

# **HONG KONG MODEL UNITED NATIONS MARCH 19-21, 2017**



## **WORLD HEALTH ORGANISATION**

### **CHAIR REPORTS**

#### **ISSUES**

1. HEALTHCARE IN CONFLICT ZONES
2. STOPPING AIR POLLUTION RELATED DEATHS
3. DISTRIBUTION OF MALARIA VACCINATIONS

#### **CHAIRS**

1. JULIA WOODRUFF
2. MURIEL SIRGI

## **WORLD HEALTH ORGANIZATION**

The World Health Organization was founded on the 7th of April, 1948, a day we now celebrate as World Health Day. Today, WHO has over 7,000 employees in 150 different countries who are dedicated to providing global leadership in public health.

We, your chairs, are incredibly excited to be working with you this year at HKMUN 2017, and hope that we can aid you in engaging in high-yielding and productive debate.

We wish you the best of luck in your research and preparation for this committee, and are looking forward to the conference!

Best Wishes,  
Julia Woodruff and Muriel Sirgi, WHO Chairs  
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Committee: World Health Organization  
Issue: Healthcare in Conflict Zones  
Name: Muriel Sirgi

## **Introduction**

Over 15 billion people are reported to live in conflict zones, including 250 million children. While the WHO is “committed to saving lives and reducing suffering in times of crisis”, the health services in affected areas are often ineffective or even inexistent, and thus frequently requiring the cooperation of medical humanitarian non-governmental organisations.

In addition, the number and intensity of attacks against healthcare workers and health facilities have increased dramatically in conflict zones around the world, a blatant violation of international humanitarian law. A key consequence of this increase is the fact that the harm done by the attacks and the persistent insecurity not only affects the health services but ultimately has a knock-on effect on the health status of the population because of the reduced availability of treatment and care. This is often exacerbated by the indifference of local governments involved in the conflict.

Armed conflicts directly and indirectly impact the mortality and morbidity of the populations affected through an increased risk of death and injury, the raised susceptibility to infectious disease from unsanitary living conditions, malnutrition, and both physical and mental suffering.

More recently, it has also been suggested that non-communicable chronic diseases which are taking an increasing share of the disease burden in conflict zones.

## Key Terms

- Conflict:** Armed conflict, both international and non-international conflicts, as well as situations that fall short of armed conflict, including internal disturbances such as political or civil violence.
- Health care facility:** Any building that is known to be the site for the provision of medical services, treatment or storage of medical supplies, whether temporary/permanent or mobile, marked or unmarked.
- Health care personnel:** Any person providing or attempting to provide health care or attention to a patient such as doctors, nurses, midwives, nurses' aids, community health workers, ambulance attendants and drivers, pharmacists, and voluntary first aid providers.
- Health care transport:** Any vehicle used to transport persons in need of care or medical supplies (e.g. marked or unmarked ambulance, private car, etc.)
- Health services:** All services dealing with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health.
- Humanitarian space:** Areas in which civilians can seek shelter and aid workers provide assistance in safety.
- Infectious disease:** Disease caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi; the diseases can be spread, directly or indirectly, from one person to another.
- Medical supplies:** Any items necessary for the rendering of medical diagnostic services, treatment, management or preventive services.

Non-communicable disease:	Medical condition or disease that is by definition non-infectious and non-transmissible among people.
Right to health:	Access to timely, acceptable, and affordable health care of appropriate quality

## Background Information

### Ensuring access to health care in conflict zones

In conflict zones, millions of individuals are in need of health care due to civilian injuries, population displacement, and the lack of available resources for humanitarian aid. This is evident through the inspection of approximations concerning the number of individuals directly affected by various ongoing conflicts: it has been estimated that 14.1 million people are affected by the Yemeni Civil War, 11.5 million people by the Syrian Civil War, 8.5 million people in Iraqi Civil War, and 2.25 million people by the Northern Mali Conflict. The provision of health care is essential to the survival and well-being of affected populations and should be a constant priority for humanitarian assistance.

Health issues are often ranked as low importance by governments participating in conflicts, which results in the breakdown of the health infrastructure. The loss of qualified health personnel who leave warzones and die while providing care creates an additional major human resource challenge. Service delivery is also complicated by the type of conflicts taking place and by the fact that the intrinsic nature of warfare has changed drastically in the past decades. Wars and conflicts now often stretch over longer periods of time, take place within rather than between countries, in urban areas rather than open battlefields, use mass shelling and bombardments by air forces rather than pistols, and feature a majority of civilian losses, with civilian populations becoming the focus of hostilities. Furthermore, armed conflicts are more frequently being fought by irregular armed groups who are often unaware or unwilling to follow international conventions, leading to enhanced violence against civilians.

Given the reduction of the humanitarian space, health care provision in conflict settings is thus becoming increasingly difficult. Health care workers must not only attempt to deliver regular health programmes, but also address conflict-related injuries, increases in infectious diseases and outbreaks, malnutrition, mental health problems and gender-based violence. National and international health workers work are often left with an increasing workload, insufficient resources and supplies, insecurity, and bureaucratic obstacles.

In addition, health facilities also often face the risk of becoming involuntarily associated with the conflict when as they provide health care to both parties involved in the conflict, and it is not uncommon to have soldiers or members of different factions looking for insurgents in the hospitals or forbidding health care workers to treating opponents.

Despite these difficulties, non-governmental organisations such as Doctors Without Borders (Médecins Sans Frontières – MSF) and the International Committee of the Red Cross (ICRC) have relentlessly continued to grant populations in the midst of an armed conflict with healthcare services, resources as well as support to the existing facilities in affected zones with impartiality.

### **Protecting health care facilities and staff**

Alongside the apparent modernisation of warfare, there has been an upsurge of attacks against health care in conflict zones. These include not only violent aggressions on health care workers and patients and destruction of facilities and health care transports, but also other types of offenses such as threatening or coercing health care providers to give preferential treatment to armed fighters, hijacking ambulances, or using patients as human shields. This is in total violation of human rights and international humanitarian laws as stated during the Geneva conventions. These laws clearly state that parties must not attack or interfere with health workers, facilities, ambulances, and people who are wounded or sick.

It is estimated that there were 594 reported attacks on health care between January 2014 and December 2015 in 19 countries with emergency situations, and that these resulted in 959 deaths and 1561 deaths respectively. In 2015 and the first quarter of 2016, deliberate or indiscriminate strikes have killed medical workers and patients, destroyed medical infrastructure, and interfered with the provision of vital medical care to the population of 19 countries around the world: Syrian Arab Republic, West Bank and Gaza Strip, Iraq, Pakistan, Libya, Ukraine, Central African Republic, Yemen, Sudan, Afghanistan, South Sudan, Guinea, Democratic Republic of Congo, Nigeria, Colombia, Somalia, Liberia, Sierra Leone, and Myanmar. The types of attacks are varied and include: bombing, shelling, burning, and looting of healthcare facilities or medical transport; violence inflicted on health workers independent of attacks on facilities or medical transport; hospitals being taken over by military groups or fights in or near hospitals; and interference in the access and delivery of health care, medicine, and supplies. Other recorded attacks against healthcare workers includes the kidnapping and subsequent murder of polio vaccination teams, who have been the long-standing victims of attacks by the Taliban in Afghanistan. It was also noted in a report by MSF concerning the attack on their hospital in Kunduz that in many instances, parties participating in conflicts failed to take required steps to avoid harm to medical facilities, staff, and patients and obstructed access to health care.

The deliberate attack on healthcare services has also had a frequent knock-on or cumulative effect on affected populations. Indeed, the systematic assaults on health care facilities and staff has become an aim for combatants, as their loss is a direct blow to population health. As reported by Amnesty International, the destruction of healthcare services through attacks on hospitals, as the airstrikes prevalent in the Syrian Civil War, or the murder of healthcare staff has been used strategically to stimulate the exodus of a population away from a location because of the decreased probability of survival associated with the loss of the lifeline that is healthcare in conflict zones.

In May 2016, the former UN Secretary General, Ban Ki Moon urged all Member States, parties involved in conflicts and other relevant actors, to observe the Security Council's demands by facilitating humanitarian access, developing domestic legal frameworks that protect health care facilities and workers, training armed forces so that they understand their obligations, and prosecuting those responsible for attacks and violations.

### Health in populations affected by conflict

Armed conflicts have major detrimental impacts on the lives and health of the populations affected by conflicts; this can happen through different pathways as shown in Figure 1.

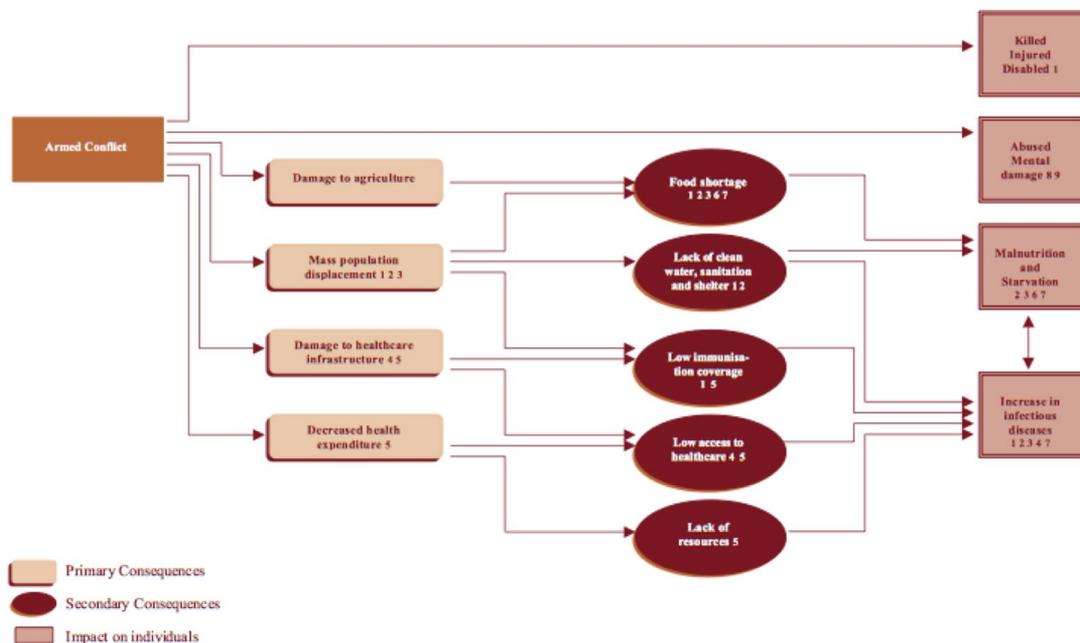


Figure 1. Impact of armed conflict on health  
(Guha-Shapir and van Panhuis)

Populations affected by conflicts have to suffer a large health burden. Although violent deaths are more visible to media, in the majority of cases, disease is the major cause of death. This is often due to the prevalence of poor living conditions caused by warfare, and the subsequent spread of infectious disease. Contagion is further facilitated due to often reduced

vaccination coverage, poor nutritional status and hunger. This is caused by systematic destruction of crops and killing of livestock to decimate local production, often leading to collapse of trade affecting both food importation and its distribution. As with healthcare, the destruction of primary food resources is used with strategic intent, and may feature the mining of agricultural land. The malnutrition which results from these practices affects children's health in particular, but also facilitates the spread of disease in a population.

A prominent example of the spread of a communicable disease in conflict zones is the increased incidence of HIV/AIDS in afflicted regions, which is widespread in affected populations. Indeed, the increase in incidence of sexual violence which has been reported during conflicts, including that linked to the recurring and large-scale use of rape and sexual assault on women to establish dominance during war, has contributed significantly to the rise in HIV cases in war-afflicted zones. In addition, the decrease in accessibility of healthcare services and the scarce access to medical resources in conflict zones has exacerbated the issue, as antiretroviral treatments often becomes completely unavailable to victims of HIV/AIDS in war zones, rendering them unable to pursue the treatment necessary for the successful management of the condition.

In recent years, it has also been noticed that non-communicable diseases have been increasingly present in conflict zones. Despite this, non-infectious chronic diseases have often been disregarded in favour of communicable diseases as well as war-caused conditions and causalities. According to the Lancet and United Nations High Commissioner for Refugees, the lack of a systematic approach to non-communicable diseases results in "much excess morbidity and mortality".

### **Other points of interest**

Delegates may wish to consider the health issues associated with the migration of populations affected by conflict. Indeed, migrant populations are

more likely to be affected by conditions which are endemic to the region they are travelling to, against which they have not yet built an immunity. In addition, migrants escaping from conflict zones are often affected by both physical and mental conditions resulting from their experiences in conflict. These populations continue to be affected by the problems of scarce resources and access to healthcare services prevalent in conflict zones, and delegates may aspire to include the importance of considering the compromised access to health care faced by populations in refugee camps and fleeing conflict zones.

## Timeline of Events

April 17, 2013	UN Human Rights Council Resolution 22/32 on children and the right to health, calling upon parties involved in armed conflict to respect the prohibition of attacks on schools, hospitals and medical facilities
March 7, 2014	UN Security Council Resolution 2143 on children in armed conflict, calling for children's continued access to health care, condemning attacks on health facilities and health workers, and affirming children's right to access services.
December 12, 2014	UN Security Council Resolution on Global health and policy, calling for the insurance of safety of health worker and health facilities
May 3, 2016	UN Security Council Resolution 2286 condemning attacks against medical facilities, personnel in conflict resolution
May 24, 2016	World Humanitarian Summit on Strategies for ending attacks on health workers, facilities and patients.

## Key Parties Involved

Amnesty International:	NGO organising action to prevent and end abuses of human rights, and demand justice for those whose rights have been violated, including during armed conflicts.
Department of Peacekeeping Operations (DPKO):	UN Department dedicated to assisting the Member States and the Secretary-General in their efforts to maintain international peace and security.
Human Right Council (OHCHR):	UN office dedicated to the promotion and protection of international human rights.
Médecins Sans Frontières (MSF):	Medical humanitarian non-governmental organisation delivering emergency aid to populations in crisis, with currently 450 projects in 69 countries.
Médecin du Monde (Doctors of the World):	NGO involved in France and 64 countries to support victims of conflicts or migrant populations, promote health and risk reduction.
International Committee of the Red Cross (ICRC):	International humanitarian movement providing assistance to victims of armed conflict and other situations of violence.
United Nations Security Council:	Peace and Security organ of the UN. Has passed resolutions condemning attacks against medical facilities, personnel in conflict resolutions.

## United Nations Involvement

The United Nations have been highly involved on this issue through the UN Security Council, the World Health Organisation and the Human Rights Council. Several resolutions have been adopted during the past years, including the World Assembly Resolution 2286 in May 2016. This resolution addressed attacks on health facilities, health workers, health transports, and patients. It reaffirmed the importance of the basic principles of international

law, including international humanitarian law, in particular their obligations under the Geneva Conventions of 1949 and their Additional Protocols of 1977 and 2005, and demanded that all parties involved in conflicts comply with their provisions and facilitate the safe and unimpeded passage for medical and humanitarian personnel. The resolution also requested immunity from attack for health services and staff and called for health workers to be allowed to follow their ethical obligations to provide care, no matter the identity or affiliation of the patient. Finally, prominent UN figures such as former Secretary General Ban Ki-Moon have persistently denounced violence against health care staff and facilities, stating that: “All too often, attacks on health facilities and medical workers are not just isolated or incidental battlefield fallout, but rather the intended objective of the combatants. This is shameful and inexcusable”.

## **Useful Links**

- <http://www.worldbank.org/en/topic/fragilityconflictviolence>

Comprehensive website featuring research papers focusing on healthcare in regions affected by conflict.

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Committee: World Health Organisation  
Issue: Stopping Air Pollution Related Deaths  
Name: Julia Woodruff

## Introduction

According to the World Health Organisation, 7 million people each year die prematurely due to diseases related to air pollution, and many more are dealing with permanent health effects after long term exposure.

Air pollution, is defined by the WHO as, “contamination of the indoor or outdoor environment by any chemical, physical or biological agent that modifies the natural characteristics of the atmosphere”. Common sources of air pollution include: motor vehicles, factories and other industrial facilities, forest fires, and even household combustion devices.

There are many types of hazardous pollutants that are a danger to public health, including carbon monoxide, nitrogen dioxide, and sulfur dioxide, among others. If exposed to for extended periods of time, these harmful pollutants can result in respiratory diseases, and even death.

88% of all the premature deaths caused by air pollution occur in low- and middle- income countries, the greatest number in the WHO Western Pacific and Southeast Asia regions (the highest rate of deaths by air pollution being in India).

Aside from outdoor pollution, an issue that is rarely addressed is indoor pollutants that come from smoke and fumes from cooking—some 3 billion people who cook and heat their homes with biomass fuels and coal are at risk of pollution-related diseases.

This issue is more relevant than ever before and it is our duty as the World Health Organisation to try and find a solution to it.

## Key Terms

Household (Indoor) Pollution:	This is pollution that comes from within households, including sources like smoke from cooking/heating, and the usage of other household appliances.
Ambient (Outdoor) Pollution:	This is pollution that comes from outside sources, including factories, other industry, and vehicles, among others.
Ozone (O <sub>3</sub> ):	One of the major constituents of photochemical smog, caused by the reaction of pollutants from vehicles and industry with sunlight.
Nitrogen Dioxide (NO <sub>2</sub> ):	A common air pollutant, however if high enough in concentration (exceeding 200 µg/m <sub>3</sub> ), can be a toxic gas.
Sulfur Dioxide (SO <sub>2</sub> ):	Similar to Nitrogen Dioxide. Levels should not exceed 20µg/m <sub>3</sub> over a 24 hour period.

## Background Information

The majority of the deaths caused by air pollution occur in the developing economies of China and India. The main contributor to this high concentration of air pollution is the emission of small particles from power plants, factories, the burning of coal and wood, and vehicle exhausts.

According to Dan Greenbaum from the Health Effects Institute in Boston, MA, "In Beijing or Delhi on a bad air pollution day, the number of fine particles (known as PM2.5) can be higher than 300 micrograms per cubic meter. The number should be about 25 or 35 micrograms."

The negative health effects of this amount of exposure to pollutants can be severe. It increases the risk of heart disease and stroke, as well as respiratory complaints, and even cancer. The amount of deaths caused by exposure to air pollution is growing with time, the progress made by developed nations to decrease this.

Air pollution causes more deaths globally than malnutrition, obesity,

alcohol and drug abuse, and unsafe sex, however awareness on this issue is incredibly low. The Global Burden of Disease project marks air pollution as the fourth greatest health risk behind high blood pressure, dietary risks, and smoking.

In China and India, there are a combined total of 2.9 million deaths annually due to air pollution, yet the main sources of this pollution differ according to separate nations. In China, for instance, the dominant factor is particle emissions from coal burning whilst in India, the main source of pollution comes from burning wood, dung, crop residues and other materials for cooking and heating. This "indoor pollution" causes far more deaths than "outdoor pollution".

## Timeline of Events

1926 - Smoke Abatement Act	Aimed at reducing smoke emissions from industrial sources.
1948 - Donora, PA	Donora is covered in smog, awareness about the dangers of air pollution spreads.
1952 - Great London Smog	Resulted around 4,000 extra deaths in the city. Lead to the Clean Air Acts of 1956 and 1968.
1974 - Control of Air Pollution Act	Further regulations introduced, including regulating the composition of motor fuel and limiting sulphur content of industrial fuel oil.
1995 - Environment Act	Publication of the National Air Quality Strategy to set standards for the regulation of the most common air pollutants.

## United Nations Involvement

The 1979 Geneva Convention on Long-range Transboundary Air Pollution Resolution aims to diminish international air pollution (<https://www.unece.org/fileadmin/DAM/env/lrtap/full%20text/1979.CLRTAP.e.pdf>). In addition to this resolution, WHO has also implemented Ambient Air

quality guidelines that limit annual mean exposure to particulate matter with a diameter of less than 2.5 micrometres (PM<sub>2.5</sub>), such as sulfate, nitrates and black carbon, which penetrate deep into the lungs and cardiovascular system, posing the greatest health risks. The Sustainable Development Goals (SDGs) of the 2030 Agenda, adopted at a UN summit last year, and called for substantially reducing the number of deaths and illnesses from air pollution. In May 2016, WHO issued a new roadmap for accelerated action with local health sectors increasing monitoring and assuming a greater leadership role in national policies affecting air pollution.

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Committee:	World Health Organisation
Issue:	Distribution of Malaria Vaccination
Name:	Muriel Sirgi, Julia Woodruff

## Introduction

More than 3 billion people are at risk of Malaria in 99 countries, undoubtedly making it a global health priority. There were around 219 million cases of Malaria in 2010, which resulted in around 660,000 deaths globally.

Approximately 90% of these deaths occur in the WHO African Region, with the majority being young children and pregnant woman.

Malaria is a preventable disease, and the biggest issue at hand is the distribution of Malaria vaccinations globally, and especially in African regions. As the World Health Organisation, it is our responsibility to make the efficient spread of immunisation vaccines a priority.

There are three current immunisation techniques implemented by the United Nations today: long-lasting insecticidal nets (LLINs), Intermittent Preventive Treatment in Infants (IPTi-SP), and Intermittent Preventive in Pregnant Women (IPTp).

As a result of these immunisation techniques, there has been a 21% global decrease in Malaria incidence between 2010 and 2015, as well as a 29% mortality decrease.

Although progress has been immense, priority status on the topic of making Malaria treatments more accessible has not changed.

## Key Terms

Vector:	A vector is a non-human living organism which is able to transmit infectious diseases between humans and animals, be it from humans to animals or animals to humans. These are often blood-sucking insects and other parasites, including but not limited to various mosquito species (e.g. the <i>Aedes</i> mosquito, which
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	transmits the Zika virus and the <i>Anopheles</i> mosquito, which transmits malaria).
Vector-borne disease:	This term refers to diseases which have been transmitted to humans by the vectors, mentioned above. These have been defined by the WHO as: “illnesses caused by pathogens and parasites in human populations”.
Vaccine:	A biologically active substance containing one of three components administered to improve immunity to disease: “weakened or killed forms of the microbe, its toxins or one of its surface proteins”
Preventive therapy:	Medical action which allows the concentration of a drug to be of constant concentration in an individual’s body when he is most at risk of contracting malaria. These include IPTp, IPTi and seasonal malaria chemoprevention (SMC).
Chemoprophylaxis / Chemoprevention:	The use of a chemical to prevent the development of a disease in the human body.
Pilot programme / study:	A small scale study or set of trials executed to obtain statistical information used to predict whether trials could be reproduced at a larger scale. With medical drugs, the potential after-effects are further studied and statistical variance in the response of participants is taken into account.
Endemic area:	A region where there has been a measurable incidence of malaria over a certain time interval (measured in years).

## Background Information

Despite the hope brought by the trialling of a vaccine against malaria, this vector-borne parasitic infection is still a worrisome issue at a global scale.

Indeed, despite a 21% drop in the incidence of malaria in susceptible populations, it is estimated that approximately 3.2 billion individuals are considered at risk of contracting malaria. As mentioned previously, not all groups present equal chances of being affected by the infectious disease: the WHO reports that 90% of malaria cases occurred in Sub-Saharan Africa, where malaria is caused in the majority of cases by the *Plasmodium falciparum* parasite, one of 5 species which transmit malaria. Other regions at risk include South-Asia, where regions such as the Greater Mekong Subregion have seen drastic decreases in the incidence of malaria, as well as Latin America and the Middle East. Furthermore, the WHO also recommends that particular attention is granted to groups such as pregnant women, children born in regions where malaria is endemic (with 70% of malaria-linked deaths occurring in children less than 5 years of age), individuals suffering from HIV-AIDS as well as travellers and non-sedentary groups, as they are the most likely to develop severe symptoms after contracting malaria. Additionally, malaria in pregnant women has been reported to influence the health of infants in utero: malaria has been recognised as a cause of low birthweight and increased mortality rates, and conditions such as anemia in newborns.

In the past, malaria has been effectively controlled by preventive measures which have targeted the human immunity or relied on the method of vector-control, which in the case of malaria aims to limit the population of the *Anopheles* mosquito present in malaria endemic regions. Protective measures which target populations at risk include the prescription of preventive therapies, in mothers and infants especially, as well as the recommended use of malaria chemoprevention with antimalarial drugs such as Malarone or Primaquine for travellers. Methods such as the use of insecticide treated mosquito nets and indoor spraying with residual insecticides remain ways to reduce malaria transmission, nevertheless, antimalarial drug resistance and insecticide resistance have emerged from these practices and are a major concern in the elimination malaria.

In view of these recent difficulties, the need for malaria immunisation has become increasingly important. Although this has triggered intense research development efforts during the past decades, there is still no commercially available malaria vaccine. Nevertheless, more than 20 different vaccine constructs are currently being evaluated, the most advanced and promising vaccine candidate being the RTS,S/AS01 vaccine against *P. falciparum*, the most deadly malaria parasite globally. However, this vaccine candidate does not provide protection against *P. vivax* malaria, which is the predominant form of malaria parasite in many countries outside Africa.

RTS,S/AS01 was tested in a Phase 3 clinical trial in 7 sub-Saharan African countries between 2009 and 2011, with 15 460 children enrolled. The encouraging results that led the European Medicines Agency to adopt a positive scientific opinion for the vaccine in July 2015. The different stages of approval are shown in Figure 1 for additional clarity regarding drug and vaccine approval processes.

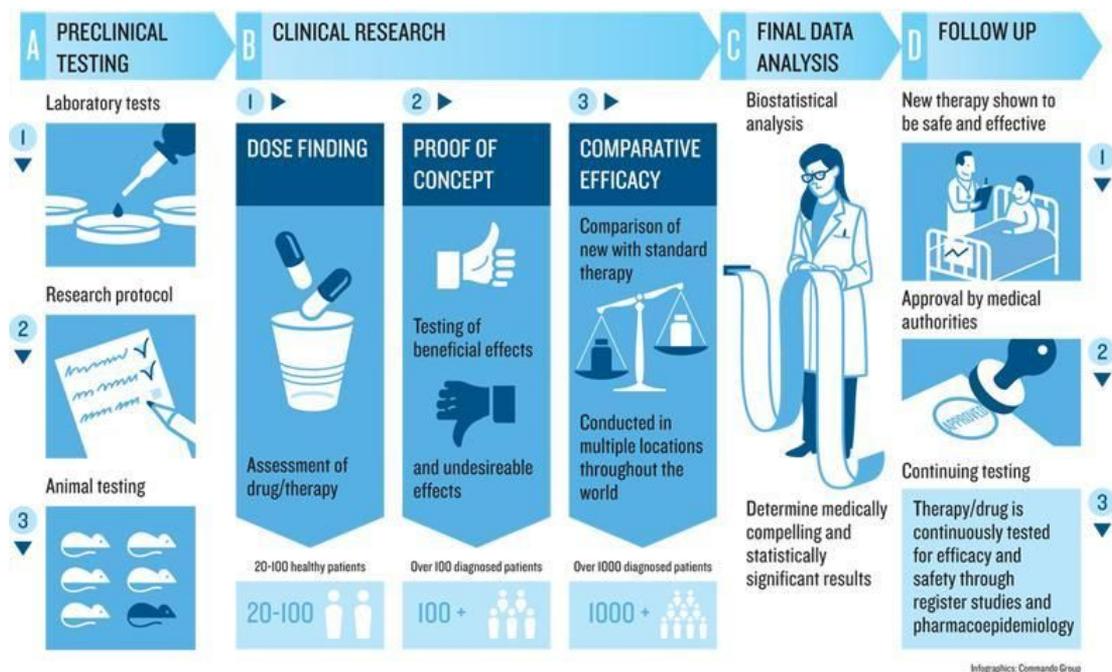


Figure 1. Stages of therapy/drug approval  
 (“Clinical Trials Explained”)

Following this, 2 WHO advisory groups recommended pilot implementations of the RTS,S/AS01 in a limited number of African countries to assess the feasibility of delivering the vaccine as well as its safety and effectiveness. In November 2016, WHO announced that the RTS,S vaccine would be piloted in 3 sub-Saharan African countries in 2018. If deemed appropriate, the vaccine could potentially be used as a malaria control tool in complement to preventive, diagnostic and treatment measures.

## Timeline of Events

1946 - CDC and Malaria	Start of the Communicable Disease Center's mission to combat and eliminate malaria began
1947 - 1951	Eradication of Malaria in the United States
1955 - WHO resolution	Resolution proposed by the WHO to eliminate malaria
2016 - Global Technical Strategy for Malaria 2016 - 2030	Resolution WHA68.2 adopted by the World Assembly to define a new timeline to combat Malaria - Proposed by the WHO

## Key Parties Involved

Communicable Disease Center (CDC)	Stemmed from the Malaria Control in War Areas (MCWA), is involved in trying to prevent the spread of malaria around the world.
European Medicines Agency (EMA)	EU Agency responsible for the scientific evaluation, supervision and safety monitoring of medicines developed by pharmaceutical companies for use in the EU.
Malaria Policy Advisory Committee (MPAC)	Group of 15 global malaria experts providing WHO with independent advice for the control and elimination of malaria.
WHO Global Malaria	Coordinates WHO's global efforts to control and

Programme (GMP)      eliminate malaria

## United Nations Involvement

The most recent United Nations involvement in the spread of the Malaria vaccination has been the WHO Global Malaria Programme (GMP), which is responsible for coordinating WHO's global efforts to control and eliminate malaria. There has been a timeline created to measure progress from 2016-2030 (*Global Technical Strategy for Malaria 2016 - 2030*), adopted by the World Health Assembly in May of 2015. More information can be found at [http://www.who.int/malaria/about\\_us/en/](http://www.who.int/malaria/about_us/en/).

## Useful Links

- <http://worldmaliareport.org/>

Global Malaria Mapper: Includes an interactive mapping program granting access to data concerning malaria across the world.

- <http://www.mmv.org/sites/default/files/uploads/docs/publications/infographics/how-we-could-have-a-world-without-malaria.pdf>

Malaria: Infographic containing useful statistics on malaria and its prevention.

- <https://www.cdc.gov/malaria/about/history/>

The history of malaria, an ancient disease: A history of malaria and attempts at its eradication

- [http://www.mmv.org/sites/default/files/uploads/docs/publications/infographics/Fight\\_the\\_Fakes\\_Fake\\_Medicines\\_Malaria\\_FINAL.pdf](http://www.mmv.org/sites/default/files/uploads/docs/publications/infographics/Fight_the_Fakes_Fake_Medicines_Malaria_FINAL.pdf)

Fake medicines and malaria: Infographic considering the issue of falsification in the fight against malaria; this may be particularly relevant to nations particularly troubled by a national market of counterfeit medical drugs.

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