



# International Monterrey Model United Nations Simulation

American School Foundation of Monterrey



## World Health Organization

**Topic:** Debating possible solutions towards disease control in humanitarian emergencies

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### I. Committee Background

The World Health Organization (WHO) is responsible for all health-related issues that are tackled by the United Nations (UN). The organization was inaugurated on April 7, 1948, a date that came to be known as World Health Day. The decision-making body for the WHO is the Health Assembly, which mainly determines the policies of the organization and appoints the director-general. The Health Assembly usually convenes in the UN headquarters in Geneva each year during the month of May. The Health Assembly also instructs the Executive Board “in regard to matters upon which further action, study, investigation or report may be required” (*Information and rules ... procedure*, 2021). The Executive Board consists of thirty-four technically qualified experts in the field of public health, elected for three-year terms. Generally, the purpose of the Executive Board is to facilitate the work of the Health Assembly. The WHO also relies heavily on its Secretariat, a body consisting of around eight hundred people, who are stationed across the globe in the institution’s headquarters and in the organization’s regional offices.

The primary goals of the WHO include improving equity in health, reducing health risks, promoting healthy lifestyles and settings, and responding to the underlying determinants of health (*What we do*, n.d.). Resolutions passed by the WHO are non-binding and must be approved by both the Health Assembly and the Executive Board. The meeting in which resolutions are approved occurs annually in January. In this conference, resolutions which had been proposed by the WHO are then approved by the Executive Board and passed on to the Health Assembly. There is a shorter meeting in May to address the details of these resolutions and put them into effect.

### II. Introduction

#### Description and Definition of the Topic

Crises varying from armed conflicts to natural disasters continue to proliferate in multiple countries; such calamities cause humanitarian emergencies. A humanitarian crisis is an event or series of events that represents a critical threat to the health, safety, security, or wellbeing of a community (*What is a ... emergency?* 2021). Examples of these include epidemics, famine, armed conflicts, natural disasters, and other consequential hazards. During a humanitarian

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emergency, populations can not withstand the negative consequences by themselves, overwhelming their capacity to cope. Moreover, those affected get resettled in temporary locations with high population densities, receiving inadequate food, shelter, unsafe water, and poor sanitation—all characteristics of sudden population displacement. These conditions exacerbate the spread of transmittable diseases, causing excess morbidity and mortality. As stated by the World Health Organization: “various risk factors interact to produce a higher incidence of diarrhoeal diseases, acute respiratory infections, vaccine-preventable diseases such as measles, and vector-borne diseases such as malaria” (*Disease control in ... emergencies* 2006). This, in turn, leads to serious health and socioeconomic consequences.

## The Problem

The spread of disease in humanitarian crises is now condemning millions of individuals to unsustainable, threatening situations. The issue is that complications, including unsafe water, sanitation, and hygiene, are coupled with other risks, such as mass population and displacement, making matters worse (Hammer et al., 2018). In 2020, the WHO published a report demonstrating that “death rates among refugees and displaced persons are over 60 times the baseline rate, with over three-quarters of these deaths being due to communicable diseases” (*Global Humanitarian Response ... COVID-19* 2020). Additionally, these crises have severe impacts on low and middle-income countries. Vulnerable nations already suffer from poverty, inequality, malnutrition, and a lack of basic needs, causing them to be less prepared to respond during the emergencies. Thus, their vulnerability compromises their ability to deal with the dilemma. At the same time, migrants and those displaced by conflict have lower vaccination rates and lack fundamental medical care; according to the WHO, “1.6 billion people in the world have no access to basic medical care” (*What are the ... today?* 2021). The implications of such a situation is that infectious disease and access to health care are both a substantial impediment to humanitarian aid. Nations undergoing armed conflicts are also victims of the problem; insecurity resulting in social disruption intensifies the risk of disease by hindering their access to health services, “making adequate humanitarian responses more difficult” (Hammer et al., 2018). Likewise, women’s social status in humanitarian crises presents a significant issue: “during such emergencies, women lose access to family planning services, prenatal care, postpartum care, and other health services” (*Why are women ... crises?* 2021). Hence, the heightened risk of female health and safety makes them vulnerable to disease.

The problem fails to end because disease control in humanitarian emergencies regularly demands a large-scale international response. While research in this field is growing, there remains inadequate understanding of the risk factors associated with transmittable diseases in humanitarian crises. Besides, although progress in the control of specific communicable diseases

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has been achieved, complex emergencies affecting vast geographical areas pose a greater challenge. Yet, it is imperative to reach a solution seeing that the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) predicts that this problem will get worse, especially with the rise of the COVID-19 pandemic. The OCHA estimates that around “235 million people around the world will be dependent on humanitarian aid and protection in 2021, increasing 41% in one year” (*Global Humanitarian Overview 2021* 2021).

### III. History of the Topic

#### Chronological History of the Topic

One of the most complex relationships comes from contagious diseases and humanitarian crises, which often complement each other to culminate into catastrophic results. That is why, historically it has been human tendency to create temporary or permanent methods that mitigate the presence of these illnesses, especially when there are external factors involved that worsen the circumstance to the point where there are significant declines in the population. For example, in the 1300s, the strain of Y. Pestis became prevalent in the Eastern Asian nation of Mongolia, which was believed to be “passed to humans by a type of marmot known as tarabagan” (Podewils et al., 2006). This disease came at a period of tension between the Mongol King Jani Beg and the communities surrounding his conquered lands. Hence, when thousands of the Tatar troops belonging to Beg began to exhibit symptoms of infection, it was not long before the disease was transmitted to the inhabitants along the borders, and subsequently to the nearby European countries. At first, the soldiers did not have any intentions of spreading the deadly strain, yet as they began to suffer massive losses from conflicts they had with the Genoese traders and Muslim collective, under direct orders, the infected corpses were thrown to the city walls of Kaffa as a direct biological warfare attack. Paired with the substandard conditions that Genoese individuals had to undergo and susceptibility to hypothermia as “they escaped through the black sea”, the notorious Black Plague gradually spread within the parameters of Constantinople (*Cause and outbreak* 2021). Soon, the epidemic would present itself to a population that was not prepared to fight it. In fact, the Middle Ages proved to be a perfect environment for the Bubonic Plague, as homes would typically be cold, lack any hygienic measures, and were located in streets that were infested with natural carriers of this illness including rats and fleas. Not to mention, nations like Greece and Bulgaria suffered from massive tsunamis that caused mass destruction of physical property and left citizens prone to more diseases, as floating debris scattered around populous areas and contaminated the local water supply. Furthermore, the governments did not have any knowledge of what medical resources could fully fix the problem; therefore, succumbing to solutions such as “ordering ship

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inspections and burning those with contagions, shutting down taverns, and restricting wine from unknown sources” to restrict the movement of people (Seven, 2020). Even using the Flagellants, religious figures influenced by the Catholic Church sought to release the disease out of their bodies by whipping themselves as signs of penance, all the while deeming it a punishment for the sins of society. Although these remedies proved to be unsuccessful, as “between 1347 and 1351, the plague killed an estimated 25 million people”, they marked the need for authorities to take into consideration the humanitarian impacts of illnesses and the urgency to address both political and medical crises prematurely before they create irreversible damage.

By the early 1800s, the medical field transformed its approach from relying largely on the assumptions of exterior forces to acting solely on the basis of empirical research. One of the main reforms came with how hospitals operated. Before this change, medical centers were allowed to house multiple individuals, regardless of the severity and how contagious their sicknesses were. Nonetheless, “with recommendations on sanitation and hospital environment first outlined in Notes on Nursing (1860)”, it was a requirement for patients to be isolated in different spaces to control any possibility of cross-infection (Wright, 2014). Even though it was a small change in common procedures, it prevented patients from worsening due to outermost bacteria, fungi, and other factors that could affect their condition, while keeping them in a quarantine state where they could not pass on or receive an illness from others. Another control measure was the encouraged use of vaccines, a substance that helps the body produce enough antibodies for immunity against a particular disease. This innovation proved its efficiency with the success of the cowpox vaccine in 1796 that created immunity to a once deadly disease; in the process, it “quickly [made] the practice widespread” (*All Timelines Overview* 2021). Unlike the previous methods discovered, this measure became a necessity, as armed conflicts, inadequate food sources, cultural shifts, and other factors became a breeding ground for illnesses that could only be halted in the long-term with immunization. Additionally, the massive quantities that this product could be produced in, aided in targeting a greater number of those passing through humanitarian disasters.

In 1846, a Measles outbreak took place in the Faroe Islands. Measles, a disease that spreads through respiratory droplets from an infected human to non-infected human and causes visible Koplik’s spots to appear, killed somewhere around one and two percent of the population in that area, until it dwindled down due to the “critical community size” of 250,000 (Harper, 2020). Yet, this only signaled its ability to thrive in high population environments, so if transmitted in areas of high density with similar underdeveloped infrastructure as the Faroe Island, it is bound to cause more harm at a greater scale. Four years later, in the midst of a transitional period for the government of Hawaii, “several epidemics struck Hawaii, beginning with measles and pertussis, then diarrhea and influenza” (Ludlow, et al., 2015). With plantation

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workers not being taken care of by the government and alternative medicine largely being the sole cure available, “10% to 33% of the population died from Hilo, Hawaii, to [throughout] all the islands”; making the disease to continue spreading until it became a health crisis for the international community, where “7–8 million children died each year due to Measles virus infections” (Ludlow, et al., 2015). Similarly, tuberculosis, a bacteria that ambushes the lungs, worked in a fashion where it would seasonally infect millions of people, especially those belonging to a lower socioeconomic status. The first wave happened “during the Industrial Revolution, the second during WWI, and later during the HIV epidemic” (Ludlow, et al., 2015). The rise of this bacteria is attributed to the overcrowding that happened with women and children during WWI and the malnutrition that weakened the immunologic defense of the individuals within the previously mentioned period of time; as a result, enhancing the overall progression of tuberculosis. Fortunately, for both of these cases, after the vaccine was introduced to the communities affected and later on to the South-East Asian and African Region that developed varying strains: they decreased both the mortality and infection rate. In fact, for “TB it was cut by half” and for measles at approximately “80% less” than what it was in 1990 (*Tuberculosis* 2021). By the end of the 20th century, it became evident in the medical field that the creation and distribution of vaccines was the most appropriate solution to eradicate diseases from areas that cannot afford the negative effects that they entail. Now, ensuring access to the immunization process is the cornerstone of public health, primarily when there are emergencies that compromise the livelihoods of individuals and drive nations to be completely distraught.

Even though the vaccine is still an integral part of disease control in regions riddled with illnesses, it still needed support from other systems, as it mainly worked in circumstances where populations were able to receive the medicine, rather than “those that suffered large-scale displacements and the disruption of normal life to an extent that is beyond the means of typical coping mechanisms of a society” (Reed & Keely, 2001). For instance, at the end of the breakup of Yugoslavia, when the Kosovo Liberation Army emerged in non-violent uprisings, as a counterattack measure, the Serbian forces began an ethnic cleansing campaign against the Muslim Albanian majority. At the end of the armed conflict and “movement of 375,000 Kosovars refugees to neighboring Albania”, a large outbreak of Tularemia occurred in Kosovo. This proved to manifest itself into a complex emergency, as the disease surveillance and outbreak response collapsed in a matter of months. Additionally, NATO had diminished the violence; nevertheless, the country still remained under “severe social and economic disruption”, with a “breakdown of sanitation and hygiene” to such a degree that the authorities were unable to better it (Reintjes, et al., 2002). Rural areas had mice, rats, insects, and domesticated animals that carried this disease and infected the community in high frequency. All the while, citizens in more populated cities were vulnerable to contracting the infection by inhalation and consumption of

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infectious specks of dust exerted from the water supply that was severely contaminated. On April 14, 2000, Kosovo along with the assistance of the UN, began an epidemiological investigation that found that the treatment to combat Tularemia would be to improve the infrastructure of the homes—pathways to the rodents—educate the traumatized individuals on the basic hygienic protocols in cooking, and encourage them to boil the rubbish-filled water supply. It is this case study among others that laid the foundation for solutions like rain catchment tanks, elimination of pest entry points, as well as others to thrive as widely accepted solutions in times of cataclysm. Despite the notion that there needed to be a type of serum to lessen the outbreak, the most effective results came from areas that had not just been given the resources to distance themselves from the sickness but also were knowledgeable of how to implement them in the future re-emergences.

Most recently, the WHO, along with nations in West Africa, have put an emphasis on “strengthening the preparedness and capacity for timely response to outbreaks and emergencies” for underdeveloped governments (Pheage, 2017). This five-year term plan seeks to nourish the health systems, under the grounds of the health-related Sustainable Development Goals (SDGs), to upgrade the quality of primary health care and decrease the prices to make it affordable to people that are poverty-stricken. Not to forget, with the commonness of corruption in those in charge, WHO officials find it critical to modify who controls the budget and how it is placed in different sectors. During the months of the Ebola epidemic in 2014, “low trust levels contributed to the spread of rumors that the Liberian government had exaggerated or even concocted the Ebola crisis as a way to get access to international funding that could be siphoned off for private uses” (Dupuy & Divjak, 2015). Therefore, a portion of the communities that were infected with Ebola trusted this misinformation and resisted the help of medical personnel, which led a variety of them towards a death that could have been easily prevented. For that reason, full transparency in how the materials are being handled became encouraged, as populations that are reassured that the volunteers and officials are acting on reasonable intentions are not as easily swayed to believe medical conspiracies or resist treatments altogether. Finally, as nations experience the devastating consequences of diseases such as Malaria, Yellow fever, Chikungunya fever, Dengue, African trypanosomiasis, and Onchocerciasis, according to country experts, “defining a clear emergency approach” has the “potential to save millions of lives when disasters strike” (Demissie et al., 2020). Following the 2017 Ebola Outbreak, the Democratic Republic of Congo (DRC) used the research gathered from the previous flare-up to create a national response network that prepared the citizens with information that would prematurely mitigate the number of infections. All in all, “it took 42 days to curtail the Ebola outbreak with only eight total cases and four deaths across the whole of the DRC” (Demissie et al., 2020). The apparent unpreparedness and absence of disease control initiatives in the international community are still

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left to be figured out; however, it is a proposal that has shown efficiency and if looked into, could be a defining factor whether the combination of turmoil and diseases can conclude with order and opportunity, instead of further mayhem.

## Historical Case Studies

### Salmonella in the Caribbean

Salmonella are a group of bacteria that can prompt foodborne disease in humans by eating food that is contaminated with animal feces (Indar-Harrinauth et al., 2001). This food is typically of animal origin such as, but not limited to, eggs, beef, or milk. Symptoms include diarrhea, fever, abdominal cramps, vomiting, bloody diarrhea, nausea, myalgias, and headaches (Indar-Harrinauth et al., 2001). During the mid-1980s, both tourists and locals in the Caribbean began having diarrhea; eventually, salmonella was deemed the cause of it. The disease continued to grow because surveillance systems did not effectively detect what was occurring and at what scale. Their surveillance system consisted of clinician-based reporting which was more often than not, incomplete, inaccurate, and inefficient. The outbreak affected “public health, food safety, agriculture, trade, and tourism” in the Caribbean area (Indar-Harrinauth et al., 2001).

### Botulism in Argentina

Botulism is an illness that comes from toxins generated by a bacteria called Clostridium botulinum. These toxins most commonly enter a human either when they are infants, through wounds, food, or injections. They affect a human’s nerves and cause symptoms such as “descending, symmetrical skeletal muscle weakness, paralysis, and respiratory failure” (Villar, 1999). In January 1998, the capital of Argentina, Buenos Aires, experienced a botulism outbreak. It began with two men who drove buses for the same company and had the same shifts. After conducting a thorough study, Rodrigo Villar, a medical epidemiologist for the Centers for Disease Control and Prevention, found that a rapid-response surveillance and antitoxin release system would have been helpful to distribute antitoxin to patients in Argentina who suffered from botulism (Villar, 1999).

### Norovirus in Vermont

Noroviruses can be transmitted in many ways such as “contaminated food, person-to-person contact, contaminated environmental surfaces, and airborne droplets of vomitus” (Podewils et al., 2006). They cause approximately 23 million cases of acute gastroenteritis in the United States each year and symptoms include vomiting, diarrhoea and consequent dehydration severe enough to require hospitalization (Podewils et al., 2006). In early February of 2004, people in Vermont who had recently been to a specific swimming facility

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reported cases of acute gastroenteritis. Eventually, an investigation determined that the facility's chlorine equipment was experiencing failures, their operators did not have sufficient nor quality training, they had unreliable maintenance checks, and their records were not properly kept (Podewils et al., 2006). All of these factors made it easier for their pool's water to be contaminated with norovirus.

## Ebola in West Africa

In mid-march 2014, the World Health Organization reported cases of the Ebola Virus Disease in Guinea. The disease prompted many symptoms such as fevers, aches, pains, weakness, fatigue, sore throat, diarrhea, hemorrhaging, bleeding or bruising, abdominal pain, and many others (2014-2016 Ebola ... Africa 2019). As a result of "weak surveillance systems and poor public health infrastructure", Ebola spread throughout West Africa and even reached countries like Italy, Spain, the United Kingdom, and the United States (2014-2016 Ebola ... Africa 2019). The disease was circulating in crowded urban areas and there was a clear conflict between "infection control practices and prevailing cultural and traditional practices" in the region (2014-2016 Ebola ... Africa 2019). The outbreak was eventually contained via prevention programs and the implementation of policies all over the globe.

## **Past UN Actions**

To try and eradicate these issues, the World Health Organization has created a branch called the Division of Programmes for Disease Control, which aids in trying to prevent infectious diseases from spreading. This division works out of the WHO country offices and focuses on three main areas. The first area is ending communicable diseases, which include Tuberculosis, HIV/AIDS and other vector borne and neglected tropical diseases. The second area focuses on eliminating diseases that are preventable by vaccines, as well as reducing the number of new infections by improving the availability of said vaccines. The final area works on treating the people that are affected by these diseases and others affected by mental health issues (Giang Tran, 2021). Throughout its time working, the program has been able to eliminate leprosy, and "is close to eliminating measles, maternal and neonatal tetanus, malaria, lymphatic filariasis and blinding trachoma regionally" (Giang Tran, 2021). The DCE coordinates with experts on topics like diarrhoeal diseases, malaria, acute respiratory infections, tuberculosis, HIV, water and sanitation, and child health to ensure that these problems are tackled with the help of experts. These specialists set technical standards in communicable disease control and they are able to provide technical support in severe situations and as they continue to evolve.

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## IV. Key Players and Points of View

### The United States of America

The United States' government agency that concerns itself with disease control is the Centers for Disease Control and Prevention, also known as the CDC. However, according to an article published in USA Today, “a survey, conducted by the Robert Wood Johnson Foundation and Harvard T.H. Chan School of Public Health,” demonstrates that the ratings of the public health system have dropped from “43% in 2009 to 34% in 2021” (Rodriguez, 2021). This is clearly reflected in how the US handled the COVID-19 pandemic. For starters, when the pandemic started to become a problem in the US, the CDC did not take a central role in controlling the situation: the Public Health department of the country did not enforce any regulations during the pandemic. Moreover, the governors of each state took their own approach to handle the situation; the difference in responses to the situation caused a variety of results—some positive and others negative (*The United States ... response 2020*). However, around the start of the COVID-19 pandemic, on March 21, 2020, the US closed its border to prevent the spread of the disease. This strategy was implemented by countries all over the world in an effort to prevent the spread from or to the country (*Travel restrictions - Fact Sheet 2021*). People from the US have also contributed to the World Health Organization in order to make the world a healthier place: during the 2016-2017 period, the US was the number one donor to WHO, investing over 945.6 million dollars (*The United States ... Health n.d.*).

### The Democratic Republic of Congo

The International Organization for Migration (IOM) has worked with the Democratic Republic of Congo (DRC) to create a crisis response plan for the country, which includes the “monitoring of population mobility to inform outbreak preparedness and response” (*Democratic Republic of ... 2021 2021*). Some of the main objectives of this response plan are: saving lives and responding to humanitarian assistance, addressing the drivers and long term impacts of the crisis, and strengthening preparedness and prevention (*Democratic Republic of ... 2021 2021*). The COVID-19 pandemic placed pressure on the government, seeing as the country had very “limited infrastructure and basic social services” (*Democratic Republic of ... 2021 2021*). The DRC experienced 9.8 million people in need of humanitarian assistance, while also reporting 3,201 cases of cholera in the time between January and October of 2021 (*UNICEF Democratic Republic ... 2021 2021*). The World Health Organization has been working with the Alliance for International Medical Action (ALIMA), who “support 13 health centers and three district hospitals”; all of which are hosting multiple internally displaced persons (*Strategic Response and ... Congo 2018*). Overall, the DRC still needs to work on improving its healthcare infrastructure





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and it must keep polishing its crisis response plans in order to guarantee the safety and wellbeing of all people in the midst of possible future crises.

## Belgium

Belgium's health system is a shared responsibility between the federal government and all of the entities within it. Federal authorities regulate and finance the compulsory health insurance, hospital budgets, and define the qualifications for medical personnel, as well as regulate the price of pharmaceuticals. Meanwhile, the provinces are in charge of the “financing of health infrastructure and medico-technical services, the definition of recognition norms for hospitals, health promotion and prevention, health workforce planning, maternity and child health care, social services, coordination in primary care, elderly care, mental health care, and long-term care” (Parmenov, 2016). Currently, Belgium runs checks on all people that arrive from countries where there is widespread of a disease. Such a process involves “intensive collaboration” between all parties involved, including airports, airlines, and health authorities (Tsolova & Fraser, 2015). Adding on, the country has hospitals for specific treatments such as Ebola; the structures of these hospitals were modified to increase isolation and protection. In 2017, Belgium had a healthcare expenditure of 10.3%, one of the highest in the European Region, and equivalent to \$5,119 USD per capita (*Belgium HiT (2020) 2021*). Overall, Belgium has a great investment in the healthcare system and has implemented prevention measures throughout the entire country.

## China

China has the Public Health Emergency Center (PHEC), which leads the country's preparedness and response activities. Its main mission is to “reduce the impacts of emergencies by preparing systematically for public health threats and responding effectively” (*Health Emergency* n.d.). This organization is a subsidiary of the Chinese National Center for Chronic and Noncommunicable Disease Control and Prevention (NCNCD), which is in charge of creating a safe environment and promotes health through the prevention and control of disease (*Chinese Center for ... (NCNCD)* n.d.). At the beginning of the COVID-19 outbreak, the government implemented a “series of policies to control infectious disease” (Li et al., 2021). Overall, it was found that strong and capable leadership was a key aspect of controlling the spread of the disease. Likewise, coordinated action between the central government and local governments showed to be beneficial when dealing with this crisis. In other words, the Chinese medical and political infrastructure is set up in such a way that it can respond to the outbreak of diseases rapidly, as long as the central and local governments are able to coordinate their response.

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## V. Possible Solutions

For decades, disease control has been a demanding issue. The conflict has been around for a while causing more information to be collected and has helped develop multiple solutions. The first solution is improving surveillance and establishing an Early Warning, Alert and Response Network (EWARN). EWARN is comprised of a network of health partners that report and collect surveillance of specific epidemic-prone diseases. This helps detect the epidemic disease quicker and therefore avoids the possibility of spread. As diseases are detected, an alarm system goes off. Every disease has a different threshold; when the threshold is overpassed, the alarm goes off. There are two types of alerts—one of them, and the most important, is an immediate alert signal, which is activated once the threshold is overpassed and is labeled as a possible crisis. Subsequently, an immediate investigation of the situation is conducted. This is done in the early stages of the disease spread to avoid any further conflicts.

Secondly, implementing a system for weekly reporters would benefit and decrease the spread of any new arisen diseases. If the disease is discovered on time, it would be much easier to reduce and control. Therefore, having a systematic storage of weekly reports would help avoid increased spread and save many lives. Additionally, a Country Epidemiological Profile is a document in which the effects of certain diseases and viruses on a population are recorded. Every country has a document with the specific diseases pertaining to and affecting their population. By having these profiles, it would be easier to detect and therefore prevent diseases. If the authorities already know that a certain country is being affected by a disease, actions can be taken much faster and ultimately reduce the burden of the spread. Lastly, strengthening local and global partnerships is extremely important. Countries that have established relationships with non-governmental organizations, UN Agencies, and academic institutions, are likely to have more resources to combat disease outbreaks during a crisis. To create a thorough and pertinent resolution paper, member-states must work together and craft solutions that address disease control in humanitarian emergencies from multiple perspectives.

## VI. Current Status

Global disease control and prevention is and will continue to be a demanding and critical task. Today, the World Health Organization continues to act against this pressing issue, but it is not enough. In partnership with the Programme on Disease Control in Humanitarian Emergencies (DCE), WHO aims to reduce the excess morbidity and mortality caused by infectious diseases in humanitarian crises. The DCE coordinates the Communicable Diseases Working Group on Emergencies (CD-WGE), which sets technical standards for communicable disease control while providing rapid support in acute, global emergencies. In 2016, the United

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Nations Office for the Coordination of Humanitarian Affairs estimated that 125 million people needed humanitarian assistance, but that number is constantly changing (Boyd et al., 2017). Today, the amount of people affected by humanitarian emergencies each year is unprecedented, and thus, controlling diseases in these situations is extremely difficult. Moreover, now more than ever, political instability and weak governance exacerbate these emergencies' effects on communities, creating what the WHO defines as “complex emergencies” (Boyd et al., 2017). The Center for Disease Control and Prevention leads the development and understanding of epidemiology and the effects of humanitarian and complex emergencies. Their work began in 1968, during the war-induced famine in West Africa. The CDC continues working on humanitarian crises through its humanitarian emergency response branch, the Emergency Response and Recovery Branch (ERRB), in hopes of adapting to and addressing new threats to global health security (Boyd et al., 2017).

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