

# **Vancouver Youth Model United Nations Conference**



## **World Health Organization (WHO)**

Director – Jessica Dorfmann

Chair – Katrina Kaur

Assistant Directors – Jack Bacon, Katherine Griffin, Stephanie Tai

Dear Delegates,

It is my pleasure to welcome all of you to Vancouver Youth Model United Nations 2011 and to the World Health Organization. VYMUN is a great experience for all of those who are new to Model UN. This year, the WHO will make sure every debate gives all delegates a chance to increase the skills and knowledge about Model UN. I hope that all delegates are as enthused about the topics that will be discussed and that they are all eager to participate in the debate.

The two topics this year will allow delegates to explore two wildly different issues that are both heavily impacting our world today. Topic A: Emergency Preparedness and Topic B: HIV/AIDS, will make for some very interesting diverse debate. We hope to see delegates work towards achieving an action plan to be implemented for a major disaster for Topic A as an emergency can strike anywhere at anytime. The human suffering that accompanies any major disaster is unimaginable. In addition, I hope to see delegates discuss the possible benefits to people changes that could take place to health care for Topic B. As well, delegates to do a thorough research of their country as this will only allow them to further explore these topics accurately as well as to understand how it benefit their country. Together these two topics will allow delegates to explore two very different, yet equally important issues.

Position papers are mandatory and are a great way to get a basis of understanding of the topics at hand as well as their country. These papers will only enhance the delegates experience and will make sure that all delegates come into debate prepared.

Best of luck!

Sincerely,

Katrina Kaur  
Chair, World Health Organization  
Vancouver Youth Model United Nations 2011

# Topic 1: Emergency Preparedness

---

## Definitions for reference

### *Crisis*

- Any event or series of events that poses a threat to the health or safety of a community.

### *Disaster*

- Any significant disruption to the functioning of a community which causes severe widespread human, material, economic, or environmental losses which exceed the abilities of a society to cope with using its own resources. **(1)**.
- Any occurrence that causes damage, environmental loss, loss of human life or worsened health services on a large scale sufficient to need an extraordinary response from outside of the affected community. **(2)**.

### *Emergency*

- A sudden occurrence which demands immediate action that may be due to an epidemic, to natural/technological occurrences, or to other man-made causes **(1)**.

### *Hazard*

- Any occurrence which has the potential to create severe destruction or damage to people and their community. **(1)**.

### *Risk*

- The probability that a harmful consequence, or expected loss which could be in the form of deaths, injuries, property, economic activity disruption or environmental damage resulting from interactions between natural/human-induced occurrences **(1)**.

### *Vulnerability*

- The extent to which a community is unable to prepare and cope with/recover from the after effects of a disaster. **(1)**.
- The conditions which increase the susceptibility of a community to deal with the impacts of disasters. This is determined by physical, social, economic and environmental factors. **(2)**.

## Background

### **Introduction**

Humanitarian efforts as well as community emergency preparedness programmes are both eminent and critical in reducing the effects of emergencies and disasters. Having a stockpile of relief goods is undoubtedly important. However these short term responses are not sufficient enough, now action must be taken to reduce economic and social consequences of emergencies. Therefore a proactive plan is needed to put into action to create a comprehensive approach to emergencies. All communities must start to work with authorities in order for them to strengthen their own individual responses to disasters. With legislation, thought out procedures, budgets, personnel, and the correct information, there can be an immense reduction in the after effects of any emergency.

### **Past Crises**

#### *The 1997 cyclone in the southeast of Bangladesh*

Though it left 1 500 000 people homeless, there were only 127 people whose lives were lost. Since there was a community based warning and evacuation system as well as shelters for all, a lot of lives were saved.

#### *The floods in Mozambique in 2000*

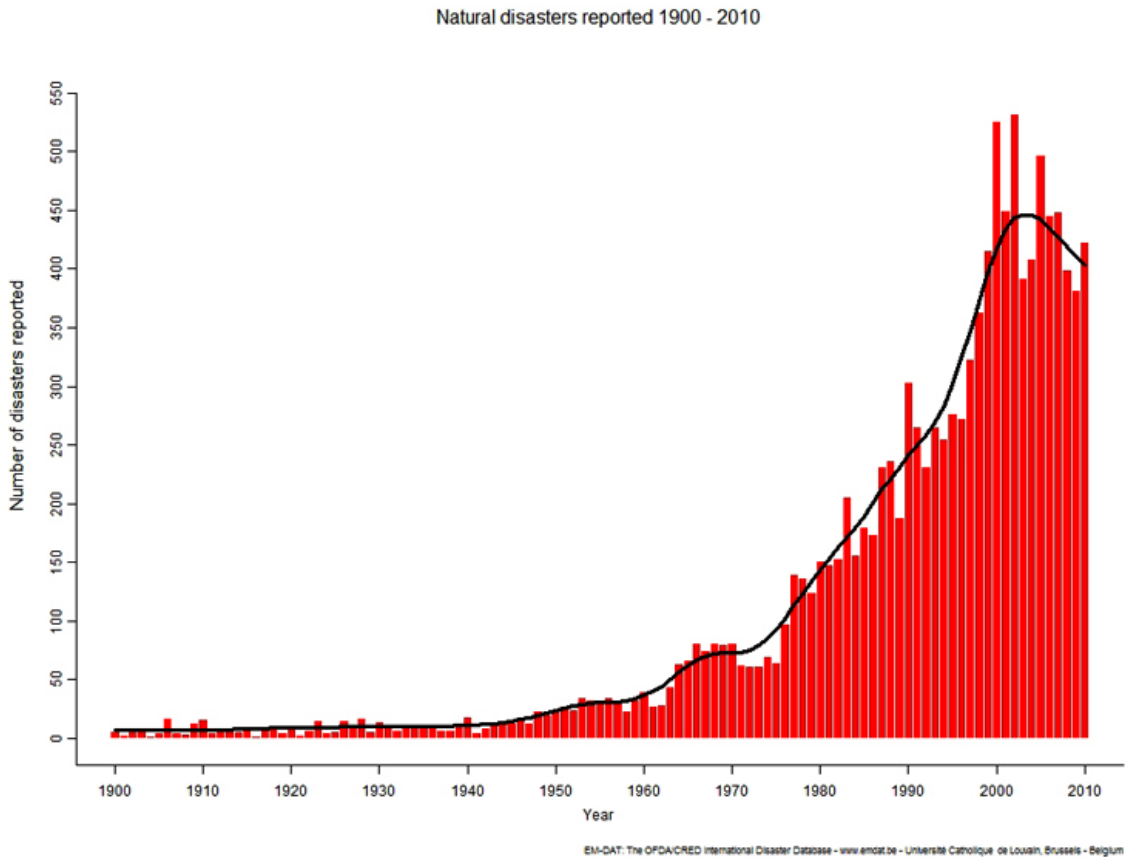
45,000 lives were saved due to the local rescuers. In floods that occurred a year later, another 7000 survived. There was one unforgettable incident of a mother who gave birth while sheltering in a tree. Though the floods were the worst in over a century, due to strategies that were in place, many lives were saved and Mozambique exceeded expectation in other countries eyes in their preparedness to an emergency.

#### *The Indian Ocean tsunami in 2004*

Health organizations and the training of health professionals constitute for a majority of a developing country's investment, however, these systems are very vulnerable to destruction. The health infrastructure losses in Sri Lanka included at least 92 damaged health institutions, some of which included hospitals, preventive health care offices and health staff accommodation facilities. Furthermore, this tsunami destroyed many health equipments and a number of ambulances, lorries and vans.

## Statistics

The number of crises has steadily increased over the past years. The increase is most prominent in middle and low income countries. Below shows the graph of natural disasters reported from 1900 to 2010.



Due to the implementation of new approaches, less people are dying from the catastrophic events; however, the strong impacts are still affecting the people. It was estimated that 157,000,000 people were impacted by natural disasters in 2005. This does not include other disasters such as technological disasters. Furthermore, in 2004 the United Nations High Commission for Refugees recorded and assisted 17,100,000 internally displaced persons and in 2006, the number increased to 20,800,000.

## Approach

### **Risk Management**

Effective emergency preparedness involves a multitude of sectors. Appropriate land management and new facilities can contribute to the aftermath of the disaster and impact mortality rates. The effectiveness of the health sector depends on the preparation of other sectors; this includes vital communications, law and order, social services, and public services. The health sector must be prepared to for all disasters and emerging threats such as influenza pandemic. Countries often benefit from the investment in risk reduction programs and increased global awareness of the various departments and programs implemented in different countries.

#### *All-Hazard Approach*

This requires the implementation of management strategies to reduce the effects of emergencies ranging from natural to technological. Strategies such as evacuation and health services are vital and this similar model is often adopted by countries, regardless of the cause of the emergency.

#### *Whole-Health Approach*

Coordination and organizational procedures should be unified under one preparedness and response group. Apart from death and injuries, other considerations must be made to include support services to the strategy. This includes the management of diseases, child care and nutrition. This can be achieved by effective coordination with different sectors such as military medical services, international response teams and NGO's.

### **Targets**

All countries are vulnerable to one type or another of emergencies and crises. Often, developing countries are the most severely affected by emergencies and similarly, take the longest time to recover. It is important that these countries achieve adequate technical support from benefactors. These benefactors and donors should focus upon improving the skills and knowledge of the countries' health sector.

## Questions to consider

1) Given the limited resources in developing countries, what should be done and implemented to ensure that all developing countries have an adequate emergency preparedness strategy?

2) Should rules be in place, in order to monitor and mandate the implemented approaches by different countries?

### **Bibliography**

"Natural Disasters Trends | EM-DAT." *What's New | EM-DAT*. Published by SuperAdminEMDAT. Web. 5 Sept. 2011. <<http://www.emdat.be/natural-disasters-trends>>.

WHO. "WHO Emergencies." *WHO Emergencies*. WHO. Web. 5 Sept. 2011. <<http://www.who.int/topics/emergencies/en/>>.<[http://www.who.int/hac/techguidance/preparedness/emergency\\_preparedness\\_eng.pdf](http://www.who.int/hac/techguidance/preparedness/emergency_preparedness_eng.pdf)>.

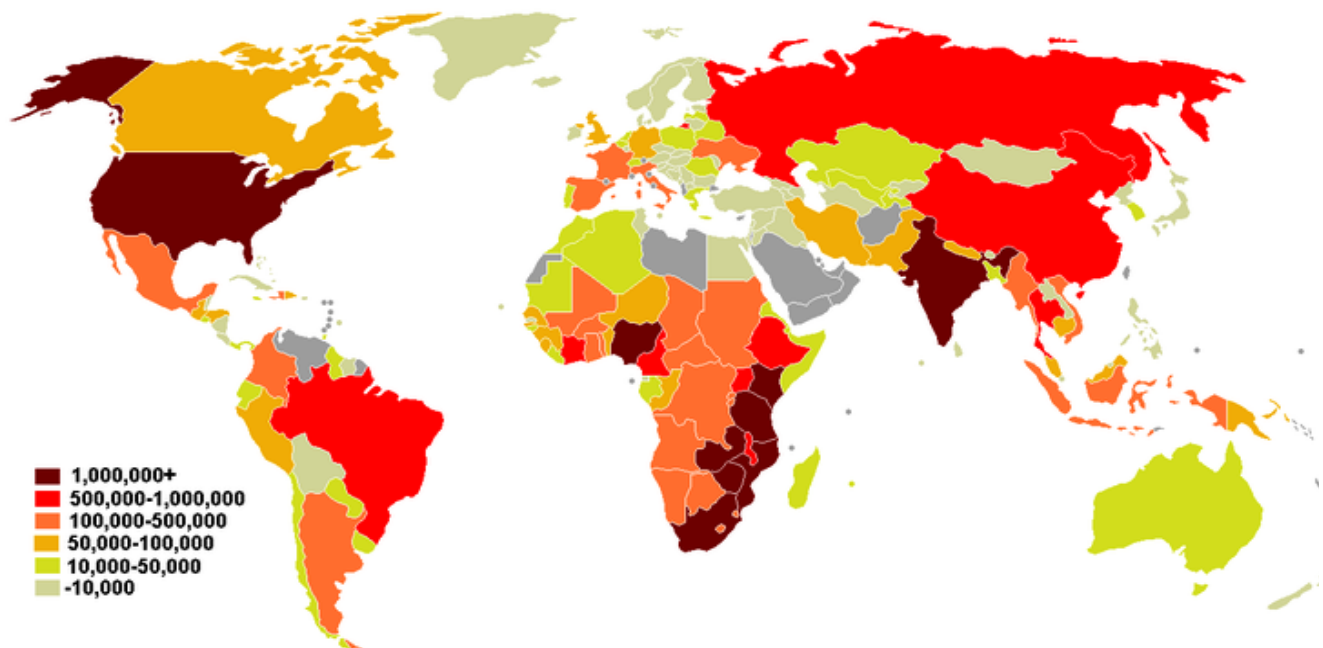
---

## **Topic 2: HIV/AIDS**

---

## About HIV/AIDS

The human immunodeficiency virus (HIV) is thought to have been transmitted from sick primates to humans in 19th century Africa where bush meat was a common source of nutrition. After being infected with the HIV, the virus slowly disables the immune system of the infected, eventually causing acquired immunodeficiency syndrome (AIDS). The Center of Disease Control and Prevention (CDC) first reported AIDS in the 1980s. It soon advanced into an epidemic and subsequently an international pandemic. By the estimates of the UN, at the conclusion of the 20th century, upwards of 36 million people around the globe were living with HIV/AIDS. 90% of those sick were from developing countries, 75% from sub-Saharan Africa. Presently, there is no vaccine to counter HIV and, as such, HIV/AIDS continues to kill masses without a cure. While there have been numerous attempts at creating a vaccine, the unstable and adaptable nature of HIV has rendered poor results. This has seriously discouraged scientists from conducting additional tests and governments from offering funding towards the effort. Delegates on this committee must tackle such issues.



**Map of People Infected With HIV/AIDS**

In June 2001, the United Nations General Assembly declared HIV/AIDS to be “a global emergency”. Member States agreed to meet new targets for HIV prevention and care. These included a 25% reduction in infection rates among 15–24 year olds in the worst-affected countries by 2005 (and globally by 2010) and a 20% reduction in the number of infants infected with HIV by 2005 (and by 50% by 2010). UNAIDS and co-sponsors/partners have

urged countries to implement a comprehensive package of strategies for prevention and care, including:

- Access to affordable condoms
- Prompt treatment of other sexually transmitted infections (which increase the risk of infection with HIV)
- Access to voluntary HIV testing and counseling
- Prevention of mother-to-child transmission
- Promotion of advice and support to reduce HIV infection among intravenous drug users
- Sexual health education in schools and the community
- Improved access to care, support and treatment, including sustainable access to affordable supplies of medicines and diagnostics.

While effective HIV care and prevention strategies, together with strong political commitment, have helped reverse the tide of HIV in some countries – notably Senegal, Thailand and Uganda – a vaccine is also needed to complement existing strategies

## Transmission

### **Sexual Transmission**

The majority of HIV infections are acquired through unprotected sexual relations. One of the key problems to be dealt with by the committee is spreading awareness about this fact so as to allow people to make informed decisions. In the developed world the risk of transmitting the virus is as low as 0.04% per act whereas in the developing world the rates are 4-11 times higher.

The most effective means of preventing transmission is the promotion of abstinence. But when abstinence cannot be encouraged for either religious or ethnic reasons, there are also other options:

- The promotion of condoms and other protections
  - “A 1999 meta-analysis of studies of condom use showed that the consistent use of latex condoms reduces the risk of sexual transmission of HIV by about 85%”
  - “Male circumcision is now recognized as an additional important intervention to reduce the risk of HIV infection in men”

Percentage using condoms	Number of countries reporting condom use at last higher-risk sexual activity	
	among men aged 15–24	among women aged 15–24
Less than 50 per cent	17	35
50–69 per cent	18	16
70 per cent or more	6	4
Data not available	18	4

## **Number of low- and middle-income countries reporting percentages of condom use at last higher-risk sexual activity among young men and women men**

### **Body Fluid Exposure**

An extremely prevalent means of transmitting the HIV is through either direct or indirect contact with an infected individual's body fluid (blood). Committee members should consider which members of society would come into contact with blood the most often (i.e. Hospital Workers) and how transmission rates could be decreased. Remember that HIV can infect the body through the most unlikely of places, for instance the eyes and nose. Good strategies for preventing contamination include gloves, masks, protective eyewear, and frequent washing of the skin. Finally, sharp objects like needles, scalpels and glass, should be carefully disposed of to prevent needle stick injuries with contaminated items.

Another important issue to be addressed, especially in the developing world, is the screening of donated blood before transfusion. "The World Health Organization estimated that, as of 2000, inadequate blood screening had resulted in 1 million new HIV infections worldwide" Delegates should analyze current safety regulations in different countries, identify where the problems are occurring, and take action accordingly.

### **Mother to child**

Mother-to-child transmission has been defined as the transmission of HIV from an HIV-positive mother to her child throughout pregnancy, labor, delivery or during breastfeeding. At the end of 2009, an estimated 2.5 million children were living with HIV, and 2.3 million resided in sub-Saharan Africa. With effective interventions, the rate of transmissions can be reduced to below 5%. However, if these interventions are not present and accessible, rates vary from 15-45%. Every single day, more than 1,000 infants are newly infected with HIV during pregnancy, delivery and breastfeeding. Progress has recently been optimistic, and a record 53% of pregnant women who required services received them in 2009 around the globe. However, access to timely interventions are still lacking for many pregnant women and their babies. Most concerning is the low global treatment coverage for children who are HIV positive- 28% in 2009, lower than the antiretroviral therapy access of 36% for adults. It is evident that this is, and will continue to be, of high priority and concern for the international community.

## **Prevention**

### **HIV Testing**

A critical step toward the containment and prevention of HIV is effective and universally accessible HIV testing. Thus far, very few countries with a high prevalence of HIV have been able to effectively supply HIV testing to their population, or they have been unable to encourage them to take the test due to the widespread stigma and hatred that commonly results toward a HIV-Positive individual. Some of the most important criteria for HIV testing as set down by the WHO in 2007 include: absolute confidentiality, the inclusion of

counseling for those who test positive, and the performance of the test with the informed consent of the person being tested.

Currently a HIV test may consist of a quick oral swab or a more in depth blood analysis, as a result it can be extremely easy to establish HIV testing clinics if only the appropriate funding can be allocated.

## **Education**

HIV/AIDS education provides people with information about what the virus is and how it is passed on, which helps individuals to protect themselves from becoming infected. Education also plays an essential role in decreasing stigma and discrimination against HIV positive people by reducing misconceptions about the disease. The reduction in stigma not only improves the lives of those with HIV/AIDS, but also makes it more likely that people will seek testing and treatment for HIV/AIDS.

HIV/AIDS education can be delivered in a few ways:

- In schools: Schools are a great way to deliver information about HIV/AIDS before children become sexually active. However, in low-income countries in which schooling is not universal (particularly for girls and other parties at risk of contracting HIV/AIDS) it isn't wide reaching enough to inform the masses about HIV/AIDS.
- In the workplace: It is estimated that 9 out of 10 HIV positive people are working. The workplace is a way to reach people who have missed out on HIV/AIDS education in schools or to reach those working in occupations with an increased risk of HIV infection (eg health care workers).
- Mass media: Media such as the radio, television, billboards, and comic strips can help to raise general awareness about HIV/AIDS. However, while mass media makes people aware of the disease, it does relatively little to encourage behavior changes, which reduce the risk of HIV transmission. Also, if constructed badly, mass media can serve to increase stigma surrounding HIV/AIDS.

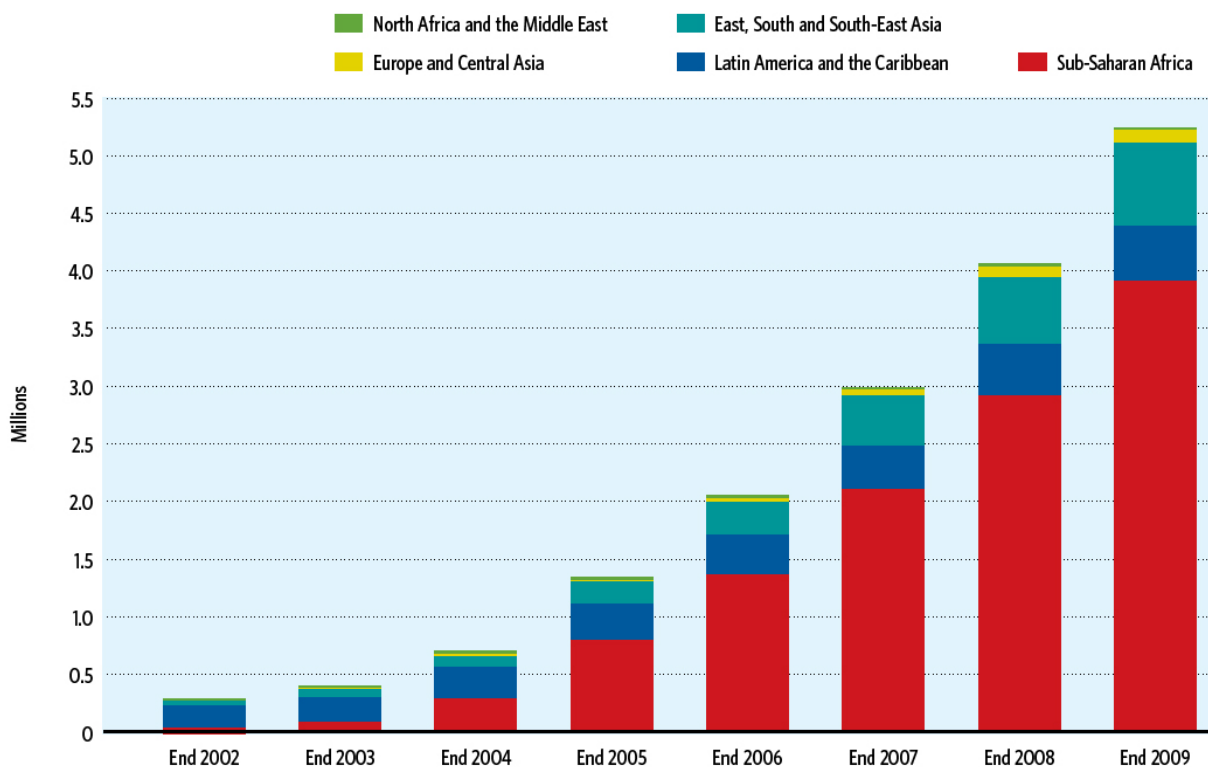
However, HIV/AIDS education remains controversial because of ideological and religious views. In many parts of the world, sex education and the promotion of contraceptives are frowned upon. Countries with strong Roman Catholic influence, such as Poland, do not regularly teach sex and HIV/AIDS education in schools, instead promoting abstinence.

## **Universal Access to HIV treatment**

Recently, there has been a movement towards providing universal access to treatment for HIV and AIDS. Most countries striving to expand access have set themselves a goal of providing antiretroviral treatment to around 80% of those in need. While access to HIV and AIDS drugs has greatly expanded in the past 5 years, treatment coverage in low to middle income countries is still only 36%, well below the goal.

Despite this relatively poor number, there have been some extraordinary successes: 15 countries including Botswana, Guyana, and South Africa are able to provide more than 80% of pregnant women in need with the necessary drugs and services to prevent mother-to-child transmission. 14 countries including Brazil, Namibia, and Ukraine provide treatments to over 80% of HIV positive children in need. 8 countries including Cambodia, Cuba and Rwanda have achieved universal access to antiretroviral treatment for adults. Eastern and Southern Africa also increased access to treatment by 10% in one year. Universal access seems to be a reasonable goal, yet barriers still exist to its implementation.

**The following table shows the percent of those in need receiving antiretroviral therapy in various regions (as of 2010)**



### Barriers to universal access

- Funding shortages: Currently \$13.7 billion (US) is available for HIV programs in low/middle-income countries. UNAIDS projects that over \$10 billion are still needed to pursue universal access for those in need.

- Limited human resources: There are not enough qualified doctors and staff to administer treatments.
- Difficulty attaining resources
- Difficulty managing resources: A better supply management system is needed for HIV drugs and diagnostic equipment. In 2009, one third of countries reported supplies of HIV medicine being halted because of organizational failures.

### **Potential solutions**

In 2010, UNAIDS reported that key actions had to be taken by the international community including:

- Renewing political and funding commitments to achieve universal access to HIV/AIDS prevention, treatment and care.
- Improving integration and linkages between HIV/AIDS and related services such as tuberculosis, maternal and child health, sexual health and harm reduction for drug users. There are many severe health issues tied to HIV/AIDS that must be dealt with at the same time.
- Strengthening health systems to achieve broader public health outcomes. The quality of care must be increased.
- Taking bold measures to address legal and structural barriers that increase HIV vulnerability, particularly for most-at-risk populations.

## **Treatment**

### **Antiretroviral Therapy for Those Infected**

When provided treatment with anti-retrovirals, the life expectancy of those infected with HIV has been shown to increase, in some cases by more than 20 years. Someone whose HIV has progressed to AIDS usually faces death within a year; with antiretroviral treatment, the average survival time is estimated to be upwards of 5 years (as of 2005). In 2009, 5.25 million people around the world were able to access this therapy in low and middle income countries. However, both WHO and UNAIDS approximate that at least 14.6 million people required this therapy in the same year. Children receiving antiretroviral therapy improved from around 75,000 in 2005 to almost 360,000 in 2009. At the present time, this treatment remains the best chance of survival for those infected with HIV. An agreement has been reached between experts that once begun, this antiretroviral treatment must never be stopped.

Region (lower- and middle-income countries)	Antiretroviral therapy coverage	Estimated number of people receiving antiretroviral therapy	Estimated number of people needing antiretroviral therapy
<b>Sub-Saharan Africa</b>	37%	3,911,000	10,600,000
Eastern and Southern Africa	41%	3,203,000	7,700,000
Western and Central Africa	25%	709,000	2,900,000
<b>Latin America and the Caribbean</b>	50%	478,000	950,000
Latin America	51%	425,000	840,000
The Caribbean	48%	52,400	110,000
<b>East, South and South-East Asia</b>	31%	739,000	2,400,000
<b>Europe and Central Asia</b>	19%	114,000	610,000
<b>North Africa and the Middle East</b>	11%	12,000	100,000
<b>Total</b>	36%	5,254,000	14,600,000

## Number of people receiving antiretroviral therapy in low and middle income countries by region 2002-2009

However, the unfortunate reality exists that antiretroviral therapy has many concerns and negative effects surrounding it. These include intolerance and serious side effects, especially for those in the further stages of the disease. Depending on the specific drug, ethnicity, interactions with other drugs and simply the individual themselves, adverse reactions vary. In addition to initial resistance among a small number of patients, missing doses create the development of resistance to anti-retroviral treatment. HIV has the ability to mutate as well as reproduce itself, despite the presence of antiretroviral drugs further creating drug resistance. Resulting from this resistance is treatment failure, increased health costs (due to starting additional treatment), and most significantly the spread of resistant strains of HIV. This creates the need to develop new anti-HIV drugs, and also put the surrounding population at risk, not just the current patients themselves, as multi-drug resistant strains increase. Furthermore, supplying anti-retroviral treatment is expensive and requires many resources that put this potentially life-saving treatment out of reach for the majority of suffering individuals around the world.

## **Antiretroviral drugs for HIV negative people**

In July 2011, the US center for disease control announced that antiretroviral medicine (a daily Tenofovir/Emtricitabine tablet) taken by people who do not yet have HIV/AIDS could reduce their chances of contracting HIV/AIDS by as much as 72%. This conclusion came from research conducted in Uganda, Kenya, and Botswana. Tenofovir/Emtricitabine is available generically in much of the world for as little as \$0.25 a day.

Effective new prevention tools are greatly needed to reduce the spread of HIV/AIDS, and antiretroviral drugs could very well be revolutionary in this area. The WHO has also suggested that this new medication will encourage more people to get tested for HIV, discuss HIV prevention options with their partners and access essential HIV services. However, it should be noted that no single method is fully protective against HIV. If antiretroviral drugs were widely used, this would have to be done in combination with other HIV prevention options.

If the WHO were to expand access to and publicize the use of antiretroviral drugs as a means of prevention this could be a very effective means of combatting HIV/AIDS. However, considering that countries are already struggling to provide antiretroviral drugs to all the HIV positive people in need, it is questionable whether or not this is the right allocation of available resources.

## **Generic HIV/AIDS Drugs**

Generic drugs are identical copies of brand name drugs (therefore just as safe and effective) that can be offered at a lower price because manufacturers don't have to incur the price of drug discovery or trials. The manufacturers simply reverse engineer already known drugs. In the early 2000s, generic drug manufacturers began to sell HIV/AIDS drugs at prices significantly lower than brand name companies. These prices undercut the brand name companies and forced them to lower their prices in order to compete. Between 2000 & 2001 the prices for antiretroviral therapy dropped from over \$10,000 a year to just over \$200 a year. In the past 10 years, generic drugs have kept the prices of AIDS/HIV treatments reasonable, which have allowed them to be accessible to low-income countries.

However, members of the WTO (World Trade Organization) are now required to issue and enforce patents on drugs, which prevent them from being produced generically. While the patents on most first-line HIV/AIDS drugs have expired, rendering them available to generic manufacturers, new and second-line medicines are still patented and can't be copied. Newer drugs are now, on average, 6 times more expensive than first line drugs. This is problematic, as new drugs have a lot of benefits:

- Drugs are less toxic and easier to take
- Drugs are more effective in combatting HIV/AIDS
- New drugs (called second-line drugs) are used to combat strains of HIV/AIDS resistant to most first-line drugs (the oldest and most commonly used medications)
- Some people *have to* use newer drugs, either because of resistance or because of the toxicity of older drugs.
- The number of people needing new drugs is expected to increase.

Because new drugs are so expensive, better drugs are available to wealthier countries while poorer countries must wait until the patent expires. By the time the patent expires and generic drugs become accessible, millions of people will have died unnecessarily.

## **Solutions**

Some have suggested that WTO legislation pertaining to intellectual property rights (called TRIPS) should be adjusted so that it doesn't apply to medicines. The WTO has also proposed two means to get around the patents called "Voluntary Licensing" and "Compulsory Licensing". These WTO endorsed solutions would make generic drugs available to middle-income countries and those with considerable political influence, but still makes it difficult for the poorest countries to secure new drugs.

## **Future Research**

Research continues into the improvement of currently available treatments, and includes diminishing side effects, the simplification of existing drug regimens, and discovering the best regimens to combat drug resistance.

Experts have speculated that the only method capable of halting the alarming pandemic is the development of a successful vaccine. This is due to the fact that a vaccine could be of a lower cost, resulting in increased affordability for developing countries.

Also, this vaccine would eliminate the need for inconvenient daily treatments. Despite almost 30 years of research, the disease of HIV continues to pose challenges to the creation of an effective vaccine. Previously developed vaccines have unfortunately been proven ineffective because of the nature of HIV itself. The virus is highly variable and continues to mutate. Therefore, vaccines must be equipped to combat the variety of HIV effects.

A number of factors are inhibiting the efforts to create such a vaccine. Firstly, while classic vaccines are able to imitate the natural immunity of patients who have recovered from an infection; in the case of HIV/AIDS there are nearly no AIDS patients who have recovered. Another issue is that vaccines are generally designed to protect against disease rather than infection, which is the nature of HIV prior to causing AIDS. In addition to this, most vaccines only possess the ability to defend against infections that are encountered irregularly, while individuals at high risk may be exposed to HIV even daily. Economic issues have also arisen from the potential of developing a vaccine. In a June 2005 study, it was estimated that \$682 million is spent each year on AIDS vaccine research. Following the formulation of an AIDS vaccine, governments as well as NGOs must bid to decrease the price of this vaccine to a marginal cost. As a result, advance purchase commitments are necessary.

## **Bloc Positions**

*South & Latin America:* South American countries such as Brazil and Chile have put considerable amounts of resources towards averting the HIV/AIDS epidemic. Brazil in particular has an HIV/AIDS epidemic on their hands and would benefit from international support for AIDS education, prevention, and treatment programs.

*Sub-Saharan Africa:* Because this region is the most affected by HIV/AIDS they have a huge incentive to want to see this problem resolved. However, many of these countries lack the organization and wealth to deal with the problem on their own. Therefore, they must rely on

the international community and NGOs to support them in averting the crisis. The nations in this region have a lot to gain from HIV/AIDS prevention programs as well as low-price generic drugs.

*Middle East & North Africa:* While the prevalence rate of HIV/AIDS is relatively low in this region (with the exception of Pakistan), there is a negative stigma against those who have HIV/AIDS and very low treatment rate (11%). This stigma and inaction spurs from misconceptions about the disease and general homophobia. Countries in this region have displayed a sense of apathy about the disease and resistance to implementing HIV/AIDS education or prevention plans which contradict their culture of abstinence.

*Southeast Asia:* Southeast Asia has a significant HIV/AIDS epidemic. As such, they are in need of better, more available treatment and prevention mechanisms. Discrimination against HIV/AIDS sufferers is high in this region, particularly in India. Countries would benefit from awareness and education campaigns.

*Affluent nations:* Many affluent nations such as the USA and Western European countries currently face their own HIV/AIDS epidemics and are motivated to research better prevention and treatment methods. These nations also have the capacity to support developing nations incapable of fighting HIV/AIDS on their own, and many have shown a willingness to do so. However, some affluent countries such as the USA have recently moved to limit production and distribution of generic drugs in order to support brand name drug companies.

## Questions to be Answered

1. Which methods of prevention are most endorsed and practiced by your nation? Are these currently effective and should these be adopted by other nations?
2. What steps has your nation taken towards HIV prevention and treatment thus far?
  - Should these remain in place and what future directions should the programs take?
3. What are there barriers preventing effective HIV testing/treatment from being carried out?
  - How can they be overcome?
4. What education programs are in place to educate the general population about HIV/AIDS?
  - What additional education should be implemented and how?

5. What resources are available and accessible within your country, especially in terms of medications, facilities and trained medical staff?
6. Is it practical to allocate funding providing anti-retroviral therapy to individuals who are HIV negative?
7. What are some potential solutions to counter the problem of patented HIV medications?
8. What should the focus be of current and future HIV/AIDS research? Who should fund these initiatives?

Remember to communicate with members of your bloc to share common ideas and create a solid basis for the formulation of working papers