World Health Organization
Chair: Lena Hu
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Dear Delegates,

My name is Lena and I am the chair for the World Health Organization this year. I am a sophomore at Princeton majoring in Economics and minoring in Finance and French, and I have 5 years of experience with Model UN - four as a high school delegate and one staffing PMUNC last year! Outside of MUN, I compete on the Debate Team, work in the Office of International Programs, and spend my free time travelling, trying out new food, and hanging out with friends.

I am so excited to hear your discussions on climate change and public health and women’s health throughout this year’s conference. These are topics that are highly relevant in the global community and issues that all countries have a stake in. It is crucial that delegates stay up to date with the most recent current events and updates in both of these areas to facilitate a meaningful and pertinent discussion.

Both of these topics have purposely been left broad so that delegates may advocate for the specific subtopics that are important to their country. For example, I expect that island nations experiencing flooding will have different health policy goals than landlocked countries experiencing drought. Similarly, developed versus developing nations will have vastly different resources and may have contrasting cultural norms that create divergent priorities for women’s health care. Through the caucuses, I anticipate two or three focuses each emerging under Climate Change and Women’s Health Care. It will be to a delegate’s advantage to research the most pressing concerns for their nation, be it the prevention of waterborne disease or improved prenatal care, and push for those focuses verbally and within committee resolutions.

Questions you may want to consider for Climate Change Health Policy include: What is the best way to mitigate increased tropical, vector-borne, and/or waterborne diseases from climate change? What national systems of natural disaster response are in place to help the injured? Should my country invest in water and air purification systems? Some questions you may ask yourself on women’s health care are: What is my country’s position on contraception and abortion? Should sexual education be mandated in schools? What degree of prenatal care should be available for women? Does my nation need to prioritize solving the HIV/AIDS epidemic?

Besides researching your own objectives, it is crucial to research the goals of potential allies and to align in committee to push for common agendas. Most importantly, delegates should authentically represent the political and cultural views of their nation, even if those views conflict with their personal ideology. With this in mind, I look forward to meeting all the delegates and running a fun and engaging committee!

Best,

Lena Hu
TOPIC A: Climate Health-Risks

Introduction

The urgency of addressing anthropogenic climate change has become increasingly apparent in the past few decades. Much of international discussion on climate change has focused on a single issue: the mitigation of greenhouse gas emissions. For example, the Kyoto Protocol committed several countries, including Australia, Japan, Russia, and European Union member states to penalty-based, legally binding emission reduction targets. Similarly, the Paris Agreement emphasizes emissions mitigation, but lacks the non-compliance punitive mechanisms of the Kyoto Protocol. While these proactive measures indicate a global willingness to broadly combat climate change, less international attention has been placed on the solutions needed to specifically address the health risks of climate change.

It is important to note the degree of uncertainty when determining which of the numerous climate-related health risks will be the most likely to occur in the future. However, there is a scientific consensus that there is an extremely high certainty that climate change will increase the risks of food and waterborne disease, a high certainty that it will increase the risks of heat-related injury and death, and a medium certainty that it will increase the risk of vector-borne disease. These three higher-certainty implications indicate that there will be lower labor productivity and potential displacement of vulnerable populations, such as the elderly and poorer individuals, who reside in high-temperature zones.

The task of WHO during committee is thus to come up with global solutions for these three climate-related health risks: food and waterborne disease, heat-related injury, and vector-borne disease. It is up to the delegates to decide the order in which these will be discussed, but discussion of all topics should address both the technical and diplomatic responses to the risks
History of the Topic

Climate change has had a serious impact on human health for tens of thousands of years. Forty thousand years ago, the Neanderthals are thought to have gone extinct because climate change resulted in the extinction of their primary prey animals and because Neanderthals’ bodies were ill-adapted to survive the warmer temperatures. From then onwards, the collapse of major civilizations was correlated with periods of climate change. The falls of the Akkadian Empire (2000 BC), the Mayan Empire (900 AD), the Angkor Empire (1400 AD), and several others coincide with periods of severe drought. Much more recently, Syria experienced the worst drought in its history when its civil war began in 2011, leading to massive crop failure and livestock death, heightened social tensions, and exacerbating factors that led to the conflict seen today, which has been deemed by the WHO as a public health crisis.

The trend is clear: climate change is linked to the widespread death and suffering of human populations. Part of the link is due to famine and higher food prices, which leads to starvation protests and insurrections. Another part of the correlation is due to the lack of health technology to cope with the extreme weather events: during these time periods, people lacked both the technical expertise and/or the accessibility to primary health care to prevent climate-related injury and death.

Another particularly striking historical record is the past pattern of vector-borne diseases. From the black plague, which wiped out tens of millions of people in the 14th century, to the outbreaks of Yellow Fever in the Caribbean and New England in the 17th and 18th centuries, vector-borne disease epidemics have a significant role in human history. Many of these epidemics became global outbreaks due to increased globalization and international trade, particularly the trade of African slaves. These trade interactions introduced new diseases to populations without biological resistance due to lack of past exposure, resulting in mass infection and death.
Given that climate change is projected to amplify the frequency and effects of diseases such as vector-borne disease, water and foodborne disease, and heat-related illness, it is imperative that this committee learns from the crises of the past to mitigate climate-related health risks.

**Current Situation**

There have been several resolutions passed related to climate change and public health, which I encourage you to research and read through. Below are brief synopses of some of the agreements that have already passed; however, you should do further independent research that is more specific to your country.

*World Health Resolution A61.19 (Climate Change & Public Health)*

Adopted in 2010, this resolution outlines a public health awareness campaign with posters, PSAs, and fact sheets, encourages partnerships with other UN and related groups, and recommends partnerships between developed and developing nations.

*World Health Resolution A66.12 (Neglected Tropical Diseases)*

Adopted in 2013, this resolution encourages all 193 member states to integrate tropical disease prevention and control protocols into existing health care programs, work closely with the health industry to develop new medicines, and communicate with each other to prevent global spread.

*The WHO Foodborne Disease Initiative*

In 2015, the WHO convened and released a report on the global burden of foodborne diseases. The comprehensive report details the main foodborne diseases and helps quantify previously nebulous global impact of these diseases. Furthermore, an international group of renowned scientists in fields such as microbiology, nutrition, and medicine was formed to advise the WHO and draft reports related to foodborne disease. This group is called the Foodborne Disease
Burden Epidemiology Reference Group (FERG). Delegates may want to consider utilizing this resource of top researchers within their resolutions.

*The Global Vector Control Response 2017-2030*

Largely in response to the recent Ebola and Zika outbreaks, in June 2017, the WHO passed a vector-borne disease strategy for the next 13 years. The plan supports case-by-case national need analysis, the creation of training and education programs in public health, the development of vector surveillance systems and predictive geoinformatics, and investments in technology and research. Delegates should decide whether they agree with this strategy, wish to add onto it, or wish to pass a more regionally focused resolution on vector-borne disease.

Some foodborne, waterborne, vector-spread, and heat-related illnesses already have treatments available, but others have yet to have developed cures. Even in cases where a treatment exists, it can often be prohibitively costly for poorer communities.

*Current Treatment status for major vector-borne diseases:*

- **Yellow Fever Vaccine** - the 17D vaccine, cost ranges from $150-$350.
- **Japanese Encephalitis Vaccine**, cost is about $100.
- **Schistosomiasis** (Very prevalent in sub-saharan Africa) - can be successfully treated with praziquantel, cost is ranges from $0.20-$0.30.
- **Malaria** - there is no commercially available malaria vaccine, but preventive medications and reactive treatments exist.
- **Lyme disease** - can be successfully treated with antibiotics.
- **Dengue fever** - no commercially available vaccine exists, but trials are being run to develop one.
- **Zika virus** - scientists are currently in phase 1 of developing a vaccine for this virus.

*Current Treatment Status for Major Food and Waterborne Diseases:*
• Cholera - treatment is intake of simple rehydration solution (e.g. drinking electrolyte water)

• Salmonella food poisoning - Most people recover without treatment, but some may need antibiotics such as ampicillin or ciprofloxacin.

• Diarrhea - This is often a symptom of food poisoning, and can be treated with rehydration, physical rest, and potentially antibiotics in more serious cases of infection.

• Listeria - Can be successfully treated with antibiotics.

• Typhoid Fever - Best prevented with the typhoid vaccine.

• Giardia - This infection can be treated with prolonged antibiotic treatment.

• Hepatitis A - Best prevented with the 2-part vaccine. No treatments, besides bedrest and fluid intake, exist outside of the vaccine.

*Current Treatment for Heat-Related Injury*

Most treatments for heat related injury are rest-based rather than pharmaceutically or medicinally based.

• Heat Exhaustion - Treat by drinking fluids, taking a cool bath, and applying ice towels to the body.

• Heat stroke (more severe than heat exhaustion) - Treat with an ice bath or cool body sponging. Immediate response is crucial and any delay can result in death.

• Sunburn - Best treatment is preventative: using sunblock, wearing protective clothing, and limiting outdoor activity during peak sun hours. Reactive treatment includes cool clothes, soothing lotions, and cool showers on affected areas. Chronic overexposure may result in skin cancer, which requires more invasive chemical treatments.

The topic of climate change and public health is greatly influenced by location. In other words, the geography and demography of each delegation’s country will determine its priorities.
Coastal and Island Nations

These countries have a particularly strong stake in climate-related public health. For example, the small island state of the Maldives faces eventual submersion if sea levels continue to rise at current levels. The vulnerability of the Maldivian Islanders to climate-related health risks is worsened by the high level of malnutrition in children, diminished accessibility and quality of healthcare, and low income levels. Other island and coastal nations that have been identified as high-risk for coastal flooding include Bangladesh, Vietnam, the Philippines, China, and India. Overpopulated, low-lying delta areas in Asia and Africa will see the largest number of affected people.

High Temperature Zones

High temperature zones are areas that are expected to experience drastically hot temperatures (upwards of 140°F) and heatwaves should climate change continue at its current “business as usual (BAU)” pace. It is especially important that these countries have the medicine and technology to deal with heat-related injury and the health system capacity to react quickly to unexpected heat waves. Middle Eastern and North African nations such as Qatar, the UAE, Saudi Arabia, Bahrain, Iran, Egypt, Algeria, and Libya will experience the hottest temperatures.

*Note that across the board, least developed countries (LDCs) and small island developing states (SIDS) will be hit the hardest by climate change.

Country Policy

In 2015, the WHO collaborated with the UN Framework Convention on Climate Change (UNFCCC) to release a global overview of climate and health country profiles. Brief explanations of some of these profiles are listed below.
**United States**

Both the East and West coasts of the United States face severe flooding if climate change continues at this rate and several of its cities will face heightened temperatures and heat waves. The National Institutes of Health (NIH) has recommended the formation of emergency preparedness plans for cities at risk of heat waves, the introduction of proper protocols for infectious disease outbreaks, and the creation of shelter facilities with backup generators and surge capacity in high-risk areas. Several cities, including Portland and Seattle, have piloted these types of programs with varying degrees of success.

**Bangladesh**

Bangladesh is expected to experience severe flooding, saltwater intrusion, and stronger storms on its expansive coastal regions due to climate change. It has appropriately made climate-related health risk mitigation a top goal. Among its priorities are strengthening climate-change resistant health infrastructure and reducing water contamination by increasing access to toilets and running water.

**China**

China’s rapid industrial growth has compounded the environmental impacts of the simultaneous climate change. Heat waves have resulted in increased injury and death in urban centers like Beijing and Shanghai, and water and air pollution has been linked to higher rates of cardiopulmonary mortality. China uses a four-tier warning system to alert the public to daily air pollution levels; the highest level “red alert” results in schools, factories, and construction sites closing down for the day and is more likely to occur on high-heat days. Currently China’s health system included administrations in charge of infectious disease control and public health emergency response.
India

Like China, India is particularly susceptible to heat waves, particularly in its most densely populated cities. The Indian government released a heat-wave action plan in 2016, which included the development of early warning systems, public outreach through mass “heat alert” text messages, the construction of heat shelters and “public cooling spaces” with free drinking water, and the integration of dedicated heat treatment wings within hospitals.

The Netherlands

The Netherlands is at high risk for climate change-related flooding in the future. However, it is notable for constructing some of the most advanced flood-prevention infrastructure in the world. They have built numerous dams that seal off high risk waterways, strategically rerouted canals, and invested billions in levee construction.

Uganda

Uganda is at high risk for vector borne disease, notably malaria and schistosomiasis around bodies of water like Lake Victoria and the Nile River. Poverty and poor sanitation make it difficult to access basic necessities such as clean water, vaccines, and primary health care, especially in rural areas that lack transportation and health infrastructure. Uganda does not have a formal EMS (Emergency Medical Service) system, and the lack of first responder personelle greatly increases the rate of death in otherwise treatable medical emergencies. Setting up an ambulance system is among Uganda’s top priorities.

Brazil

Brazil has suffered from several highly-publicized infectious disease outbreaks in the past, including the mosquito-transmitted Zika viral outbreaks and waterborne disease transmission from Rio’s sewage-tainted waters during the 2016 summer olympics. Analysis of the Brazilian government’s response to these outbreaks has been mixed. Some have condemned the slow
identification of Zika, the poor sanitation that worsened the outbreak, and the crackdowns on abortions in microcephaly pregnancies. Others have stated that the Brazilian health authorities did their best during a period of political turmoil and economic instability in Brazil. Since the height of the crisis has passed, the Brazilian and other Latin American governments have discussed ways to make clean water and hygiene a priority.

**Key Terms**

*Food and waterborne disease*

Food and waterborne diseases are diseases caused by bacteria, viruses, parasites, or chemical substances entering the body through contaminated food or water. These contaminants can include salmonella, listeria, heavy metals like mercury and lead, human and animal fecal matter, and parasites such as tapeworms and giardia. Rising temperatures from global warming heighten the risk of spoiled food, especially in areas that lack refrigeration capabilities. Similarly, flooding increases the risk of spreading polluted water, particularly in communities that lack surge capacity sewage systems or communities that employ open air toilets.

*Vector-borne disease*

The WHO defines vector-borne disease as “illnesses caused by pathogens and parasites in human populations.” Vector-borne diseases are transmitted by organisms such as mosquitoes, ticks, fleas, snails, and rats and include Zika, malaria, yellow fever, dengue fever, schistosomiasis, west nile fever, and Lyme disease. As with waterborne disease, maintaining access to clean, sanitary water is crucial to reducing the risk of infection.

*Heat-related injury and illnesses*

Heat-related illnesses are triggered by higher temperatures and extreme weather events like heat waves and drought. Effects of heat-related injury and illnesses include dehydration, heat stroke,
and physical exhaustion. Groups that are particularly vulnerable to heat-related illness include elderly individuals, young children, pregnant women, and individuals with a pre-existing medical condition that could be compounded by higher temperatures.

*Note: Heat waves are defined differently by different nations. For example, India classifies a heat wave as a period of two or more days where the temperature exceeds 113°F. On the other hand, the UK defines a heatwave as a period when the daily maximum temperature exceeds the average temperature by 41°F for five or more days. By this definition, the August 2003, 101°F, 10-day period in the UK was considered a heatwave by the British government, even though it would not have been classified as a heat wave by the Indian government. Make sure you know your nation’s definition of a heat wave.

Questions

- How does my country’s geography affect its climate change priorities?
- What vectors are native to my country?
- Should emergency response be primarily nationally or internationally-based?
- What is the status of the healthcare infrastructure in my country?
- Should my country prioritize investing in primary care for all or higher level scientific research?
- Should public health solutions be more preventative/proactive or response-based/reactive?
- Is treatment to infectious disease (waterborne, foodborne, vectorborne) available and accessible to people in my country?
- Which nations can I partner with to share technology, information, funding, infrastructure, etc.? Do I want to create a regional bloc (e.g. a North African, South East Asian, Middle Eastern, European, South American, etc. coalition)?
Useful Links

**Heat-Related Illness**

- WHO Europe: Public health advice on preventing the health effects of heat
- IPCC Fifth Assessment Report (AR5) on climate change, including evidence of increased heat waves and prolonged heat events
- WHO fact sheet on management of heat-related illnesses
  - [http://www.searo.who.int/myanmar/areas/factsheet_heat-related_illnesses_whofinal.pdf?ua=1](http://www.searo.who.int/myanmar/areas/factsheet_heat-related_illnesses_whofinal.pdf?ua=1)
- WHO Heat-Health Action Plans
  - [http://www.euro.who.int/__data/assets/pdf_file/0006/95919/E91347.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0006/95919/E91347.pdf?ua=1)

**Vector-Borne Disease**

- WHO: A global brief on vector-borne disease
- Global Vector Control Response 2017-2030
- Guide to Integrated Vector Management (IVM)
  - [http://apps.who.int/iris/bitstream/10665/44768/1/9789241502801_eng.pdf](http://apps.who.int/iris/bitstream/10665/44768/1/9789241502801_eng.pdf)

**Food and Waterborne disease**

- WHO’s report on the global burden of foodborne diseases
• http://www.who.int/foodsafety/areas_work/foodborne-diseases/ferg/en/

• WHO’s communicable diseases fact sheet
  o http://www.who.int/hac/techguidance/ems/flood_eds/en/

• WHO’s Guidelines for Drinking-water Quality (2011)
  o http://apps.who.int/iris/bitstream/10665/44584/1/9789241548151_eng.pdf

Final Note

As always, feel free to email me at lenah@princeton.edu if you have any questions or concerns regarding committee preparation.
TOPIC B: Reproductive Health Education

Introduction

The modern debate on reproductive health rose to the forefront of global discussion following the alarming outbreaks of HIV and AIDS in the 1970s. Since then, reproductive health has become increasingly relevant, particularly in low-income, developing countries with disproportionately high populations under the age of 18. Although medical research and new technological developments have made sexual health care decisions more effective and factually based, significant sociocultural barriers still exist to the adoption of safe sex practices. Many rural and politically conservative communities still consider it taboo to discuss reproductive health, which hinders the implementation of sex education programs and access to contraceptives, sexual health checkups, proper maternal health care, and other health services.

The World Health Organization defines sexual health as a state of physical, emotional, mental, and social-well being in relation to sexuality\(^1\). Given the broad scope of this definition, this committee will focus on two subcategories to guide discussion: sexual health education and HIV/AIDS prevention and treatment. The World Health Organization, as well as other UN organizations like UNICEF and UNFPA, have previously convened and written on these topics extensively. Past documents resulting from such conventions will be of great use to you, and I encourage you to research and read them. However, more importantly, try to see where those documents failed. Look at whether teen pregnancy and HIV rates have gone down in your country since their passage, whether sexual assault or rapes decreased, whether student academic outcomes improved, whether women were empowered, and other indicators. Based on the real-

world results, pass resolutions that build on the successful aspects of past agreements and eliminate the inefficiencies and failures.

History

*Sexual Health Education*

Comprehensive sexual health education is a relatively new phenomenon. In more conservative societies of centuries past, sex was often considered a forbidden topic. As a result, young girls got their sex education through the snippets of information passed down by older women, from seeing female relatives and friends go through pregnancy, and by witnessing the reproduction of farm animals\(^2\). Information was frequently medically inaccurate and encouraged unequal gender roles within the context of the society and time period. For example, in ancient Egypt and Greece, women were taught that pungent herbal medicines and abstinence would cure the mental hysteria that occurred following female menstruation\(^3\).

While some North American and European nations recognized the need for national sex education in the 19th century, the true urgency of formal, in-school sex education was realized in the late 20th century\(^4\). The movement of people during and following the Second World War lent itself to mass outbreaks of diseases like syphilis and gonorrhoea, which increased public support for sex education. By the 1970s and 80s, progressive social movements like LGBTQ and feminist campaigns in countries like the United States heightened awareness of and support for comprehensive sex education for students in all public schools. Around the same time, the world

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was suddenly made aware of the HIV/AIDS epidemic — a harrowing sexual disease that could incubate for years before resulting in painful death. With no viable treatment at the time, the outbreaks in the UK and US sparked global panic and placed sex education, STD prevention, and contraception at the forefront of many political agendas. From this point in the mid-1980s up to now, increasing political liberalization, the strengthening of sex-positive movements, and improved medical knowledge of sexual activity have all contributed to more wider usage of comprehensive sex education.

Nonetheless, there are still many areas around the world where women still have low access to education or access to harmful, factually incorrect information. For more information on where this is occurring, refer to the next section: “Current Situation.”

HIV/AIDS

Like sexual education, the HIV/AIDS epidemic is relatively recent in the context of human history. It really began in the 1980s, when a number of previously healthy gay men died from opportunistic infections including pneumonia and Kaposi’s sarcoma cancer. By the end of 1981, over 250 people had died from opportunistic infections from AIDS, but it was still unknown that that was the cause. About a year later in September of 1982, cases were popping up all over the world, from Europe, to Africa, to Asia. At this point, the CDC coined the term AIDS to describe the immune deficiency disorder. The epidemic worsened in 1983, with thousands infected and dying throughout the year. At this point, the World Health Organization convened the first meeting in history to address the global AIDS problem and begin brainstorming solutions.

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5 Ibid.
The mid to late 1980s saw worldwide mobilization towards AIDS research and prevention. By this time, every major geographical region around the world had seen cases of the disease, with the Americas experiencing a staggering 31,000 cases, followed by Europe with close to 4,000 cases and Africa with over 2,000 cases. AIDS had become a global crisis, and it was causing international panic. Here, note that AIDS was a particularly psychologically discouraging disease. The incubation period meant that people never knew exactly when they were going to die, yet it was certain that death would occur at some point and likely in a painful way. The public panic associated with this helped push it to the top of the political agenda for many countries and resulted in high levels of international attention for the disease.

In 1987, the first antiretroviral drug was formulated to delay the onset of opportunistic infections post-HIV transmission and one year later, the World Health Organization designated December 1st as World AIDS Day to draw awareness to the disease. In the 1990s, media coverage of AIDS shot up as several famous athletes and celebrities publicly revealed their HIV status: Magic Johnson, Freddie Mercury, Arthur Ashe, and more. As a result, by the late 1990s, the UN formed UNAIDS, a specific body within the UN intended to collaborate with the WHO, UNICEF, and other UN bodies to advocate policy.

Even with this coordinated response, the number of AIDS cases worldwide continued to rise. By the turn of the century, AIDS was the number four cause of death worldwide.

For information on the state of AIDS policy in the 21st century, refer to the next section: “Current situation.”

Current Situation

Sexual Health Education
Currently, sexual health education not only varies from country to country, but from region to region within a country. Generally speaking, sex education in rural areas is less comprehensive than in urban ones\(^7\). Rural areas also tend to have fewer health care institutions that provide sexual health care services such as gynecologist appointments, prenatal care, contraceptives, and family planning. As a result, women living in rural areas in developed and developing nations have sex and get married earlier than their urban counterparts\(^8\), and they also experience higher rates of relationship violence\(^9\) and teen pregnancy\(^10\).

This rural-urban split is seen all around the world. In the United States, currently the developed country with the highest teen pregnancy rate in the world\(^11\), 37 states require that any sex education curriculum include abstinence, and 26 require abstinence-based education\(^12\). The states that don’t require information on contraception but mandate teaching abstinence are concentrated in the South and Midwestern United States — areas that are more rural, politically conservative, and less industrialized\(^13\). Moreover, within this group of abstinence education

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\(^12\) Guttmacher Institute “American Adolescents’ Sources of Sexual Health Information” guttmacher.org. https://www.guttmacher.org/fact-sheet/facts-american-teens-sources-information-about-sex

states, those requiring abstinence-only education have higher teenage pregnancy and birth rates relative to states with abstinence-based and CSE curriculum states\textsuperscript{14}. Even so, the US is more liberal in its sex education compared to many other nations around the world. Listed below are some of examples of current country policy on sex education around the world.

\textit{Uganda}

Uganda is a developing country where half of the population is younger than 15\textsuperscript{15} and almost all schools teach abstinence-only education. Traditional homemaker gender roles are imbibed in girls at an early age, which is possibly correlated to the high teen pregnancy rate and prevalence of HIV. As a strongly Christian society, sex is generally considered a taboo topic and public displays of affection are impermissible\textsuperscript{16}. Nontraditional sexual orientations such as homosexuality and bisexuality are punishable by life in prison.

\textit{Thailand}

Over 85\% of schools in Thailand integrate sex education into their curriculums\textsuperscript{17} and there is public and parental support for these programs. However, comprehensive sex education (CSE) is taught inconsistently across schools; some have separate classes for CSE, while others integrate it into social science, science, or Thai language courses\textsuperscript{18}. Furthermore, while Thai CSE elaborates on reproductive anatomy and STD/STI prevention, it avoids particularly culturally

\textsuperscript{17} Kay et al. “Teaching Sex Education in Thailand”.
sensitive topics such as safe abortion and LGBTQ sex\textsuperscript{19}. On the whole, there is not one standardized national sex education curriculum.

\textit{Saudi Arabia}

Saudi Arabia does not have a formal sex education curriculum within its school system. Although some young people choose to discuss sex with their friends, most choose not to discuss it with their parents and teachers\textsuperscript{20}. As a result, the majority of students are unfamiliar with sexually transmitted diseases such as syphilis, gonorrhea, and hepatitis B. As an Islamic theocracy, conservative family values are paramount: women are expected to be abstinent until marriage, abortion is illegal, and homosexuality is punishable by execution.

\textit{Colombia}

An overwhelmingly Catholic country, Colombia faces specific cultural challenges when it comes to sparking conversation about sex, sexuality, and relationships. Sex education has been present in the country since 1993, when the government launched the National Project for Sex Education aimed at changing the restricted narrative around sex and promoting sexual responsibility\textsuperscript{21}. However, homophobia, limited family planning services, and the taboo of discussing sex both in public and at home have still limited the effectiveness of the initiative\textsuperscript{22}. Nationally, unplanned teen pregnancy rates remain high at around 20\%, and rural areas like

\textsuperscript{19} Ibid.
\textsuperscript{21} Martinez Mendez D, Columbia’s “National Project for Sex Education”, SIECUS REP. 1996.
Chocó, Guainía, and Putumayo have rates closer to 30%\textsuperscript{23}. This indicates that without sufficient logistical capacity to enter isolated rural areas, it is difficult to successfully implement a nationwide sex education protocol.

\textit{The Netherlands}

The Netherlands mandates comprehensive sex education in all of its schools, beginning at age 4 and going through all of primary school\textsuperscript{24}. Sexual diversity, assertiveness, and acceptance are all core tenets of the curriculum. The curriculum teaches human sexual anatomy early on, then moves on to types of families, communicating consent, safe sex, and preventing sexual abuse. The Netherlands currently has one of the lowest teen pregnancy rates in the world, and overwhelmingly teens are aware of and utilizing contraceptive methods the first time they have sex.

\textit{Zambia}

Since 2014, Zambia has been testing out a comprehensive sex education curriculum (CSE) in select schools starting in primary school\textsuperscript{25}. The curriculum includes lessons on previously taboo topics such as the process of puberty and preventing STD transmission. While some parents feel like CSE is contradicting traditional cultural values, others support the school program as a complement to sex education taught at home\textsuperscript{26}. Two years after its debut, many

\textsuperscript{23} Tackling teenage pregnancy in Colombia, Daniels, Joe Parkin, The Lancet, Volume 385, Issue 9977, 1495 - 1496
teachers have noticed a gradual shift towards more equal gender roles. As of now, the program is mostly funded by UNESCO and teacher trainings are done via the web and to a lesser extent, on the ground.

There have been several past international reports and agreements regarding sexual health education. You do not need to know every detail of all of these agreements, but they will be useful as a starting point for brainstorming your own country’s strategies. Make sure to conduct further delegate-specific research on your own.


This meeting discussed definitions of sexual health, looked at barriers to sexual healthcare, and proposed solutions that considered the cultural context of the implementation region. Note that this consultation was not a full committee meeting of the World Health Organization. Therefore, while it makes policy recommendations, it is no way a full resolution with countries committing to enact the recommendations.

Document:


Preventing through Education: A Ministerial Declaration (2008, Mexico City)

This is a declarative pledge by Latin American and Caribbean Ministers to provide comprehensive sex education in schools. Signatories commit to CSE teacher training, HIV and STI prevention, media outreach, and more. This document has technically “expired” in that its goals were given a 2015 deadline, but it is good indicator of past commitment and provides some policy ideas.

UN Sustainable Development Goal (SDG) 3: Ensure healthy lives and promote well-being for all
at all ages

In 2015, the United Nations adopted 17 Sustainable Development Goals (SDGs) to improve global quality of life for all people by 2030. Part of SDG 3 is achieving universal access to family planning, sexual health education, and reproductive health-care services.

HIV/AIDS

There are currently 36.7 million people living with AIDS; the majority live in sub-Saharan African “AIDS belt” countries such as South Africa, Zambia, Botswana, and Zimbabwe\(^\text{28}\). Of those infected, approximately half (18.2 million) are using antiretroviral therapy (ART). While this may not seem like a lot, it marks an over 200% increase from the turn of the century, when antiretroviral drugs were prohibitively expensive and costed thousands of dollars. UN-facilitated negotiations with pharmaceutical companies\(^\text{29}\), along with the creation of the UN Global Fund\(^\text{30}\) aimed at promoting prevention and treatment, have contributed to increased drug accessibility. Over the past ten years, research has only continued to reveal more about the


disease: male circumcision reduces the risk of transmission\textsuperscript{31} (2006), early antiretroviral treatment reduced risk of transmission by over 90\%.\textsuperscript{32} (2011), etc.

In terms of official declarations, UNAIDS has set a “90-90-90\textsuperscript{33}” goal for 90% of people to be diagnosed, getting treatment, and successfully suppressing HIV effects by 2020.

Furthermore, Sustainable Development Goal (SDG) 3 committed the world to end the entire AIDS epidemic by 2030\textsuperscript{34}. With these highly optimistic goals, it is more important than ever to think of new and innovative ways to eradicate AIDS, especially as people develop resistance to antiretroviral drugs\textsuperscript{35}. Other potential challenges with HIV/AIDS is the funding structure of HIV drugs and treatments. Though some sub-Saharan African countries have increased domestic HIV investment, developed western countries, certain corporations, and international philanthropists have historically been the major funders of HIV research, drug development, and treatment around the world. In fact, developing countries usually get about 75% of their HIV treatment funding from outside sources\textsuperscript{36}, and some countries get up to 95% of their funding externally.

With private and foreign investment rates expected to steadily decrease in the next decade, it will

\textsuperscript{33} UNAIDS. “UNAIDS announces that the goal of 15 million people on life-saving HIV treatment by 2015 has been met nine months ahead of schedule”. UNAIDS. Published July 14, 2015. http://www.unaids.org/en/resources/prescentre/pressreleaseandstatementarchive/2015/july/20150714_PR_MDG6report
be critical to identify ways for countries to become more financially and technologically independent. For more questions to consider, refer to the last section of this guide.

**Geographic and Demographic Information**

**HIV/AIDS**

A last note — be aware that HIV/AIDS epidemics have different stigmas in different geographical regions. For example, the AIDS epidemic in Africa has historically been associated with heterosexual transmission as opposed to the homosexual transmission more prevalent in Western countries\(^37\). In Latin America, transmission is linked to injection drug use and homosexual sex. In Southeast Asia, HIV was first documented in and associated with women working in the sex industry. In the Caribbean, transgender women and female sex workers not only have some of the highest infection rates, but also face higher rates of interpersonal violence and significant barriers within the healthcare system. The stigmas attached to HIV/AIDS in each region influence the way the healthcare system treats some of the most vulnerable patients in a country, and they are important to know in order to balance cultural sensitivity and effective policy making across different regions.

Although the related stigma differs from region to region, they all share a common global burden that is heightened for low and middle income countries. Socioeconomic instability, lacking health infrastructure and technology, economic and political displacement of communities, and stronger gender inequalities all contribute to higher transmission rates in developing countries like South Africa, Indonesia, Panama, and Antigua.

Important Terms

Sexual Health Education

Sexual health education is the teaching and learning of topics related to sex and sexuality\(^38\). This includes lessons on human biology and reproductive development, sexually transmitted diseases, contraception, and healthy interpersonal and sexual relationships. There are many types of sexual health education; the most common ones include\(^39\):

- **Comprehensive sex education (CSE):** K-12 education programs that provide medically accurate lessons on a complete set of topics related to sexuality: human reproductive anatomy, healthy sexual relationships, decision-making, pros and cons of different contraceptive options, STDs and STI prevention, and more.

- **Abstinence-based:** Education programs that primarily highlight the benefits of abstinence (completely abstaining from sex), but peripherally cover the relationship and contraceptive options for those who choose to be sexually active.

- **Abstinence-only:** Education programs that only advocate for abstinence from all sexual behaviors. They do not include information on contraception.

- **Abstinence-only-until-marriage:** Education programs that advocate sexual abstinence until marriage. Sex outside of marriage is typically depicted as immoral.

- **Fear-based education:** Education programs that use fear, shame, and guilt to discourage sexual behavior. Lessons often send negative messages about sexuality and typically

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condemn untraditional gender and sexual orientations such as homosexuality and transgender identity.

**HIV/AIDS**

Human Immunodeficiency Virus, or HIV, is a fluid-transmitted virus that attacks and weakens the human immune system over time. HIV can be transmitted through four human fluids: semen, vaginal fluid, blood, and breast milk. Acquired immunodeficiency syndrome, or AIDS, is defined as the occurrence of an opportunistic infection or cancer resulting from the weakened immune system. The most common opportunistic AIDS infections are tuberculosis, hepatitis B, meningitis, pneumonia, and certain cancers such as Kaposi’s sarcoma. Without treatment, AIDS typically manifests within 5 to 10 years. With treatment using antiretroviral drugs, HIV development can be slowed to the point where HIV-positive individuals can live for several decades. The cost of antiretroviral drugs has significantly decreased over the past 17 years, going from $10,000 per person in 2000 to less than $100 per person today.

There are currently 36.7 million people living with HIV. Two-thirds of HIV-positive people reside in Sub-Saharan Africa, where over 4% of the population is HIV-positive. More broadly speaking, over 95% of HIV infections occur in developing countries, so these countries bear the brunt of the challenge with the global HIV/AIDS epidemic.

**Questions to Consider**

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Sexual Health Education

- Should comprehensive sex education (CSE) be the international standard?
- Where do abstinence-based and abstinence-only curriculums fit into the school system?
- Should sex education begin in primary school, secondary school, or later? What should be the content at each level?
- How can sex education be provided to people in rural areas?
- Who should fund sex education?
- Should nations collaborate on a standardized international curriculum and training plan?
- How should cultural practices like female genital mutilation (FGM) and child/teen marriage be addressed when teaching sex education?

HIV/AIDS

- How can we combat antiretroviral drug resistance?
- Should more money be invested in HIV research? If so, who should conduct the research, and how much should be invested?
- How can countries become more independent with domestic HIV/AIDS treatment?
- What are the different solutions needed for different geographical regions around the world?
- How can vulnerable populations with HIV/AIDS (transgender men & women, LGBTQ patients, victims of sexual abuse) be protected and provided for in the healthcare system?
- Should any strategic geographical partnerships be made?

As always, feel free to reach out to me at lenah@princeton.edu with any questions.