding public health so as to have the ability to grant a compulsory license.

World Health Organization. (2003, May 28). *Intellectual property rights, innovation and public health*. (WHA56.27). Geneva: Author.
This is the WHO resolution on intellectual property. This resolution should be read first before all others. It will serve as a most useful introduction to the WHO's current work to-date on this topic.

III. Resource Allocation for HIV/AIDS: Prevention Versus Treatment

Avert.org. (2004). *AIDS around the world.* Retrieved August 10, 2004, from http://www.avert.org/aroundworld.htm
Avert explores the global epidemic from the perspective of an activist group. It provides useful figures and statistics regarding the epidemic. The information is broken out by geographical region for convenience.

Department of Gender and Women's Health. (2003). *Integrating Gender into HIV/AIDS programs.* New York: World Health Organization.
The Department of Gender and Women's Health is primarily responsible for integrating gender issues in WHO's programs. This particular report describes the realities of integrating gender concerns into HIV/AIDS programs. There are often unforeseen problems with well-intentioned gender interventions.

European Federation of Pharmaceutical Industries and Associations. (2003). *Access to Medicines: The Right Policy Prescriptions.* Retrieved October 1, 2004, from http://www.efpia.org/4_pos/access/policyprescriptions.pdf
This basic document describes the basic issues holding up Access to Medicines. This is a basic overview of what access to pharmaceuticals should be. This document is used just to illustrate the issue behind treatment of HIV/AIDS.

Global HIV Prevention Working Group. (2003, May). *Access to HIV Prevention: Closing the Gap.* New York: UNAIDS.
The resource gap is widely recognized as one of the largest troubles faced in the fight against HIV. Referred to as the "outcome" gap, because income influences the access you have to treatments that influence the outcome of the disease. This pamphlet explores those gaps on a regional level.

Human Rights Watch. (2004). *Program Overview.* Retrieved October 3, 2004, from http://www.hrw.org/doc/?t=hivaids&document_limit=0,2
One of the NGOs that will be participating in the committee has an extensive prevention program that describes the correlation between HIV/AIDS and human rights violations. Human Rights Watch advocates for the abatement of human rights violations as not just a means to an end, but an end in itself. There work in HIV/AIDS is extensive and important.

Kristofferesson, Ulf. (2000). *HIV/AIDS as a human security issue: a gender perspective.* (EGM/HIV-AIDS /2000/WP 2). New York: UNAIDS.
This working paper demonstrates some of the inherent difficulties of gender related problems in conflict. It also speculates possible solutions. Human security is the integration of development and security concerns. HIV/AIDS is recognized as a threat to international security.

Kuesters, Gabriele. (1999). *The Problem of Access to Pharmaceuticals.* Retrieved October 1, 2004, from http://www.washington.edu/wto/issues/pharmaceuticals.html
This document is description of the issues related to access and the various factors that could be utilized for remedy. This is a good document to review for assessing the issues that are could be impeding access to healthcare and pharmaceuticals.

Médecins sans Frontières. (2004). *2 Pills a Day: Treat HIV/AIDS Now!* Retrieved October 2, 2004, from http://www.doctorswithoutborders.org/pr/2004/07-29-2004.shtml
Médecins sans Frontières has worked for years bringing medical care to those that cannot afford it. Their work in HIV/AIDS treatment has assisted countless in developing nations. They have effectively allocated resources towards real ends on the treatment end of the spectrum.

Network. (2002). *The Durban AIDS Conference & Beyond: The Challenge of Partnership in the Global Fight against AIDS.* Retrieved October 1, 2004, from http://www.earthsummit2002.org/es/newsletter/Issue%204.rtf
This is a document that discusses the Durban AIDS Conference and what lies ahead. It also discusses the Challenge of Partnership in the Global Fight Against AIDS initiative. This document was used to obtain facts regarding providing medication for treatment of HIV/AIDS.

Obaso, Milicent. (2001, May 8). Plague upon Plague: AIDS and Violent Conflict in Africa. [Transcript of speech]. United States Institute of Peace.
This speech was given at a United States Institute of Peace seminar on AIDS in conflict situations. Ms. Obaso is a recognized HIV/AIDS expert. She is currently working on providing effective procurement for ARV therapy.

Piot, Dr. Peter. (2003). *One on one with Dr. Peter Piot.* Retrieved July 17, 2004, from http://www.tpan.com/publications/positively_aware/mar_apr_03/one_on_one_piot.html
This is a question and answer interview that discusses his ambition and vision for tackling HIV/AIDS. It also touches on why he chose this issue. This basic document will allow you to understand his position on HIV/AIDS.

Shaw, Amelia. (2004, July 14). Personal Communication.
Ms. Shaw is completing a Fulbright Fellowship in Haiti regarding HIV/AIDS prevention programs amongst youth. She is working with numerous NGOs in Haiti to prevent disease transmission. Her expertise lies primarily with the ABC protocol.

UN Chronicle. (2003). *Pharmaceuticals: Improving Equity of Access to Medicines.* Retrieved October 1, 2004, from http://www.un.org/Pubs/chronicle/2003/issue2/0203p12.html
This article reviews from a UN perspective the issue of improving access to medicines by developing countries around the world. Identifies it as and issue of great significance. Emphasizing good health is vital for the economic development of nations, and promoting the health of their citizens is one of the most important duties of Governments.

UNAIDS. (2004). *2004 Report on the Global AIDS Epidemic.* UNAIDS. New York: UNAIDS.
The 2004 report on the Global AIDS epidemic explores the state of the world concerning HIV/AIDS today. It provides a number of useful data about the disease. It is essentially a statistical reference with a number of useful narratives.

UNAIDS & World Bank. (2002). *UNAIDS-World Bank Workshop, Building a Sustainable M&E Technical Resource Network in Southern and East Africa*. Retrieved August 19, 2004, from http://www.unaids.org/html/pub/Topics/M-E/Technical_Resource_Network-Africa_en_doc.htm
Participants in this workshop evaluated the evaluations. They discuss best practices in monitoring systems for prevention programs to ensure success. Monitoring and Evaluation is vital to ensuring good programming.

World AIDS Campaign. (2004). *Women, Girls, HIV and AIDS: Strategy Notes.* New York: UNAIDS.
This strategy note introduces the theme of World AIDS day 2004. It provides relevant information on how vulnerable this population group is to the disease, while setting out some ideas for better prevention campaigns. Also useful is its description of global goals for the campaign.

World Bank. (2004). *Anti-Retroviral (ARV) Treatment in Developing Countries: Questions of Economics, Equity and Ethic.* Retrieved September 3, 2004, from http://www.worldbank.org/aids-econ/arv/
Numerous conferences have been held to explore the usefulness of ARV therapy. This conference by UNAIDS and the World Bank provides some basic information about the effectiveness of the programs. The recognized fact is that ARV is not the ultimate answer.

World Health Organization. (2004). *About 3 by 5 Strategy.* Retrieved September 3, 2004, from http://www.who.int/3by5/about/strategy/en/index.html
The 3 by 5 strategy is the foremost prevention campaign of WHO. It attempts to provide guidelines for assisting 3 million AIDS afflicted individuals by 2005. This strategy should be deemed the proper guideline for this committee.

World Health Organization. (2004). *Scaling up antiretroviral therapy in resource-limited settings: Treatment guidelines for a public health approach.* Retrieved September 3, 2004, from http://www.who.int/3by5/publications/documents/arv_guidelines/en/
ARV is the predominant treatment mechanism for HIV/AIDS. The drugs fight the virus, though they cannot rid the body of its presence. This Web site describes the methods used for ARV therapy.

World Health Organization. (2003). *WHO and HIV/AIDS.* Retrieved October 1, 2004, from http://www.who.int/hiv/aboutdept/en/
This webpage is a basic introduction to the WHO and HIV/AIDS and how the issue is being dealt with by the WHO. It provides many links and news articles that will provide further information on the programs that are being implemented. There are also key articles that can be read to learn about such programs as the 3 by 5 program.

Suggestions for Further Research

This background guide has been developed to provide an introduction to the topics this committee will address at the NMUN. The guide is not intended to provide delegates with the history of their individual foreign policies. In order to successfully represent your assigned State or NGO, considerable additional research is required.

In seeking additional information regarding the topic areas themselves, carefully review the footnotes and bibliography within the guide. The footnotes and bibliography serve as a reference list and provide research resources of primary importance in the preparation of the background guide. These sources are annotated for your convenience. However, particular attention should be given to the conventions and declarations contained within, as these documents provide the historical mandates and goals of the United Nations and other international organizations. All delegates should acquire copies of the *Charter of the United Nations and Statute of the International Court of Justice*, as well as the *Universal Declaration of Human Rights,* the *International Covenant on Civil and Political Rights and Optional Protocols,* and the *International Covenant on Economic, Social and Cultural Rights.*

To assist in the understanding of your individual State's foreign policy, begin by researching the history and culture of your assigned State or NGO. Understanding the cultural basis for particular policies will assist you in the development of creative solutions for which there may be no policy precedent. The general debate at the opening session of the United Nations General Assembly provides an excellent overview of each Member State's policy on a broad range of issues. The opening ceremonies are generally attended by leading State representatives who use this opportunity to express their country's aspirations and goals for the work of the organization in the upcoming year. These records provide an immensely valuable resource for delegates in search of State-specific policy citations. The verbatim records of Member States, as well as their voting records, can be located at UN Depositories at many university libraries or through the UN Web site *www.un.org*. You can also look at the National Model United Nations Web site at *www.nmun.org* for additional research material. Consult with your advisor and/or school librarian regarding a depository nearest to you.

Delegations may also wish to contact the mission of the assigned Member State; however, due to the limited time and resources available to most missions this contact should be made through one delegate on behalf of the delegation and not by individual delegates. This contact can be initiated in the process of setting up your delegation's mission briefing. Ideally, delegations will prepare a list of committee topics and specific questions relating to the issues encompassed therein. This list should be introduced by a formal letter explaining your ambitions to accurately represent the mission of your assigned State at the NMUN Conference. The letter should additionally express your recognition of the honor bestowed on you in the opportunity to represent the assigned State. In addition, you should express your gratitude for any assistance they may be able to render. Please be aware that in many cases, the limited fiscal budgets of your missions do not allow for the resources necessary to distribute State information to private individuals; however many are more than capable and willing to assist these efforts.

In addition to contacting your State's mission, delegates should utilize the United Nations Information Service, which has offices in New York and Washington D.C. You should also consider contacting relevant international agencies, such as the World Health Organization (WHO), the Commission on Human Rights, the World Trade Organization (WTO), the UN Development Programme (UNDP), and/or regional and alliance related organizations, such as the European Union, NATO, the Organization of African Unity (OAU), or the Inter-American Development Bank (IADB), that conduct work related to the committee topics.

The UN Department of Public Information has released a number of volumes that comprise *The United Nations Blue Book Series.* Within the *Blue Book Series*, you will find a comprehensive review of the historical work and operations of the United Nations regarding: the Advancement of Women; Apartheid; Cambodia; El Salvador; Human Rights; Mozambique; and Nuclear Non-Proliferation, among other topics. These resources contain countless illustrations of international declarations, conventions and treaties, as well as numerous statements from the United Nations Secretary-General, the Security Council, the General Assembly, ECOSOC and related agencies, regarding the responsibility of Member States for the promotion and advancement of the principles and standards adopted by the organization.

Current events are continually changing. As a delegate, you should track the events that affect the issues before your Committee. Periodicals which will assist in this task include the *UN Chronicle, World Press Review,* the *New York Times, The Christian Science Monitor, The International Herald Tribune, Foreign Affairs, Foreign Policy, Human Rights Quarterly, The American Journal of International Law, International Legal Materials, Far Eastern Economic Review,* and the *Journal of Modern African Studies*. Further, tune into National Public Radio (NPR) for *The Morning Edition, All Things Considered, Monitor Radio,* and *Pacifica Radio*; each of these NPR programs provide comprehensive coverage of global events.

Computerized research resources are also available. The Internet provides access to a wealth of information, but please remain aware that not all sources on the Internet are equally credible. Official government and intergovernmental sites like the UN Web site are good starting points. In addition, universities and well-established NGOs like the Red Cross may also provide valuable and credible information. Lexis/Nexis is also an excellent source for daily news from around the world and operates using search terms and the Boolean style of computerized library searches. Finally, the NMUN Web site at *www.nmun.org* has been designed to assist you in your research through the provision of these guides online, topic updates, and continuously updated committee pages with links to many topic specific sites.

Should you have any questions or experience any particular difficulties in your research endeavors, please do not hesitate to contact your Committee Director or Assistant Director, departmental Under-Secretary-General, or the Director-General. Contact information for those individuals is listed at the bottom of the introductory letter which is on the first page of this guide.

Rules of Procedure
World Health Organization

INTRODUCTION

1. These rules shall be the only rules which apply to the World Health Organization (herinafter "the body") and shall be considered adopted by the body prior to its first meeting.

2. For purposes of these rules, the Committee Director, the Assistant Director(s), the Under Secretaries-General, and the Assistant Secretaries-General, are designates and agents of the Secretary-General and Director-General, and are collectively referred to as the "Secretariat."

3. Interpretation of the rules shall be reserved exclusively to the Director-General or his or her designate. Such interpretation shall be in accordance with the philosophy and principles of the National Model United Nations, and in furtherance of the educational mission of that organization.

4. For the purposes of these rules, "President" shall refer to the chairperson, or acting chairperson of the body.

I. SESSIONS

Dates of convening and adjournment

Rule 1

The body shall meet every year in regular session, commencing and closing on the dates designated by the Secretary-General.

Place of Sessions

Rule 2

The body shall meet at a location designated by the Secretary-General.

II. AGENDA

Provisional Agenda

Rule 3

The provisional agenda shall be drawn up by the Secretary-General and communicated to members of the United Nations at least sixty days before the opening of the session.

Adoption of the Agenda

Rule 4

The agenda provided by the Secretary-General shall be considered adopted as of the beginning of the session. The order of the agenda items shall be determined by a majority vote of those present and voting in the body. Items on the agenda may be amended or deleted by the body by a two-thirds majority of the members present and voting.

The vote described in this rule is a procedural vote and as such, observers are permitted to cast a vote. For purposes of this rule, "those present and voting in the body" means those delegates, including observers, in attendance at the session during which this motion comes to vote.

Rule 5

[deleted]

Explanatory memorandum

Rule 6

Any item proposed for inclusion in the agenda shall be accompanied by an explanatory memorandum and, if possible, by basic documents.

III. SECRETARIAT

Duties of the Secretary-General

Rule 7

a) The Secretary-General or his/her designate shall act in this capacity in all meetings of the body.

b) The Secretary-General shall provide and direct the staff required by the body and be responsible for all the arrangements that may be necessary for its meetings.

Duties of the Secretariat

Rule 8

The Secretariat shall receive, print, and distribute documents, reports, and resolutions of the body, and shall distribute documents of the body to the members of the United Nations, and generally perform all other work which the body may require.

Statements by the Secretariat

Rule 9

The Secretary-General, or his/her representative, may make oral as well as written statements to the body concerning any question under consideration.

Selection of the President

Rule 10

The Secretary-General or his/her designate shall appoint, from applications received by the Secretariat, a President who shall hold office and, inter alia, chair the committee for the duration of the session, unless otherwise decided by the Secretary-General.

Replacement of the President

Rule 11

If the President is unable to perform his/her function, a new President shall be appointed for the unexpired term at the discretion of the Secretary-General.

IV. LANGUAGES

Official and working language

Rule 12

English shall be the official and working language of the body.

Interpretation

Rule 13

Any representative wishing to address any United Nations body or submit a document in a language other than English shall provide translation into English.

This rule does not affect the total speaking time allotted to those representatives wishing to address the body in a language other than English. As such, both the speech and the translation must be within the set time limit.

Quorum

Rule 14

The President may declare a meeting open and permit debate to proceed when representatives of at least one third of the members of the body are present. The presence of representatives of a majority of the members of the body concerned shall be required for any decision to be taken.

For purposes of this rule, "members of the body" is based on the number of total members (not including observers) in attendance for the Tuesday night session.

General powers of the President

Rule 15

In addition to exercising the powers conferred upon him/her elsewhere by these rules, the President shall declare the opening and closing of each meeting of the body, direct the discussions, ensure observance of these rules, accord the right to speak, put questions to the vote and announce decisions. The President, subject to these rules, shall have complete control of the proceedings of the body and over the maintenance of order at its meetings. She or he shall rule on points of order. She or he may propose to the body the closure of the list of speakers, a limitation on the time to be allowed to speakers and on the number of times the representative of each member may speak on an item, the adjournment or closure of the debate, and the suspension or adjournment of a meeting.

Included in these enumerated powers is the President's power to assign speaking times for all speeches incidental to motions and amendment. Further, the President is to use his or her discretion, upon the advice and at the consent of the Secretariat, to determine whether to entertain a particular motion based on the philosophy and principles of the NMUN. Such discretion should be used on a limited basis and only under circumstances where it is necessary to advance the educational mission of the Conference. For purposes of this rule, the President's power to "propose to the body" entails his or her power to "entertain" motions, and not to move the body on his or her own motion.

Rule 16

The President, in the exercise of his or her functions, remains under the authority of the body.

Points of order

Rule 17

During the discussion of any matter, a representative may rise to a point of order, which shall be decided immediately by the President. Any appeal of the decision of the President shall be immediately put to a vote, and the ruling of the President shall stand unless overruled by a majority of the members present and voting.

Such points of order should not under any circumstances interrupt the speech of a fellow representative. Any questions on order arising during a speech made by a representative should be raised at the conclusion of the speech, or can be addressed by the President, sua sponte, during the speech. For purposes of this rule, "the members present and voting" means those members (not including observers) in attendance at the session during which this motion comes to vote.

Rule 18

A representative may not, in rising to a point of order, speak on the substance of the matter under discussion.

Speeches

Rule 19

a) No one may address the body without having previously obtained the permission of the President. The President shall call upon speakers in the order in which they signify their desire to speak.

b) Debate shall be confined to the question before the body, and the President may call a speaker to order if his/her remarks are not relevant to the subject under discussion.

The body may limit the time allowed to speakers and all representatives When debate is limited and a speaker exceeds the allotted time, the President shall call him or her to order without delay.

In line with the philosophy and principles of the NMUN, in furtherance of its educational mission, and for the purpose of facilitating debate, if the President determines that the body in large part does not want to deviate from the limits to the speaker's time as it is then set, and that any additional motions will not be well received by the body, the President, in his or her discretion, and on the advice and consent of the Secretariat, may rule as dilatory any additional motions to change the limits of the speaker's time.

Closing of list of speakers

Rule 20

Members may only be on the list of speakers once but may be added again after having spoken. During the course of a debate the President may announce the list of speakers and, with consent of the body, declare the list closed. When there are no more speakers, the President shall declare the debate closed. Such closure shall have the same effect as closure by decision of the body.

The decision to announce the list of speakers is within the discretion of the President and should not be the subject of a motion by the body. A motion to close the speaker's list is within the purview of the body and the President should not on his own motion the body.

Right of reply

Rule 21

If a remark impugns the integrity of a representative's State, the President may permit a right of reply following the conclusion of the controversial speech, and shall determine an appropriate time limit for the reply. No ruling on this question shall be subject to appeal.

For purposes of this rule, a remark that "impugns the integrity of a representative's State" is one directed at the governing authority of that State and/or one that puts into question that State's sovereignty or a portion thereof. All rights of reply shall be made in writing addressed to the Secretariat and shall not be raised as a point or motion. The reply shall be read to the body by the representative only upon approval of the Secretariat, and in no case after voting has concluded on all matters relating to the agenda topic, during the discussion of which, the right arose.

Suspension of the meeting

Rule 22

During the discussion of any matter, a representative may move the suspension of the meeting, specifying a time for reconvening. Such motions shall not be debated but shall be put to a vote immediately, requiring the support of a majority of the members present and voting to pass.

Adjournment of the meeting

Rule 23

During the discussion of any matter, a representative may move the adjournment of the meeting. Such motions shall not be debated but shall be put to the vote immediately, requiring the support of a majority of the members present and voting to pass. After adjournment, the body shall reconvene at its next regularly scheduled meeting time.

As this motion, if successful, would end the meeting until the body's next regularly scheduled meeting the following year, and in accordance with the philosophy and principles of the NMUN and in furtherance of its educational mission, the President will not entertain such a motion until the end of the last session of the body.

Adjournment of debate

Rule 24

A representative may at any time move the adjournment of debate on the topic under discussion. Permission to speak on the motion shall be accorded to two representatives favoring and two opposing adjournment, after which the motion shall be put to a vote immediately, requiring the support of a majority of the members present and voting to pass. If a motion for adjournment passes, the topic is considered dismissed and no action will be taken on it.

Closure of debate

Rule 25

A representative may at any time move the closure of debate on the item under discussion, whether or not any other representative has signified his or her wish to speak. Permission to speak on the motion shall be accorded only to two representatives opposing the closure, after which the motion shall be put to the vote immediately. Closure of debate shall require a two-thirds majority of the members present and voting. If the body favors the closure of debate, the body shall immediately move to vote on all proposals introduced under that agenda item.

Order of motions

Rule 26

Subject to rule 23, the motions indicated below shall have precedence in the following order over all proposals or other motions before the meeting:

a) To suspend the meeting;
b) To adjourn the meeting;
c) To adjourn the debate on the item under discussion;
d) To close the debate on the item under discussion.

Proposals and amendments

Rule 27

Proposals and substantive amendments shall normally be submitted in writing to the Secretariat, with the names of twenty percent of the members of the Assembly]who would like the Assembly to consider the proposal or amendment. The Secretariat may, at its discretion, approve the proposal or amendment for circulation among the delegations. As a general rule, no proposal shall be put to the vote at any meeting of the body unless copies of it have been circulated to all delegations. The President may, however, permit the discussion and consideration of amendments, or of motions as to procedure even though such amendments and motions have not been circulated. If the sponsors agree to the adoption of a proposed amendment, the proposal shall be modified accordingly and no vote shall be taken on the proposed amendment. A document modified in this manner shall be considered as the proposal pending before the body for all purposes, including subsequent amendments.

For purposes of this rule, all "proposals" shall be in the form of working papers prior to their approval by the Secretariat. Working papers will not be copied, or in any other way distributed, to the body by the Secretariat. The distribution of such working papers is solely the responsibility of the sponsors of that working paper. Along these lines, and in furtherance of the philosophy and principles of the NMUN and for the purpose of advancing its educational mission, representatives should not directly refer to the substance of a working paper that has not yet been accepted as a draft resolution. After approval of a working paper, the proposal becomes a draft resolution and will be copied by the Secretariat for distribution to the body. These draft resolutions are the collective property of the body, and as such, the names of the original sponsors will be removed. The copying and distribution of amendments is at the discretion of the Secretariat, but the substance of all such amendments will be made available to all representatives in some form.

Withdrawal of motions

Rule 28

A proposal or a motion may be withdrawn by its sponsor at any time before voting has commenced, provided that it has not been amended. A motion thus withdrawn may be reintroduced by any representative.

Reconsideration of a topic

Rule 29

When a topic has been adjourned, it may not be reconsidered at the same session unless the body, by a two-thirds majority of those present and voting, so decides. Reconsideration can only be moved by a representative who voted on the prevailing side of the original motion to adjourn. Permission to speak on a motion to reconsider shall be accorded only to two speakers opposing the motion, after which it shall be put to the vote immediately.

For purposes of this rule, "those present and voting" means those representatives, including observers, in attendance at the session during which this motion comes to vote.

V. VOTING

Voting Rights

Rule 30

Each member of the body shall have one vote.

This section applies to substantive voting on amendments, draft resolutions, and portions of draft resolutions divided out by motion. As such, all references to "member(s)" do not include observers or NGOs, who are not permitted to cast votes on substantive matters.

Request for a vote

Rule 31

A proposal or motion before the body for decision shall be voted upon if any member so requests. Where no member requests a vote, the body may adopt proposals or motions without a vote.

For purposes of this rule, "proposal" means any draft resolution, an amendment thereto, or a portion of a draft resolution divided out by motion. Just prior to a vote on a particular proposal or motion, the President may ask if there are any objections to passing the proposal or motion by acclimation, or a member may move to accept the proposal or motion by acclimation. If there are no objections to the proposal or motion, then it is adopted without vote.

Majority required

Rule 32

a) Unless specified otherwise in these rules, decisions of the body shall be made by a majority of the members present and voting.

b) For the purpose of tabulation, the phrase "members present and voting" means members casting an affirmative or negative vote. Members which abstain from voting are considered as not voting.

All members declaring their representative states as "present and voting" during the attendance roll call for the session during which the substantive voting occurs, must cast an affirmative or negative vote, and cannot abstain.

Method of voting

Rule 33

a) The body shall normally vote by a show of placards, except that a representative may request a roll call, which shall be taken in the English alphabetical order of the names of the members, beginning with the member whose name is randomly selected by the President. The name of each present member shall be called in any roll call, and one of its representatives shall reply "yes," "no," "abstention," or "pass."

Only those members, who designate themselves as "present" or "present and voting" during the attendance roll call or in some other manner communicate their attendance to the President and/or Secretariat, are permitted to vote, and as such, no others will be called during a roll call vote. Any representatives replying "pass," must, on the second time through, respond with either "yes" or "no." A "pass" cannot be followed by a second "pass" for the same proposal or amendment, nor can it be followed by an abstention on that same proposal or amendment.

b) When the body votes by mechanical means, a non-recorded vote shall replace a vote by the show of placards and a recorded vote shall replace a roll call. A representative may request a recorded vote. In the case of a recorded vote, the body shall dispense with the procedure of calling out the names of the members.

c) The vote of each member participating in a roll call or a recorded vote shall be inserted in the record.

Explanation of vote

Rule 34

Representatives may make brief statements consisting solely of explanation of their votes after the voting has been completed. The representatives of a member sponsoring a proposal or motion shall not speak in explanation of vote thereon, except if it has been amended, and the member has voted against the proposal or motion.

All explanations of vote must be submitted to the President in writing before debate on the topic is closed, except where the representative is of a member sponsoring the proposal, as described in the second clause, in which case the explanation of vote must be submitted to the President in writing immediately after voting on the topic ends.

Conduct during voting

Rule 35

After the President has announced the commencement of voting, no representatives shall interrupt the voting except on a point of order in connection with the actual process of voting.

Division of proposals and amendments

Rule 36

Immediately before a proposal or amendment comes to a vote, a representative may move that parts of a proposal or of an amendment should be voted on separately. If there are calls for multiple divisions, those shall be voted upon in an order to be set by the President where the most radical division will be voted upon first. If objection is made to the motion for division, the request for division shall be voted upon, requiring the support of a majority of those present and voting to pass. Permission to speak on the motion for division shall be given only to two speakers in favor and two speakers against. If the motion for division is carried, those parts of the proposal or of the amendment which are involved shall then be put to a vote. If all operative parts of the proposal or of the amendment have been rejected, the proposal or the amendment shall be considered to have been rejected as a whole.

For purposes of this rule, "most radical division" means the division that will remove the greatest substance from the draft resolution, but not necessarily the one that will remove the most words or clauses. The determination of which division is "most radical" is subject to the discretion of the Secretariat, and any such determination is final.

Amendments

Rule 37

An amendment is a proposal that does no more than add to, delete from or revise part of another proposal.

An amendment can add, amend, or delete operative clauses, but cannot in any manner add, amend, delete, or otherwise affect preambulatory clauses.

Order of voting on amendments

Rule 38

When an amendment is moved to a proposal, the amendment shall be voted on first. When two or more amendments are moved to a proposal, the amendment furthest removed in substance from the original proposal shall be voted on first and then the amendment next furthest removed therefrom, and so on until all the amendments have been put to the vote. Where, however, the adoption of one amendment necessarily implies the rejection of another amendment, the latter shall not be put to the vote. If one or more amendments are adopted, the amended proposal shall then be voted on.

For purposes of this rule, "furthest removed in substance" means the amendment that will have the most significant impact on the draft resolution. The determination of which amendment is "furthest removed in substance" is subject to the discretion of the Secretariat, and any such determination is final.

Order of voting on proposals

Rule 39

If two or more proposals, other than amendments, relate to the same question, they shall, unless the body decides otherwise, be voted on in order in which they were submitted.

The President shall not vote

Rule 40

The President shall not vote but may designate another member of his or her delegation to vote in his or her place.

VIII. MINUTE OF SILENT PRAYER OR MEDITATION

Invitation to silent prayer or meditation

Rule 41

Immediately after the opening of the first meeting of the body, representatives may request to observe one minute of silence dedicated to prayer or meditation. This is the only time this motion will be entertained and its approval is at the discretion of the Secretariat.