

WHO

Georgia Tech
Model United Nations

Committee
World Health
Organization

General Assemblies

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United Nations

#GTMUN2025

*Bridging
technology
and
diplomacy.*



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Letter from the Secretary General

Esteemed Delegates,

It is my greatest honor to welcome you to the 26th Georgia Tech Model United Nations Conference. My name is Victoria Rodriguez, and I have the privilege of serving as the Secretary General for the 2025 session.

As a mechanical engineering student here at Georgia Tech, I can confidently say that participating in Model United Nations (MUN) has opened several personal, academic, and professional doors. In this journey of 13 years, I've had the opportunity of being a delegate, a director, a mentor, and finally, a Sec-Gen. Sometimes a breeze, sometimes an up-hill battle filled with blood, sweat and tears. I've made several friends and won awards along the way, but what I truly carry with me are the important things: the value of empathy, the courage to speak when it matters, and the humility to listen when others have something to teach.

This year, we are bringing you our largest GTMUN to date. With approximately 900 delegates joining us in 16 committees, we are proud to be one of the most dynamic forums for debate in the Southeastern United States. And I can promise you that it will also be the best GTMUN yet, given the tireless work of our Secretariat and staff, who have poured their hearts and souls into building a conference that you will remember long after the gavels fall.

GTMUN is more than just a conference; it is an opportunity for exploration. Through the years, we have cultivated a space where you can explore different positions on the global stage, discover new ways to approach problems and craft solutions, and test the kind of delegate you want to become. You will experiment with speeches, refine your negotiation style, and create crisis arcs that challenge both you and your peers in committee. Just as Georgia Tech is a hub for innovation, GTMUN is the best space to challenge you intellectually, diplomatically, and personally.

But the value of this conference goes beyond leadership, teamwork, and public speaking. Like our slogan says, "bridging technology and diplomacy," GTMUN is about bringing ideas closer to people. It's about connecting logic with compassion, ambition with responsibility, and creativity with collaboration. I hope the skills you foster during this year's conference (and the friends you make along the way) will be something you carry with you far beyond these two days.

As you prepare for this conference, I encourage you to bring all your energy, passion, and curiosity into every committee session. Debate boldly, listen openly, and collaborate sincerely. On behalf of the GTMUN Secretariat, I welcome you to the GTMUN 2025 Conference. We cannot wait to see the impact you will make.

Wishing you the best of luck as you prepare for your committee,



Victoria Rodriguez

Secretary General of GTMUN 2025



Position Paper Rubric

What is a *Position Paper*?

A position paper is a paper which describes how a country intends to address the topics of the committee, detailing tangible solutions to committee issues and connection to the country's policies. A position paper should contain details for each topic that will be addressed by the committee.

Formatting Requirements

- 12-point font, double-spaced Times New Roman
- 1-2 pages per topic (excluding Works Cited page)
- A Works Cited page with citations in MLA format
- Files submitted in .pdf format with title "GTMUN25_{short committee name}_{assigned country name}.pdf"
- e.g., "GTMUN25_DISEC_GERMANY.pdf" or "GTMUN25_UNOOSA_United_States.pdf"

START EACH TOPIC PAGE WITH

- Committee: [Name of committee]
- Delegation: [Name of delegation]
- Topic: [Topic name/description]

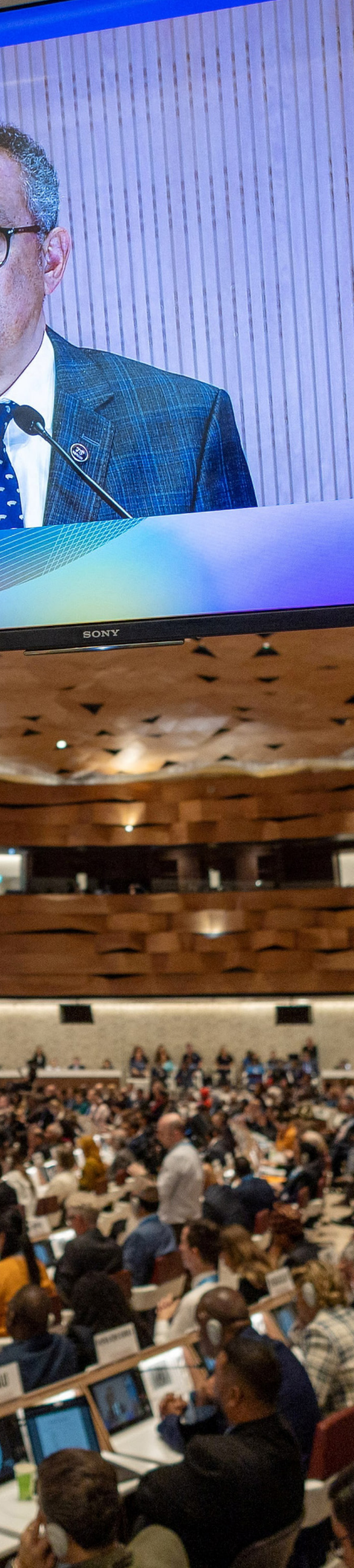
In order to be eligible for awards, delegates must submit a position paper and receive a score of at least **12/20 (for single-topic committees)** or **24/40 (for double-topic committees)**.



#GTMUN2025

	Great (5)	Good (4)	Adequate (3)	Poor (1)
Background	<ul style="list-style-type: none"> Detailed description of the topic (including dates and stakeholders) Several facts and statistics Discusses many relevant UN documents and resolutions 	<ul style="list-style-type: none"> Basic description of topic (including some dates and stakeholders) Some facts and statistics Discusses some relevant UN documents and resolutions 	<ul style="list-style-type: none"> Minimal description of topic (with no or few dates and stakeholders) Few facts and statistics Misses some key relevant UN documents and resolutions 	<ul style="list-style-type: none"> Unclear or incorrect description of topic Incorrect or missing facts or statistics No mention of relevant UN documents and resolutions
Policy	<ul style="list-style-type: none"> Country's detailed history with issue Detailed present position (or a strongly-defended inferred position) of country Several references to statements from appropriate officials or documents Several facts and statistics 	<ul style="list-style-type: none"> Country's basic history with issue Present position (or reasonable inferred position) of country Some references to statements from appropriate officials or documents Some facts and statistics 	<ul style="list-style-type: none"> Sparsely describes country's history with issue Present position (or basic inferred position) of country Few references to statements from appropriate officials and documents Few facts and statistics 	<ul style="list-style-type: none"> Incorrect or missing description of country's history with issue Incorrect present position (or unreasonably inferred position) of country No references to statements from appropriate officials and documents Incorrect or missing facts and statistics
Solutions	<ul style="list-style-type: none"> Detailed personal objectives Proposes well-supported potential solutions Identifies delegates to work with and provides strong reasoning for selections Actionable, reasonable solutions which are within the scope of the committee 	<ul style="list-style-type: none"> Expresses personal objectives Proposes reasonable potential solutions Identifies delegates to work with and provides reasonable justification for selections Actionable solutions within the scope of committee 	<ul style="list-style-type: none"> States personal objective Proposes potential solutions Identifies delegates to work with Actionable solutions 	<ul style="list-style-type: none"> No proposed goals or plans No potential collaborators mentioned Implausible or missing actionable solutions
Mechanics	<ul style="list-style-type: none"> No grammar, spelling, or punctuation errors Numerous and diverse citations from appropriate sources 	<ul style="list-style-type: none"> Few grammar, spelling, or punctuation errors Citations from appropriate sources 	<ul style="list-style-type: none"> Some grammar, spelling, or punctuation mistakes One or two citations from inappropriate sources 	<ul style="list-style-type: none"> Many grammar, spelling, or punctuation mistakes No citations from appropriate sources





Introduction to Committee

The idea of a body of the UN focused solely on health has been around since 1945, as posed by delegations from China and Brazil at one of the UN's first meetings. The constitution for the World Health Organization, however, did not come into force until April 7, 1948, a day now celebrated as World Health Day.¹ The constitution of the WHO includes the committee's current mission, aiming for "the attainment by all peoples of the highest possible level of health," a definition including social, mental, and physical health.² The WHO has 194 member states, with any state enjoying United Nations membership being allowed in, provided they have accepted the body's constitution, or been voted on by a majority vote of the World Health Assembly.³ The committee's scope during this conference will focus on two topics: the prevention of neglected tropical diseases (NTDs) and the distribution of their respective cures, and the protection of the genetic data and medical privacy of developing countries.

Scope and Functions⁸

The WHO works to create a healthier and safer world, powered by science. Their work is concentrated in a few key areas.

Universal health coverage	ensuring healthcare access to as many people as possible, with a focus on women, adolescents, and children.
Health emergencies programme	Providing countries with the rapid-response capabilities to respond to health issues if they arise
Access to medicines and health products	Addressing shortages and higher costs to ensure more access to health and medicines
Antimicrobial resistance	Reducing the prevalence of drug-resistant infections and studying the impacts of antimicrobial resistance
Science division	Using science to make guidance on public health needs that can adapt to real health solutions
Data, analytics, and delivery for impact	Measuring progress on currently outstanding objectives

The WHO is governed by the World Health Assembly, who imposes international health policies that are put into effect by its Executive Board. The Director-General of the WHO is approved by the Executive Board upon a nomination by the WHA.

Disclaimer

Model United Nations provides an opportunity for delegates to engage diplomatically with topics of global importance and explore possibilities for conflict resolution in a meaningful way. Many of the topics at hand may involve sensitive or controversial subject matter. We ask delegates to be respectful and professional when engaging with their committee and communicating with fellow delegates and GTMUN Conference staff. The content warning below is meant to warn you of potentially controversial topics that are present in the content of this background guide, as well as content that may appear in other aspects of the committee (e.g. debate, speeches, directives), so that you can prepare yourself before reading this background guide and participating in the committee.

At GTMUN, we take equity violations very seriously and require delegates to fully comply with our equity guidelines. Failure to do so will result in an immediate disqualification from awards, and you may be asked to leave the conference. Please remain respectful in committee, and avoid overgeneralizations as well as take into account individual differences and contexts during your speeches. If you have any questions regarding our equity guidelines, we encourage you to contact one of our staff members.

If, because of this committee's content warning, you have any questions or concerns, please feel free to reach out to our staff via email at gtmunconference@gmail.com.

History of the Committee⁹

1948 World Health Organization constitution accepted

1955 WHO launches Global Malaria Eradication Program

1967 WHO launches Intensified Smallpox Eradication Program

1969 World Health Assembly launches the International Health Regulations

1980 WHO and WHA declare smallpox eradicated

1983 HIV is discovered

1988 WHO launches Global Polio Eradication Initiative

2003 WHA adopts Framework Convention on Tobacco Control, WHO launches 3 by 5 treatment for HIV/AIDS. SARS outbreak

2009 Influenza A declared a public health emergency of international concern (PHEIC)

2011 WHA adopts the Pandemic Influenza Preparedness Framework

2014 WHO declares Ebola a PHEIC

2016 WHO declares Zika virus a PHEIC, launches WHO Health Emergencies Program

2017 WHO transformation timeline adopted¹⁰

2020 WHO declares Coronavirus a PHEIC

Topic 1

Global Strategy for Rare Disease Prevention



Key Terms and Acronyms

NTD Neglected Tropical Disease

Dracunculiasis Guinea Worm disease. Parasitic disease that affects drinking water, causes painful blisters that worms come out of⁵

MDA Mass Drug Administration⁷

WASH Water, Sanitation, and Hygiene⁷

London Declaration A multi-organizational plan to curb the prevalence of 10 NTDs by 2020¹¹

Kigali Declaration A political declaration to organize nations to further curb the spread of NTDs¹²

Abu Dhabi Declaration A multinational agreement to use an SDG-based indicator to judge the prevalence of NTDs¹³

lymphatic filariasis Lymphatic filariasis is an NTD caused by parasitic worms that results in swelling³¹

Introduction

Neglected tropical diseases, as targeted by the World Health Organization, are a class of 20 largely parasitic diseases (including dracunculiasis, leprosy, dengue, and leishmaniasis), which are especially prevalent in developing regions of Africa, Asia, and the Americas.¹⁴ Symptoms include blindness, disability, disfigurement, and even death.¹⁴ With over 1.5 billion individuals currently requiring intervention from NTD-

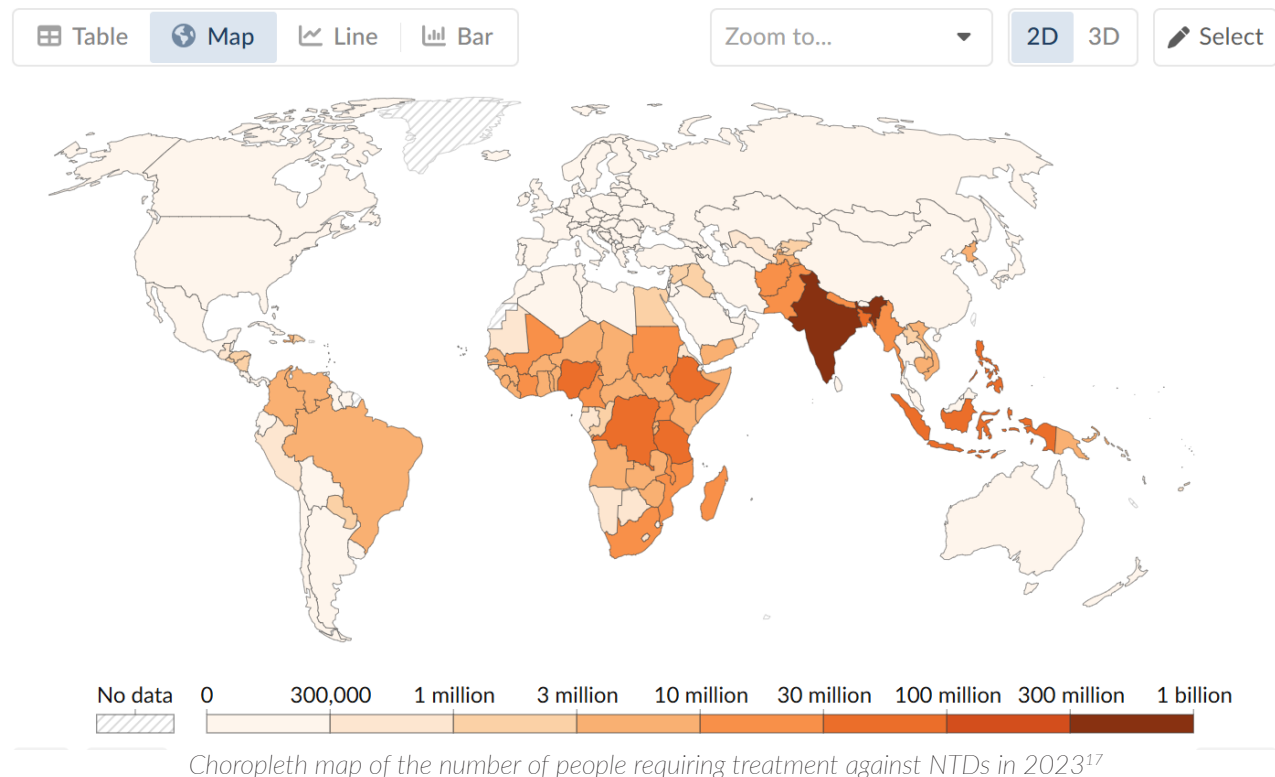
	<i>Disability-Adjusted Life-Years (in millions)</i>	<i>Deaths</i>	<i>Approximate Global Prevalence</i>	<i>Approaches to Control</i>
High-prevalence diseases	14.9–52.1	24,000–415,000	1.0–1.2 billion	MDA with rapid effect package
Hookworm Infection	1.8–22.1	3,000–65,000	600 million	MDA with rapid effect package or albendazole
Ascariasis	1.2–10.5	3,000–60,000	800 million	MDA with rapid effect package or albendazole or mebendazole
Trichuriasis	1.6–6.4	3,000–10,000	600 million	MDA with rapid effect package or albendazole or mebendazole
Lymphatic filariasis	5.8	<500	120 million	MDA with rapid effect package or diethylcarbamazine+ albendazole or ivermectin+albendazole
Schistosomiasis	1.7–4.5	15,000–280,000	200 million	MDA with rapid effect package or praziquantel
Trachoma	2.3	<500	84 million	SAFE strategy with azithromycin
Onchocerciasis	0.7	<500	37 million	MDA with rapid effect package or ivermectin
Vector-borne protozoan and viral diseases	5.0	132,000	70 million	Integrated vector management or case detection and management or both
Dengue fever	0.7	19,000	50 million	Integrated vector management
Leishmaniasis	2.1	51,000	12 million	Case detection and management and integrated vector management
Chagas disease	0.7	14,000	8–9 million	Integrated vector management
Human African trypanosomiasis	1.5	48,000	<0.1 million	Case detection and management, and tsetse control

related conditions,¹⁶ they continue to disproportionately affect the poorest and most impoverished nations of the world, often bringing with them damaging effects to the communities around them. Aside from the devastating health consequences, NTDs impact communities both socially and economically, resulting in over \$33 billion in out-of-pocket health expenditures annually across the world.¹⁵ NTDs are regarded as “neglected” for a number of reasons. They are generally not present on global health agendas, are stigmas of social exclusion, arise in communities of poor education that often have health issues exacerbated by stigmas surrounding NTDs, and are often ignored by large-scale healthcare funding.¹⁶

Number of people requiring treatment against neglected tropical diseases, 2023

Our World in Data

Estimated number of people requiring medical treatment for neglected tropical diseases (NTDs).



NTDs are generally transmitted through infected insects and the consumption of parasite-harboring food and water. Some NTDs, notably leprosy, can be spread through skin-to-skin contact.¹⁸ As a result, countries without a wide access to clean food and water or consistent access to vaccinations suffer heavily. The populations in these areas often lack the education and infrastructure to set up the proper interventions to eradicate NTDs, further growing the incidence of the diseases and further increasing the social stigma around afflicted populations.

There are a number of currently effective treatments for NTDs. Mass drug administration (MDA) reached over 1 billion individuals between 2015 and 2019²⁰,

while improvements to water, sanitation and hygiene, and increased control of disease vectors saw lower levels of efficacy.

Mass drug administration involves the in-person administration of drugs to inhibit the symptoms and spread of NTDs. MDA primarily takes place in two ways: school-based distribution, where school-aged children are directly administered doses of drugs; and community-based distribution, which can be door-to-door, individual, or at a large community center such as a place of worship or a market.²² School-based distribution is generally more effective, involving up to 364 unique stakeholders at a time in comparison to lower amounts of stakeholders in other community-based solutions.²³



IMD distributes medicine in a Tanzania school. More than a half billion children suffer from NTDs each year

Water, sanitation, and hygiene solutions (WASH) are an integrated NTD combat strategy pushed by the WHO. WASH guidelines—as implied by the title—include provision of clean water and sanitary spaces, as well as implementation of proper hygiene tactics like hand-washing.²⁴ It is incredibly important that these facilities are clean, as water contaminated with feces can serve as a breeding ground for certain worms, and poorly constructed toilet facilities lead to the growth of different kinds of mosquitoes.²⁵ WASH access is notoriously sparse in low-income communities, with only 63% of areas afflicted by NTDs receiving adequate access.²⁶

Control of disease vectors takes many shapes. Pesticides can be used to target worms, flies, and mosquitoes that act as disease vectors. Vectors can be genetically



Mosquito nets can be hung above a bed or crib to protect against mosquito bites. The CDC recommends use of mosquito nets indoors and outdoors

engineered to be parasite resistant and released into the population to breed and spread parasite-resistance. Even lower-tech actions like using a treated bed net—over 2.9 billion of which have been distributed worldwide since 2004²¹—or eliminating standing water can help control potential disease vectors.¹⁹ However, all of these solutions have issues. Pesticides may damage ecosystems, genetic technologies may be costly, and communities may struggle with adoption of technologies like bed nets.

History

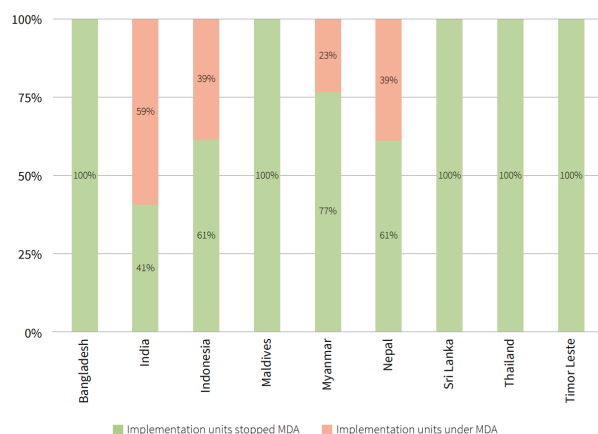
1975	Special Programme for Research and Training in Tropical Diseases established ⁶
1986	Resolution passed by World Health Organization on elimination of dracunculiasis ⁴
2003-2005	Berlin Meetings on NTD eradication, triggering more thorough developments in the eradication of the diseases ⁶
2007	First Global Partners' Meeting on NTD eradication ⁶
2008	First global plan on NTD eradication released ⁶
2010	First global NTD report released ⁶
2012	First NTD roadmap with 2015 and 2020 eradication guidelines published, London Declaration endorsed ⁶
2013	World Health Association Resolution 66.12 passed, calling for more definitive action on NTDs, as well as second global NTD report released ⁶
2016	1 billion people treated for NTD interventions in a single year ⁶
2020	NTD roadmap 2021-2030 published ⁶
2022	Kigali and Abu Dhabi Declarations released ⁶
2023	Global NTD report released, noma added to list of NTDs ⁶

Current Developments

The current operating framework for global NTD solutions is Ending the neglect to attain the Sustainable Development Goals: A road map for neglected tropical diseases 2021–2030, which calls for the increased control, eradication, prevention, and elimination of the 20 target NTDs, in line with UN Sustainable Development Goal 3.³⁰

Today, Southeast Asia bears the highest burden of NTD incidence, with approximately 833 million people in the region afflicted with 16 of the WHO's 20 target NTDs. Particularly, the region contains 60% of the world's cases that require MDA against lymphatic filariasis. As such, the Regional Committee for the WHO South-East Asia Region declared eliminating near-extinct diseases such as lymphatic filariasis as one of their top priorities starting in 2014. With the signing of the Dhaka Declaration, a multi-state working agreement similar to those released by London, Abu Dhabi, and Kigali, member states agreed to use a mixture of vector-based and MDA solutions to collaboratively combat the prevalence of NTDs in the region. By 2023, lymphatic filariasis was no longer a public health issue in Bangladesh, Sri Lanka, India, and the Maldives. Because of the prevalence of MDA treatment within South Asia, LF is no longer directly considered a public health issue in several countries. However, it has not been completely eradicated yet as there are still portions of the population who have not been treated against it. NTD prevalence continues today as a result of lack of awareness of health issues, poor ventilation, overcrowding, and lack of sanitation.²⁷

Fig 2.1. Proportion and number of implementation units (IUs) in nine LF-endemic countries that are under MDA or have stopped by the end of 2022



Proportion and number of implemetation units (IUs) in nine LF-endemic countries that are under MDA or have stopped by the end of 2022



Woman with Lymphatic Filariasis washes her legs in rural India

As of 2015, approximately 630 million people in Africa required treatment for NTDs. That number decreased to 612 million by 2019. Of that, approximately 64% of Africans were able to receive treatment in 2019. This has resulted in the elimination of sleeping sickness in Togo, as well as the near complete elimination of lymphatic filariasis in both Malawi and Togo. This reduction is due to an efficient distribution of preventative care such as MDAs across the continent, and far-reaching partnerships between the public and private sectors.²⁸ One particular example of this partnership is ESPEN, a collaboration between the World Health Organization and the OPEC Fund for International Development. It allowed for \$1 million in grant funding to strategically identify and target disease centers using data mapping, with a specific focus on schistosomiasis, river blindness, elephantiasis, trachoma, and soil-transmitted helminths. As a result of this partnership, specific sites were able to be identified, MDA was efficiently dispersed, and 11 African countries reached their goal of 75% coverage of those afflicted by soil-transmitted helminths.²⁹



OFID signed a US\$1 million grant agreement with the World Health Organization (WHO) for an initiative aimed at eliminating neglected tropical diseases (NTDs) in seven African countries

Countries in Central America have made significant strides towards fully eliminating many NTDs. Onchocerciasis has been fully eliminated in Guatemala, Colombia, Ecuador, and Mexico, with over 85% of those eligible for treatment receiving it.³³ Trachoma has been virtually eliminated in Mexico. 5.6 million remain at risk for trachoma in rural areas of Brazil, Colombia, Guatemala, and Peru, but are currently being targeted by current work and outreach methods.³⁴ Trinidad and Tobago,



The Caño Fibra community is located on the banks of the Orinoco River in Venezuela. Fifteen families belonging to indigenous groups live there. Providing integrated healthcare is especially difficult because of difficulty in accessing the territory

Costa Rica, and Suriname have been declared no longer endemic for lymphatic filariasis. Such strides are due to the collaborative work between PAHO—the Pan-American Health Organization—and national governments throughout the region. Though the nations lack some of the tools necessary to completely eliminate certain NTDs, a mixed approach utilizing targeted data analysis, WASH techniques, and

widespread MDA have contributed to widespread elimination. Current progress is inhibited by unequal distribution of education and health resources, socioeconomic issues, infrastructural issues, and income inequality—all of which became further exacerbated by the COVID-19 pandemic.³²

It now becomes the job of this organization to figure out how, in light of recent successes and setbacks in NTD elimination, to continue forth with disease prevention and eradication in light of the WHO's 2030 goals. Whether that solution is a complete eradication of NTDs, a measured mixture of control and prevention, or something else entirely, the choice is up to you to come together to build a collaborative solution and ensure that the goals are met.

Directives / QARMAs

How can this body work together to ensure the 2030 roadmap is met?

In what ways does this body work to ensure that countries most heavily burdened by neglected tropical diseases receive adequate prioritization on the global agenda?

Why should countries that are not impacted by NTDs devote time, energy, and resources to eradicating them?

How can vaccines and other medicinal treatments be financially incentivized?

What novel solutions exist to help eradicate NTDs?

What is your country's experience with NTDs?

How can the social stigma around NTD-heavy areas be alleviated?

What is the most effective currently-existing solution to the NTD issue? Is it MDA? WASH-based? Vector-based? A combination of the 3?

How can collective action be motivated more directly beyond declarations like those from London, Abu Dhabi, and Kigali?

How can the public and private sectors be motivated to help stop the spread of NTDs?

Topic 2

Underrepresented Groups in Medical Research and Data Collection



Key Terms and Acronyms

Aggregated Data

Data that is summarized and combined from multiple different samples, useful for identifying trends within and between samples, often used in reporting/research publications

Clinical Trial

The evaluation of new treatments and to test medical interventions, including medications, surgical procedures, radiological procedures, devices, or other care, typically happens in phases starting with a small sample size and increasing to larger populations with different demographics (age, national origin, socioeconomic status, ethnicity, ability, etc)⁵

Clinician-Released Patient Information

A clinician releasing patient information in special circumstances, such as for payment, treatment, or healthcare operations

Cultural Competency

The focus on being sensitive to cross-cultural differences and having the ability to adapt to other cultural environments⁶

Patient-Entered Data

Patients entering their own data, but must be fully informed about how their data will be used and must provide explicit consent⁷

Raw Data

Data that is collected directly from the sample and contains detailed information

Quantitative Data

Data that is about numeric variables and measures values/counts, expressed as numbers⁸

Qualitative Data

Data that is about categorical variables and measures 'types', expressed by names, symbols, or words

Introduction

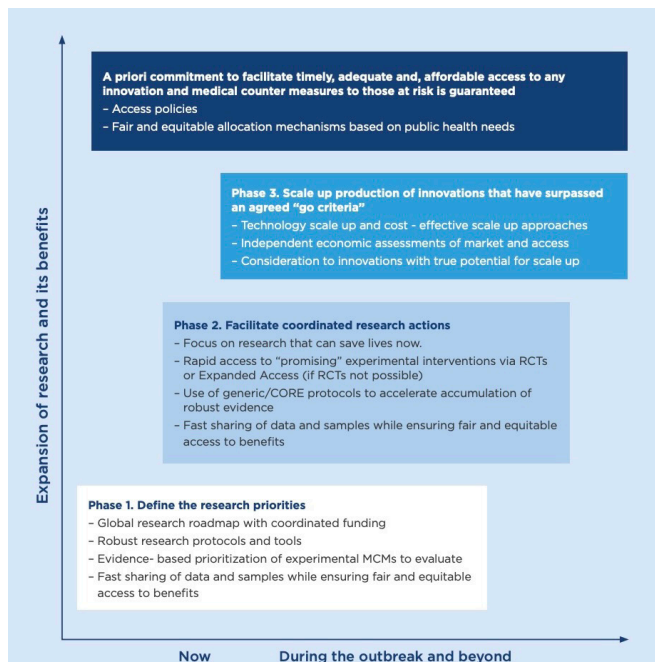
To address public health challenges, innovative strategies that enhance preparedness and response are crucial. Rapid development of vaccines and medicines is needed to mitigate and prevent the rise of chronic diseases, widespread pandemics, or a surge in infectious outbreaks. Between 2000 and 2023, global research and development (R&D) has nearly tripled from 1 trillion USD to 2.75 trillion USD.¹ However, much of this research is concentrated in South and East Asia, the Americas, and Western Europe. In 2024, the number of clinical trials conducted in South and East Asia totaled 9,347, compared to the continent of Africa, which conducted 397 clinical trials.² This difference in clinical trial administration highlights the asymmetrical access to resources, researchers, and information between different regions. Global research centering on the environmental, biological, and social determinants of health requires a unified effort to increase the amount of shared information between member states.

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The COVID-19 pandemic exposed key gaps in global health research, namely a lack of coordinated funding and data sharing, the scaling of technology, and equitable allocation of resources based on the public health needs.³ However, it also created opportunities for forums such as the Global Research Forum to identify these priorities and create action plans and roadmaps to address these gaps.

Due to the improper inclusion of vulnerable populations in medical research historically, addressing the catalysts of fear and anxiety has become difficult without

integrating culturally competent resources and education. A key example of medical manipulation happened in the 1990s in Nigeria. Nigeria was experiencing one of the worst meningitis epidemics in history, and to detect meningitis, Doctors Without Borders created a clinic to treat children with chloramphenicol, a well-known antibiotic to treat bacterial meningitis. Pfizer, an American multinational pharmaceutical and biotechnical corporation, used the opportunity to test a new antibiotic drug, Trovan, without obtaining informed consent from the participants. After reports



Implementation of critical research and key implementation phases in the area of medical research.

highlighted the subsequent deaths and disabilities suffered by children in northern Nigeria, an overwhelmingly Muslim region, the public began to claim that Pfizer was targeting and trying to kill Muslim people with vaccines.⁴

As a result of this incident, Nigerian Muslims became so distrustful towards vaccination campaigns led by Western nonprofits that in 2003, they led a boycott against a polio mass vaccination campaign, citing Pfizer's unethical trials as a key motivation for the boycott. This boycott led to a 30% increase in polio prevalence and set back global polio eradication efforts by a decade. In examining the importance of representation within medical research, it is equally important to highlight the embedded distrust of medical professionals as it pertains to vulnerable populations.

Vulnerable Groups in Medical Research & Data Collection

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Since there is no global, coordinated effort to integrate vulnerable populations in medical research and data collection thoughtfully, there are varying outcomes for research. Furthermore, since every state has different criteria for identifying vulnerable populations and how to collect information on them, there is a lack of understanding and data on vulnerable populations available.

Concepts of racial, gender, ethnic, and religious differences/groups widely vary between different regions and countries. For example, within Europe, all EU member states and the United Kingdom have some form of anti-discrimination laws; however, the categories covered within each law differ greatly. In the United Kingdom, data on religion/belief is not collected as frequently; however, in some studies, Jewish and Sikh people are defined as "racial groups".⁹ Most EU member states collect data on Romani people and identify them as an ethnic group. However, in Cyprus and Greece, the Romani people are designated as a religious category.

These categories directly reflect the structure of the population within each member state, which can pose limitations while collecting certain demographics of people in medical research or data collection. Differences in definitions of ethnic and religious groups can unintentionally ostracise a group of people in regard to research, as well as essential social services, such as specialized healthcare or housing assistance. This disaggregated data makes it more difficult to conduct discrimination monitoring or surveying.

Research on people with disabilities varies widely from region to region. Taken from a sample of the population of research papers about people with disabilities, most

research papers were situated within North and South America, with the least being from Africa and South-East Asia. 61.6% of this research was done about people with psychosocial disabilities, while 3% was about physical disabilities.¹⁰

Further marginalization has happened with women with disabilities or disabled people who are living in rural areas. Globally, most surveys on violence against women are conducted on women aged 15 - 49 years old, excluding older women in observation.¹¹ Furthermore, joint data on the intersecting identities of gender, aging, and disability is broadly unavailable. This is the case in developing and developed countries alike, meaning explanations can range from gender biases or a lack of resources to conduct this research. Partnerships between governments, the medical community, and the public must be forged to bridge research gaps, address intersecting discrimination, and address legal frameworks that perpetuate discrimination.

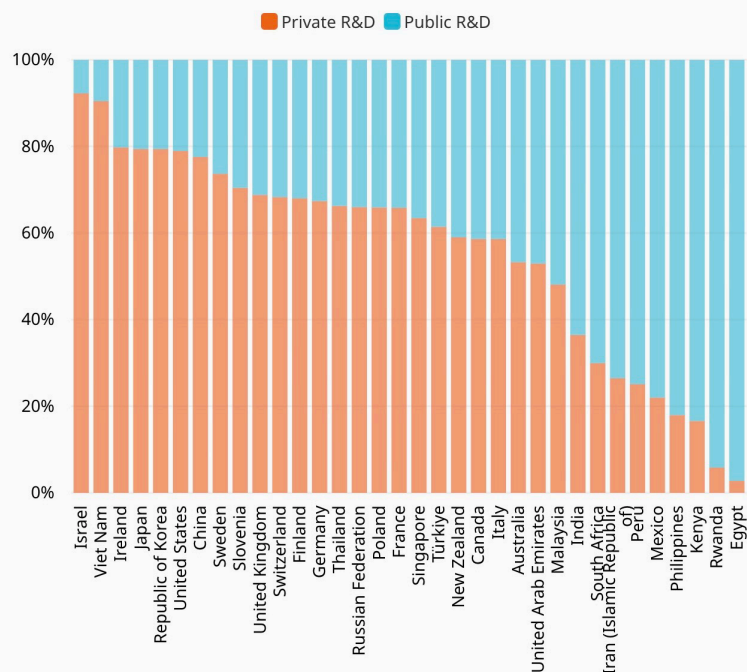


UN Women's forum in developing the UN Partnership on the Rights of Persons with Disabilities

Current Status of Research & Development (R&D)

Much insight can be given to the priorities of each nation by looking at the funding share of public and private R&D as well as the types of research projects their governments fund. The largest R&D spending region is Southeast Asia, East Asia, and Oceania (which includes the Republic of Korea, Thailand, China, and Japan), with a global share of 40% in R&D spending. The region of Latin America and the

Chart 10: The share of private in total economy-wide R&D, 2023



Source: WIPO estimates based on GII Database and data from Eurostat, OECD, RICYT, and UNESCO UIS (see background information)

The share of private in total economy-wide R&D, 2023. WIPO estimates based on GII Database and data from Eurostat, OECD, RICYT, and UNESCO UIS.

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projects in its list of high-tech industries.¹² Though these financial incentives have been going mainly to semiconductor and artificial intelligence (AI) businesses, some have gone to companies with high-tech manufacturing projects or R&D companies focusing on emerging technologies. Viet Nam does not focus on medical research directly; however, its medical research is often coupled with science and technology studies. Due to the technology-focused research priorities of Viet Nam, there is less of a medical research concentration on examining sociocultural indicators and their relationship with health outcomes.

Over the past couple of decades, Peru has experienced immense growth in biomedical research, mainly through the efforts of Cayetano Heredia University (UPCH), which accounts for a third of the publications happening in Peru.¹³ Historically, the government of Peru has not been a major source of R&D funding, with international partnerships and grants instead funding medical research there.

Caribbean has seen a decrease in its global R&D spending share, dropping from 3% to 2%, with its largest contributors—Brazil, Argentina, and Mexico—also seeing a decrease in their global spending share. Within the continent of Africa, Egypt stands out as the clear leader of R&D, spending \$15 billion USD, with the second closest being South Africa, which spends \$5 billion annually. Other emerging leaders are Algeria, Morocco, and Nigeria.

Under their Investment Support Fund, Viet Nam offers financial support of up to 50% of initial R&D investment costs to businesses starting R&D

Partnerships between the Global North and the Global South

Currently, the continent of Africa bears 25% of the global disease burden, yet only 1.1% of the clinical trials were hosted in Africa.¹⁴ This leads to ineffective and disjointed solutions being implemented for a population of people who were not involved in the data collection process.

The United Nations has been working towards fostering better partnerships with vulnerable populations. For example, in 2020, the United Nations Development Programme, in collaboration with WHO and the University of Sherbrooke, began a project called Solar Energy, which includes telehealth to transform community health and provide renewable energy to health centers in Mali.¹⁵ These projects also include resilience education and social protections for internally displaced people and women, with over four hundred healthcare workers being trained in infection prevention and control.

29 The concept of “trickle-down science” has been used to describe the process of people from the Global South going to the Global North for higher education and to conduct research that focuses on the challenges in the Global South. However, around 70% of researchers seek employment elsewhere from their country of origin and do not focus on the concerns of the Global South, oftentimes due to their impact being limited, job progression in the Global North, and many other reasons.¹⁶ For the roughly 30% of people who do move back to the Global South, there are not enough resources and support for researchers to implement the solutions they studied.



Solar Panels beside a Mali Health Center, highlighting the partnership of the University of Sherbrooke and UN bodies

It is imperative for delegates to consider the positive and negative effects of global partnerships for medical research and how emerging technologies can allow for less developed countries (LDCs) to conduct their own R&D.

Directives / QARMAs

What incentives should be adopted to increase the number of local researchers globally?

How can all member states work together to strengthen state capacities to conduct clinical trials that protect human subjects, keeping in mind national regulations?

How can the effect of differing definitions of racial, ethnic, and religious groups be mitigated to conduct medical research on these populations within each member state?

What role does brain drain play in medical research being conducted in the Global South?

30

How can emerging technologies foster partnerships between countries, regions, and populations around the world?

Does the Global North have an obligation to conduct research alongside/within the Global South?

How can member states ensure data collection is done ethically to protect civilians' privacy?

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