World Health Organization

Secretary Generals: Joanna Nikolova & Diane Zhang

Chairs: Leela Fredlund & Evie Cai

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Welcome Letter

Dear Delegates,

Welcome to MITMUNC, and more specifically to our World Health Organization committee! We can't wait to see the resolutions you all come to about the two major health crises we've chosen: Female Genital Mutilation and HIV/AIDS. Both are issues which affect different populations unequally, giving them social and cultural repercussions which have historically made them difficult to solve. We hope that WHO's medical focus and your excellent diplomacy skills will provide new insights.

My name is Leela, and I'm so incredibly excited to be one of your chairs this year! This is my fourth time chairing for MITMUNC and my seventh time chairing overall; I loved and was very involved with MUN in high school, and since coming to MIT have chaired ICC, Security Council, and ASEAN committees. I would love to work in international diplomacy in the future, and MUN has been an amazing opportunity for me to explore that! I'm originally from southern California, but at MIT, I'm a junior double-majoring in Political Science and Physics with a concentration in Creative Writing; I'm also a TA for a philosophy class, president of MIT's Panhellenic Association (sorority system), and very involved with several theater groups and my living community! Outside of school, I enjoy playing water polo, writing poetry and novellas, trying to find decent Mexican food in Boston, making soap, and getting lost.

And I'm Evie, a Sophomore double-majoring in Computation and Cognition along with Business Analytics. This is my first time chairing and getting involved with MUN, and I can't wait to chair for the MITMUNC Conference! Although I didn't participate in MUN, I was a debater and wanted to learn more about the collaborative side of complex international issues. Outside of school, I enjoy playing tennis, ice skating, hiking, shopping, and journaling. I'm also really involved in PLEASURE@MIT (Peers Leading Education About Sexuality and Speaking up for Relationship Empowerment) and my living community on campus. I look forward to seeing you all at the conference!

The following background guide is only meant to provide an introduction to the committee's two topics; additional research is required for background guides and will serve you well during debate. Please email your position papers to **who-mitmunc-2023@mit.edu** five days prior to the start of the conference. I cannot wait to see each and every one of you in committee, and I very much look forward to a productive and (most importantly) enjoyable MUN experience! If you have any questions, feel free to reach out at any time.

Best of luck,

Leela Fredlund and Evie Cai

Chairs, WHO, MITMUNC 2023

Topic 1: Ending Female Genital Mutilation

INTRODUCTION TO AND HISTORY OF FEMALE GENITAL MUTILATION

Female Genital Mutilation, or FGM, is the modification or injury of a woman's genitals under circumstances other than medical necessity. The process, also known as female circumcision (especially in nations which practice it heavily) can involve a variety of different procedures. FGM is therefore classified into four types: Type I involves removal of the clitoris or clitoral hood, Type II involves some removal of the inner labia (and can include removal of the outer labia and/or clitoris), Type III involves removal of some of the labia as well as stitching the labia majora closed (with a small opening for urination and menstruation), and Type IV involves any other harm to a woman's genitals. The process used for FGM varies by culture and purpose; many surgeries are ceremonial and involve special rituals performed at landmarks in a girl or woman's life.

While no form of FGM has health benefits, the level of harm caused to a woman undergoing FGM depends on the type being performed and who it is being performed by. Side effects can include pain (short and long-term), urine retention, infection (both of the wound and STD infection from instruments), cysts, infertility, anemia, UTIs, various neonatal complications, increased infant mortality, no libido, depression, PTSD, painful sex, and death (from a variety of causes).

The origin of the practice is unknown; theories include class-related origins in ancient Egypt, mutilation of ancient Roman slaves to avoid pregnancy, and concurrent invention in the Middle East and western Africa. Regardless of its origin, trade and slave routes across the Mediterranean and northern Africa spread the practice through to sub-Saharan Africa, and later trade routes between the Arab world and the Pacific are believed to have brought the practice to

southeast Asia. Female genital mutilation (especially removal of the clitoris) was also developed in Europe and the United States in the nineteenth century, where is was widely supported and prescribed by doctors.

The reasons for FGM vary culture to culture. In some ancient cultures, FGM was used to prevent pregnancy among slaves or lower classes. In other cultures, both ancient and modern, it is used to ensure a woman stays "marriageable" by lowering her sexual desire and therefore preserving her virginity until marriage; it can also be a beauty standard in these cultures. In still other societies, it can serve as a cultural ceremony indicating a woman's coming of age, unrelated to her sexual activity. It is also sometimes believed to increase hygiene and fertility and used as a preventative measure before pregnancy.

In Europe and the United States, FGM was developed as a treatment for various diseases in women. Masturbation, for example, was considered a disease in the nineteenth century, and removing a woman's clitoris was thought to be a cure. FGM was also prescribed for epilepsy, lesbianism, "hysteria," and a lack of sexual desire. These practices persisted into the 1960s, though the general medical community had denounced them by the turn of the twentieth century.

In Africa and the Middle East, meanwhile, where FGM had been practiced for thousands of years, pushback came from multiple sources. In some areas, groups of women banded together to oppose the practice. In other areas, such as Kenya, an influx of European colonizers made FGM the center of cultural debates; Christian missionaries often opposed the practice, which led locals to push back and claim FGM as an aspect of their culture. Many local converts, however, did begin to advocate against the practice within their communities, leading to conflict over the correct status of FGM. This debate persisted throughout the twentieth century in much of Africa. Often, as was the case in Egypt in 1946, doctors opposed the practice and

legislators outlawed it, only for citizens (especially women) to perform it anyway in protest. Throughout the latter half of the twentieth century, many African women used the advent of mass media to speak up about their experiences with FGM and condemn it.

THE CURRENT EFFECTS AND SCOPE OF FEMALE GENITAL MUTILATION

As might be expected, it can be difficult to estimate the number of women affected by FGM. In areas where it is illegal but still practiced, cases can be underreported, and in areas where it is culturally expected, cases may be overreported. Additionally, due to language and modesty constraints, it can be difficult for surveys to ask what type of FGM was performed. Nevertheless, 2013 UNICEF estimates from countries which did respond put the number of affected women at over 200 million, implying that there are likely many more from countries which did not respond. Most of these are concentrated in Indonesia, Ethiopia, and Egypt, due to their large populations, but percentages of the population affected by FGM are higher in other nations, such as Somalia, where 98% of (reproductive-age) women have undergone FGM. The type of FGM is also linked to country and ethnic group; most FGM in Somalia, for example, is Type III, whereas most in Indonesia is Type IV, with variations in type based on ethnic group in Ethiopia. It is generally more common in rural areas and lower socioeconomic classes.

While FGM is concentrated in North Africa, East Africa, and Indonesia, it has also been observed being practiced in India, central America, and the Middle East, where its purpose and origins are less recorded. There are also recorded cases throughout Europe and North America, many within immigrant populations from nations where FGM is more commonly practiced. While the percentage of women who are undergoing FGM is decreasing,

the total number is increasing due to population growth in many nations where FGM is prevalent.

The age of women who undergo FGM depends on the reason behind the FGM. In cases where it is to protect health during pregnancy, it is usually in adulthood; in cases where FGM is performed as part of a coming of age ceremony, it is usually in a woman's early teens; in cases where FGM is believed to make a woman more sexually pure, and usually with Type III FGM, it is often performed when a girl is 2-6 years old. Thus, nations with different types of FGM will likely have different average ages for the procedure. In general, about ⅕ of those who undergo FGM are under the age of 14, many of whom lack the ability to consent to the procedure.

Currently, 51 nations have explicitly anti-FGM laws, 15 more have general laws which can be interpreted to prohibit FGM, and several others outlaw FGM in some states or outlaw it without a stated penalty. However, 25 nations have no prohibitions on FGM, and many of the nations that do only prohibit certain types under certain circumstances. Criminalizing FGM can also make it more difficult for those who have undergone FGM to seek appropriate medical care.

While the international community has generally pushed to criminalize FGM and many of its critics are women who underwent FGM without their consent, most of the perpetrators of FGM are women. Thus, there is significant pushback from women who do see the procedure as an important part of their culture. This debate continues in many countries in which FGM is still legal, with doctors and women in rural areas on opposing sides. Conversely, in nations where FGM is illegal, it often still occurs, leaving the question of whether to prosecute those who have underwent the procedure and thus stigmatize it more.

PAST INVOLVEMENT

- UN INVOLVEMENT:
    - Because FGM often affects young girls, UNICEF, or the United Nations International Children's Emergency Fund, has tackled FGM in the past. Through the 2008 UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation, they have partnered with UNFPA (the United Nations Population Fund) to shift social norms, increase education, provide healthcare, and aim to end FGM by 2030. (This program focuses on African nations, and not the Middle East or Indonesia.) According to their 2020 report, “Through the support of the joint programme, more than 5.5 million girls and women received prevention, protection and care services related to FGM. Some 42.5 million people made public declarations to abandon FGM. 361,808 girls were prevented from undergoing FGM.”
    - In 2012, the UN General Assembly created the International Day of Zero Tolerance for Female Genital Mutilation to bring attention and worldwide focus to the issue. They also signed into force a resolution condemning the practice and expressing their support for the UNFPA-UNICEF Joint Programme.
- WHO INVOLVEMENT:
    - As WHO focuses more on the medical implications of FGM (as opposed to UNICEF and UNFPA, which focus on humanitarian and gender equality aspects), it has complemented their efforts. In 1997 WHO released a statement against FGM, and it partnered with eight other UN agencies to release another condemnation in 2008. In 2010, it developed and published a long-term strategy

to end FGM and its negative health effects; in 2016, it followed up with a report on health complications arising from FGM and how to best combat them. Since then, WHO has also published a handbook on how clinicians should address FGM and guidelines on how to ethically research FGM.

- According to their website, "WHO efforts to eliminate FGM and Medicalization focus on: Strengthening the health sector response: developing and implementing guidelines, tools, training and policy to ensure that health care providers can provide medical care and counselling to girls and women living with FGM and communicate for prevention of the practice;
- Building evidence: generating knowledge about the causes, consequences and costs of the practice, including why health care providers carry out the practice, how to abandon the practice, and how to care for those who have experienced FGM;
- Increasing advocacy: developing publications and advocacy tools for international, regional and local efforts to end FGM, including tools for policy makers and advocates to estimate the health burden of FGM and the potential public health benefits and cost savings of preventing FGM."

POTENTIAL BLOCS AND POSITIONS

North America and Western Europe: Most modern cases of FGM in these countries are immigrants who had the procedure performed before immigration or members of ethnic groups in which FGM is common. While FGM is almost entirely illegal here, these nations should focus on treatment plans for existing women with FGM and ensuring enforcement of their laws.

Latin America and East Asia: These nations have very little incidence of FGM, and are likely more concerned with its effects on the global community as a whole.

Southern Africa, South Asia, and the Middle East: While rates of FGM in these nations are moderately low, they are non-zero, and many of these nations lack laws against FGM which could bring numbers lower. For these nations, it is important to weigh whether FGM should be culturally accepted and legally accepted.

Northern Africa, East Africa, Indonesia: Rates of FGM here are extremely high. Whether or not FGM is legal or not (and to what extent it is prohibited if at all) varies nation to nation, as do the specific customs and types associated with FGM. As a result, these nations may or may not approve of ending FGM, and likely have diverse perspectives to consider, both internally and from the global community.

DISCUSSION QUESTIONS

1. For nations which wish to end FGM, how can one convince women that a deep-seated cultural practice is not in their best interests?
2. For nations which do not wish to criminalize FGM, should it matter whether a woman consents to FGM? Should her age matter? How can one minimize the medical complications arising from FGM?
3. How does your nation's unique culture and ethnic composition shape its attitude towards FGM? Towards women and sexuality in general?

Topic 2: Addressing the Continued Prevalence of HIV/AIDS

GLOBAL HISTORY OF HIV/AIDS SPREAD AND CRISES

HIV (human immunodeficiency virus) is a virus that attacks the body's immune system. If HIV is not treated, it can lead to AIDS (acquired immunodeficiency syndrome). There are currently no effective cures for HIV. Once people get HIV, they have it for life, but with proper medical care, it can be controlled. The first stage of HIV is called acute HIV infection. In this stage, many people have flu-like symptoms. The second stage is called chronic HIV infection, where people may not have symptoms or get sick but can transmit HIV as it's still active and continues to reproduce in the body. Finally, the third stage is called Acquired Immunodeficiency Syndrome (AIDS), where people have severely damaged immune systems. In this stage, without HIV treatment, people typically survive only three more years.

In 1985, the first International Conference on AIDS was held in Georgia, USA, and the first Canadian Conference was held in Montreal. In 1999, WHO announced that AIDS was the fourth biggest cause of death worldwide and the number one killer in Africa.

Anti-retroviral treatment (ART) allows people with HIV to live longer and prevents new HIV infections. In 2016, 1 million people died from HIV/AIDS, but 1.2 million deaths were prevented as a result of ART. In addition, a person today living in a high-income country who started ART in their twenties can, on average, expect to live for another 46 years. However, this is still below the life expectancy of the general population and is not accessible by many. By 2018, 61% of HIV-positive individuals were receiving ART, but this still means that there were 14.6 million more people who could have been benefiting from the life-saving treatment.

However, only 79% of people who HIV knew their status, and in Sub- Saharan Africa, only 57% of people who are HIV positive complete pre-treatment assessments. Among those people, only 66% actually start ART treatment. Lack of awareness is an integral issue, and so is stigmatizing of people who have HIV/AIDS. This leads to a decrease in engagement with care, treatment, and prevention services. UNAIDS estimates that $29 billion will be required for the AIDS response in low- and middle-income countries, including countries formerly considered to be upper-income countries, in 2025 to get on track to end AIDS as a global public health threat.

THE CURRENT EFFECTS AND SCOPE OF HIV/AIDS

Currently, approximately 38 million people are living with HIV, and over 40 million people have died of AIDS-related cases since the beginning of the epidemic. Too many people with HIV or at risk for HIV still do not have access to prevention, care, and treatment, and there is still no cure. Furthermore, the HIV/AIDS epidemic has already devastated many individuals, families, and communities. The epidemic has left millions of children orphaned, has disrupted village and community life, and increasingly contributes to the erosion of civil order and economic growth. Many of the countries hardest hit by HIV also face serious challenges due to other infectious diseases, food insecurity, and additional global health and development problems.

The vast majority of people with HIV are in low- and middle-income countries. In 2021, there were 20.6 million people with HIV (53%) in eastern and southern Africa, 5 million (13%) in western and central Africa, 6 million (15%) in Asia and the Pacific, and 2.3 million (5%) in Western and Central Europe and North America. Of the global total of people who are living with HIV, 95% live in developing countries. As the epidemic evolves further, rates will continue

to rise in communities and nations where poverty, social inequalities, and weak health infrastructures facilitate spread of the virus.

Women and girls represent nearly half of all people living in HIV worldwide and HIV is the leading cause of death among women of reproductive age. Gender inequalities, differential access to service, and sexual violence increase women's vulnerability to HIV. In sub-Saharan Africa, young women ages 15-24 are twice as likely to be living with HIV than young men.

Expansion of treatment coverage and preventive measures have reduced HIV burden in many sub-Saharan African countries. Conversely, eastern Europe and central Asia, which are less affected by HIV historically, have begun to see an increasing incidence. Particularly, Russia had the highest annualized rate of change in incidence of 13·2% between 2007 and 2017.2 This increase in incidence might be due to limited access to ART, which is exacerbated by an absence of syringe exchange programmes, bans on opiate substitutes, and stigmatization of high-risk populations. Similarly, harm reduction services are inadequate in much of eastern Europe and central Asia.

PAST INVOLVEMENT

- UN INVOLVEMENT:
    - Since 1996, its efforts have been coordinated by UNAIDS—the Joint United Nations Programme on HIV/AIDS. UNAIDS is an innovative joint venture of the United Nations family, which brings together the efforts and resources of 11 United Nations system organizations to unite the world against AIDS. These are: UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, UN Women, ILO, UNESCO, WHO and the World Bank.

- The Global Fund to Fight AIDS, Tuberculosis and Malaria was created in 2002. And in 2006, the General Assembly held a high-level review of progress made since its special session, adopting a 53-point Political Declaration on the way towards universal access to HIV prevention, treatment, care and support services. Another meeting- General Assembly High-Level Meeting on AIDS- in 2011 defined the next steps in the global AIDS response.
- In 2015, the world delivered on the AIDS targets of Millennium Development Goal 6—halting and reversing the AIDS epidemic (first time a global health target has been met and exceeded). The epidemic has been forced into decline. Now the response is going one step further—ending the AIDS epidemic by 2030.
- The aspirational 90-90-90 goal of UNAIDS aims to globally diagnose 90% of people living with HIV, provide treatment to 90% of people diagnosed, and achieve viral suppression in 90% of people on treatment by 2020. A subsequent 95-95-95 goal is set for 2030.

- WHO INVOLVEMENT:
  - According to WHO's website: global health sector strategies on, HIV, viral hepatitis, and sexually transmitted infections for the period 2022–2030 (GHSSs) guide the health sector in implementing strategically focused responses to achieve the goals of ending AIDS, viral hepatitis B and C and sexually transmitted infections by 2030. The 2022–2030 strategies recommend shared and disease-specific country actions supported by actions by WHO and partners. They consider the epidemiological, technological, and contextual shifts of previous years, foster learnings across the disease areas, and create opportunities to

leverage innovations and new knowledge for effective responses to HIV, viral hepatitis, and sexually transmitted infections.

- The strategic directions of the GHSSs 2022–2030 are to:
- deliver people-centered evidence-based services
- optimize systems, sectors and partnerships for impact
- generate and use data to drive decisions for action
- engage empowered communities and civil society
- foster innovation for accelerated action.

- As a founding cosponsor of the UNAIDS Joint Programme, WHO takes the lead on HIV testing, treatment and care, resistance to HIV medicines and HIV/TB co-infection. WHO jointly coordinates work with UNICEF on EMTCT of HIV and pediatric AIDS and works with UNFPA on the integration of SRHR and HIV. With the World Bank, WHO convenes actions to drive progress towards achieving universal health coverage, including, and with UNICEF, through primary health care. WHO also partners with UNODC on harm reduction and programmes to reach people who use drugs and people in prison and other closed settings.

POTENTIAL BLOCS AND POSITIONS

North America, Western Europe, Australia, Canada, Brazil: In general, these countries have health care and public health systems with substantial resources. Many have put into place programs, similar to those in the United States, for controlling the spread of the epidemic through certain routes of transmission (e.g., parenteral). Also, many countries, such as the United Kingdom, have initiated national public education programs on AIDS. These countries would probably focus on the funding aspect of the international battle against AIDS.

Sub-Saharan Africa: bears the heaviest burden in the HIV/AIDS epidemic. Medical solutions alone will not be successful in beating the virus. Investments in HIV prevention and treatment gives countries the opportunity to think about how sustainable social protection can be put in place. Rwanda example: community-based health insurance that uses international aid as seed money- health insurance gives people better financial access to health services, contributes to sustainability, and increases utilization of health facilities to sustain the fight against AIDS. Asia: over the years, many countries have responded to HIV/AIDS successfully and incidence rates have declined. Advances in HIV prevention and treatment could end AIDS as a public health threat in the region, as ART usage is still behind global trends. Many of these countries still have laws that impede HIV response (criminalize same-sex relations, criminalize transmission of, non-disclosure of or exposure to HIV transmission, restricting entry, stay and residence of people living with HIV, etc.)

Latin America: moving target, successful implementation of large-scale PrEP programs urgently need political commitment, leadership, civil society advocates and the involvement of scientific and academic communities to move them forward. Also, large-scale migration across borders increases vulnerability to HIV/AIDS. Increasing access to screening tests and treatment may require legislative and administration changes in many Latin American countries in addition to increasing funds.

DISCUSSION QUESTIONS

1. How can different countries' legislatures serve as a barrier in fighting against HIV/AIDS? How do the political structures within each country help or hinder the process?

2. How does your country's cultural beliefs affect the way HIV/AIDS is viewed? What are some ways to reduce stigmatization and increase education in relation to these cultural beliefs?
3. What role does money play in relation to each country's plan and the international one?

Source for Further Consideration:

- https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation
- https://med.virginia.edu/family-medicine/wp-content/uploads/sites/285/2017/01/Llamas-Paper.pdf
- https://notchesblog.com/2014/11/18/clitoridectomies-female-genital-mutilation-c-1860-2014/
- https://data.unicef.org/topic/child-protection/female-genital-mutilation/
- https://www.un.org/en/observances/female-genital-mutilation-day
- https://www.unicef.org/protection/unfpa-unicef-joint-programme-eliminating-fgm
- https://www.un.org/en/global-issues/aids
- https://www.unaids.org/en/resources/fact-sheet
- https://www.publichealth.org/public-awareness/hiv-aids/origin-story/
- https://www.who.int/news-room/fact-sheets/detail/hiv-aids
- https://www.kff.org/global-health-policy/fact-sheet/the-global-hivaids-epidemic/
- https://ourworldindata.org/hiv-aids