WHO: Pharmacovigilance and AIDS Virus in Africa

Hello delegates! My name is Kayla Holliday, and I will be your head chair for the 2017 MVHS MUN conference. This is my second year in MUN, and I am currently the MUSG of Novice Committees at Mission, meaning that I will be helping out all of the novice delegates this year! I am greatly involved in the drama program here, as well as French Club and the Varsity golf team. I can't wait for a great day of debate with all of you! If you have any questions, please email novicewho@gmail.com, and I will be in contact with you! :)

Hello delegates. My name is Dilushi, and I will be your vice chair for the MVHS MUN 2018 conference. This is my third year in MUN and my second year in MVHS MUN. I'm involved in numerous clubs here at Mission, including but not limited to Minds of Music and Fortuna's Table. In my free time I love to draw, I also enjoy playing piano and will be testing for CM level 8. I look forward to spending this weekend with you and I hope for an amazing committee session.

The functions of the Health Assembly shall be: to determine the policies of the Organization; to name the Members entitled to designate a person to serve on the Board; to appoint the Director-General; to review and approve reports and activities of the Board and of the Director-General and to instruct the Board in regard to matters upon which action, study, investigation or report may be considered desirable; to establish such committees as may be considered necessary for the work of the Organization; to instruct the Board and the Director-General to bring to the attention of Members and of international organizations, governmental or nongovernmental, any matter with regard to health which the Health Assembly may consider appropriate.

Pharmacovigilance

I. Background

Pharmacovigilance (PV), otherwise known as drug safety, is the science of the detection and understanding of the different effects of pharmaceutical products. After a major thalidomide disaster in 1961, pharmacovigilance became known as a major international focus in order to prevent further events such as this one. Strong reactions can be known as ADRs, or adverse drug reactions, and it is up to trained professionals to perform the tests necessary in order to approve or

disprove each medical product to make sure that these do not happen. While technologies have advanced, the need for this particular testing is still greatly needed in several parts of the world, such as nations in Africa and Latin America, who have barely any medical care to begin with. While many reactions can be mild, many others can lead to visual problems, muscle tremors, liver failure and heart problems. In fact, many countries have found ADR's ranked as part of their top 10 leading causes of death. While now over 65 nations have centers for these practices, it is imperative to continue this spread in order to improve medical care across the world. Through education and the right financial control, the World Health Organization believes this issue can be easily contained and solved.

II. United Nations Involvement

After the thalidomide incident in 1961, the World Health Organization decided to recognize PV as an international issue needing to be addressed, and created a committee known as the Programme for International Drug Monitoring. By 2010, 134 countries had joined this committee in order to find the most efficient solution based on each other's needs. In 1971, a system was created and approved in order to monitor ADRs. However this has not solved the problem, just created more awareness and knowledge. A database of recordings from this system includes 3 million cases, and the obvious next step for the UN is to find a way to halt these continuous instances. The main concern for the committee is finding an effective way to reach secondary countries without the financial ability to support the organization's efforts.

III. Possible Solutions

Delegates, it is your priority to find a way to best combat the issue of ADRs. While the majority of countries in this committee agree that it is imperative to do further research on each drug in use, many do not have the necessary monetary ability in order to do this. These countries would possibly like to ask advice and financial help from more developed nations, such as those in the Western bloc, as well as ask for the opportunity to share in the information already known. This would be in the best interest of both sides because the more information known about a substance, the better. If the nations work together on this, the UN recognizes that a strong, manageable resolution will come to be.

IV. Guiding Questions

1. How many ADRs have been recorded in your country, if any, and is it a large issue needing to be addressed there?
2. Are there currently many new drugs being used in your country that have not had progress being monitored sufficiently?
3. Is your nation one to provide aid to others if needed, or are you seeking aid?
4. What can be done to help those already dealing with ADRs?

V. Country Bloc Positions

Western: The West has many research opportunities and financial support in order to be able to continue to work with this issue. Many nations here are willing to help others follow in their footsteps.

Latin: Many of these countries do not have the proper resources to verify each medicinal drug, and are seeking aid in order to make sure that ADRs do not continue to be a problem.

Asian: A majority of the Asian countries have access to research facilities, and would like to continue to make sure their citizens are able to have safe and tested products.

African: The African continent has been dealing with several new diseases, and in order to find a cure, many are being given uncertified medicine. It is important for larger countries to help them financially, as well as with advice for the future.

Middle Eastern: Several Middle Eastern countries are dealing with much larger issues at the moment, and the testing of medicine is not a priority. They would like to begin setting up areas in order to have a more secure process.

VI. Works Cited

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AIDS Virus in Africa

I. Background

Since its first clinical evidence in June 1981, acquired immunodeficiency syndrome, or AIDS, has since spread its numbers in leaps and bounds. In 2015 alone, there were 36.7 million people in the world found living with human immunodeficiency virus, otherwise known as HIV, the cause of AIDS. The AIDS virus has especially struck hard in Africa, where it is now concluded to have originated from. Experts suggest that by the 1960s, around 2000 people in Africa may have been contaminated with HIV. The first epidemic is thought to have occurred in the capital of D.R. Congo, Kinshasa, in the 1970s, when there was an upsurge of various infections, suchlike tuberculosis and cryptococcal meningitis. Since then, it most likely was carried into Eastern Africa, but did not achieve another epidemic until the early 1980s, when the spread of HIV saw transmission rates of a devastating pace, largely due to the amalgam of widespread labor migration and rampancy of sexually transmitted diseases, to name a couple of reasons. Uganda was hit especially hard by the 1980s pandemic. At this time, doctors were becoming familiar with cases concerning similar symptoms occurring in the United States. Research was put forth to find out the patterns and prevalence of HIV in Uganda and the rest of Africa.

In the mid 1980s, not much was known about HIV and AIDS. Thus, people would not know that they were infected until they reached the disease’s last stages, when death when certain. As there was no cure and no treatment in the 1980s, the predominant strategy was prevention:

revision of sexual behavior, sex abstinence, correct and consistent use of protection, having one or fewer partners, etc. However, with fear of offending large religious nations, gridlocks formed between some national governments.

The 1990s held a dreary outlook upon the AIDS history in Africa. There were few new ideas on how to deal with the crisis, and HIV infection rates were soaring. Effective treatment in Africa saw insufficient promise, and campaigns promoting “prevention” were having little effect. In 1994, a discovery found that AZT, the antiretroviral drug zidovudine, was able to reduce mother to child transmission of HIV/AIDS by two-thirds. This transformed combative measures in developed countries, but the cost of about $1000 a case was out of the question for poorer countries. Another advance occurred in 1996, when a combination therapy known as HAART (highly active antiretroviral therapy) proved effective in combating the virus. Unfortunately, it, too, was only attainable by those in richer and more developed countries.

In 2000, following an increased pressure to increase anti-AIDS drugs accessibility, an offer was made by five pharmaceutical companies to negotiate a sharp price drop of the AIDS drugs for poorer regions, including Africa. Although the negotiations were prolonged, the few following years saw frequent cuts in the prices of the world’s largest drug manufacturers’ various licensed AIDS drugs until they were only slightly pricier than generic drugs. Still, by 2001, only 8.000 of the 20 million in Africa living with AIDS attained the drug treatment.

In 2006, a behavioral change was reported in some parts of Africa. It was believed to partly be due to the young population delaying their first sex as well as their reduction in sexual partners. It appeared to account for a decline of about a quarter of HIV infections in those particular areas of

Africa. Yet, in 2009, 1.3 million people in sub-Saharan Africa were reported to have died of AIDS.

In the following decades, the infection rate has gone up, as well as the fatality rate. Eventually, however, treatment extended to those infected. By December 2015, 17 million people with HIV had access to antiretroviral therapy: significantly more than June that same year. The history of the virus is still long from over, but the lack of a cure combined with limited access to treatment in Africa indicate the millions who will continue to endure the ramifications of the AIDS epidemic.

II. United Nations Involvement

The United Nations has lead the way towards the eradication of the AIDS epidemic. In 1987 October, AIDS becomes the first disease ever debated on the floor of General Assembly . Resolution 42/8 is adopted on 22 October. In 1988, WHO declares the 1st of December to be World AIDS Day, as officially recognized by the General Assembly. January 1, 1996, UNAIDS was launched. UNAIDS coordinates much of the UN's efforts against AIDS. It joins together eleven UN organizations in the fight against AIDS: UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, the ILO, UNESCO, WHO and the World Bank. UNAIDS is also the first UN programme to have, on its governing body, a formal civil society. Five NGOs also represent the will of the people, two from developed countries and three from developed countries. In 1999, Botswana launched Africa's first programme to combat mother-to-child transmission using AZT. In December 2013, UNAIDS set up new targets for the HIV treatment goals. They established a plan going by 90-90-90, of which by 2020, they plan to have 90% of people with HIV to know their HIV status, 90% of those diagnosed to receive antiretroviral therapy, and 90% of people

receiving antiretroviral therapy will have viral suppression. In 2015, they planned to have AIDS almost eradicated.

III. Possible Solutions

Delegates, it is up to you to formulate an answer to this epidemic. This particular issue contains mostly agreeable solutions, but delegates must be able to find ways to satisfy both the national governments and the people likewise. One option in solving this issue is to propose an increase in healthcare and, more specifically, HIV and AIDS. Have governments put more money into this issue rather than something such as military. Another solution is to somehow decrease Africa's dependency on external resources by having a single African Medicine Regulatory Agency hasten the distribution of quality guaranteed HIV drugs.

IV. Guiding Questions

1. How can AIDS drugs be made more available to those in developing countries?
2. How can we increase awareness of AIDS prevention?
3. Are there any important, unaddressed steps that the international community is neglecting to consider?
4. What is the best way to also strengthen Africa's health systems?

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