Hello Delegates!

Welcome to the Third General Assembly of the University of Georgia Model United Nations Conference. My name is Jillian Turner, and I will be your director for the Third General Assembly of UGAMUNC. I am a third year student at the University of Georgia, and I am from Fayette County Georgia. I am an International Affairs major, and I am also pursuing a Master’s degree in Public Administration. I serve on the Secretariat for the UGA Model UN team as the Head Delegate, and this marks my third year on the team and my third UGAMUNC. I have been involved in Model UN for seven years. In addition to Model UN, I am involved in the Roosevelt Institution at UGA, which is a student-led think tank, and I also intern in the Office of Undergraduate Admissions on campus. Outside of my academic and extracurricular involvement at UGA, I also volunteer for organizations in the community, such as the Jeanette Rankin Foundation and Heart of Passion. In my free time, I enjoy shopping, traveling, and hanging out with my friends and family.

I am excited to be working with Brielle Terbeek your Assistant Director in GA-3. She is a freshman at UGA and a first-year team member. Brielle is also from Fayette County, and she did Model UN for four years in high school. She is majoring in International Affairs and History at UGA with a pre-law emphasis. Brielle enjoys downhill walks on campus, thought-inspiring conversation, the color yellow, and going on occasional sky diving trips. Please do not hesitate to contact Brielle with any questions also.

Brielle and I are sure that this will be an exciting conference, and we have many interesting topics to talk about. We will be discussing the following topics in our committee: the threat of the co-infection HIV and TB, the crisis in Zimbabwe, and the eradication of dracunculiasis.

Please review the background guide and familiarize yourself with the content. Please note that this background guide is a starting point, and your research should be more in depth than the basic background information that we provide. In order to have a successful committee session, we expect for you to have a strong understanding of the topics, so please also be familiar with your country’s policies regarding the issues. If you have any questions regarding the background guide or any of the three topics, please feel free to email me with any questions. Finally, please review the UGAMUNC Rules of Procedure because we will adhere to parliamentary procedure throughout the entire conference.

Brielle and I are both looking forward to the conference and seeing all of you in Athens. Go Dawgs!

Kind Regards,
Jillian Lee Turner
Director GA-3
General Assembly, Third Committee Background

The General Assembly of the United Nations was created under the United Nations Charter in 1945. The General Assembly is made up of six major committees. The Social, Humanitarian, and Cultural Committee (SOCHUM) is the Third GA Committee. The General Assembly does not have the power to make legally binding decisions, but it makes very important suggestions and recommendations on many matters. The General Assembly is currently in its sixty-third session.¹

SOCHUM was created to respond to an array of humanitarian and social concerns throughout the world. The Committee discusses the advancement of women, the protection of children, indigenous peoples’ issues, the treatment of refugees, the promotion of fundamental freedoms through the elimination of racism and racial discrimination, and the promotion of the right to self-determination.²

All member states of the UN are represented in SOCHUM, and the committee has a voting policy of one vote per state. Unlike the United Nations Security Council, no state has veto power in GA-3. The chairman, currently H.E. Mr. Normans Penke, the Permanent Representative of Latvia to the United Nations, is in charge of the Third General Assembly.

The Third General Assembly is guided by many United Nations documents including the Charter of the United Nations, the Millennium Declarations, the UN Declaration of Human Rights, and the UN Declaration on the Rights of a Child. These landmark declarations help direct the committee.

**Topic I: The Threat of TB and HIV Co-infection**

**Background**

Tuberculosis and the Human Immunodeficiency Virus (HIV) are closely linked, especially in developing countries. Tuberculosis (TB) is an airborne disease that is easily spread from person to person, and while it is mostly curable, those with HIV are extremely susceptible to contracting TB. The link between HIV and TB is almost universally acknowledged, yet there has been a widespread failure to respond to this problem of co-infection. TB is preventing the end of the HIV/AIDS epidemic. It continues to complicate treatment procedures and increases the mortality rates for those suffering from HIV. Although many advances in the treatment of HIV/AIDS are undermined by the spread of TB, efforts to combat the two diseases collaboratively remain alarmingly lacking.

In 2008 Doctors Without Borders recognized the problem of HIV-TB co-infection as one of the top 10 humanitarian crises of 2008. The number of people developing TB is increasing worldwide, but TB is especially problematic in developing countries. Over 9 million people contract TB annually, and approximately 1.7 million people die each year from TB. To make matters worse, TB rates are dramatically increasing in developing countries that also suffer from high HIV rates. Around 33 million people are living with HIV worldwide, and approximately one third of those people are co-infected with TB. People living with HIV/AIDS are 50 times more likely to contract TB than those without HIV/AIDS because HIV/AIDS greatly deteriorates the immune system, allowing opportunistic infections and diseases to develop. Co-infection rates have disturbingly increased four-fold in developing countries heavily affected by HIV/AIDS over the past 20 years.

While it is very alarming that the rate of co-infection is increasing so rapidly, it is also important to note that there are several prevention challenges related to this issue. TB is sometimes drug-resistant. According to the World Health Organization (WHO), around 55 countries and territories have recognized at least 1 instance of widespread drug-resistant TB. Multi drug-resistant (MDR) cases of Tuberculosis withstand rifampin and isoniazid, which are two powerful drugs that are often used to combat TB. In addition to MDR cases, there are other major problems that complicate co-infection treatment efforts. The drugs used to treat TB and the drugs used to treat HIV have potential negative interactions, such as liver damage and the development of new allergies. When doctors prescribe such treatments for both diseases, they do not always carefully consider the side effects and harmful complications that can occur. Additionally,

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poverty and poor access to treatment services challenge the potential to treat these two intertwined diseases. In many rural areas in developing countries, many people find it difficult to travel to a clinic or health center for screening or to access the necessary drugs.\textsuperscript{11}

Although TB and HIV affect several regions of the world including parts of Asia and Eastern Europe, the problem is especially pressing in Sub-Saharan Africa. Seventy percent of those co-infected with TB and HIV live in Sub-Saharan Africa.\textsuperscript{12} In Swaziland, an alarming 14 percent of the population between the ages of 15 and 49 are co-infected with TB and HIV, and other Sub-Saharan African countries also have soaring co-infection rates.\textsuperscript{13}

Collaboration between TB and HIV efforts and programs is necessary in order to improve this major humanitarian problem of co-infection. Collaboration can improve prevention, care, and support for those affected by both HIV and TB. Ideally, everyone infected with HIV should be tested to see if they also have TB, but this is not generally the case. Also, TB treatments must be improved in order to prevent the continued emergence of MDR TB.

**What is being done currently?**
The World Health Organization (WHO) has made a global call for help to address the issue of the connection between the HIV and TB.\textsuperscript{14} However, the two diseases are generally treated separately.

The standard process to counter Tuberculosis is Direct Observed Therapy Short-Course (DOTS), which is widely applied to treat TB in 182 countries.\textsuperscript{15} There are 5 basic components to DOTS. The first element is “political commitment with increased and sustained financing,” which is government support to stop TB, financially and politically. The second is “case detection through quality-assured bacteriology,” which is introducing sputum smear microscopy and then culture and drug susceptibility tests (DSTs) into the health system. The third component is “standardized treatment, with supervision and patient support,” which involves directly monitoring the TB treatment for the first two months. The fourth element is having “an effective drug supply and management system,” which includes having a steady and sustainable stock of anti-TB drugs. Finally, the fifth part is implementing a “monitoring and evaluation system, and

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  \item \textsuperscript{11} “Health and community care: Tuberculosis and HIV.” IFRC. \<http://www.ifrc.org/what/health/diseases/tb/tb_hiv.asp>.
  \item \textsuperscript{12} Worley, Heidi. “Intersecting Epidemics: Tuberculosis and HIV.” PRB. \<http://www.prb.org/Articles/2006/IntersectingEpidemicsTuberculosisandHIV.aspx>.
  \item \textsuperscript{13} Worley, Heidi. “Intersecting Epidemics: Tuberculosis and HIV.” PRB. \<http://www.prb.org/Articles/2006/IntersectingEpidemicsTuberculosisandHIV.aspx>.
  \item \textsuperscript{14} “TB/HIV.” World Health Organization. \<http://www.who.int/tb/challenges/hiv/en/index.html>.
  \item \textsuperscript{15} Worley, Heidi. “Intersecting Epidemics: Tuberculosis and HIV.” PRB. \<http://www.prb.org/Articles/2006/IntersectingEpidemicsTuberculosisandHIV.aspx>.
\end{itemize}
impact measurement,” which provides a dependable way to monitor and assess the TB treatment outcomes.16

While the DOTS treatment has been successful in solving 82 percent of Tuberculosis cases where it is implemented, it is not a cure for every instance of TB.17 Therefore, more strategies have been implemented, and even more treatment ideas need to be explored.

Voluntary Counseling and Testing (VCT) helps millions of people learn whether they are HIV positive or not, especially in Sub-Saharan Africa.18 Antiretroviral therapy (ART) uses at least three antiretroviral drugs to contain the HIV virus and prevent further progression of HIV. Of the 33 million people living with HIV, the World Health Organization estimates that almost 10 million are in need of ART.19

Conclusion
The connection between HIV and TB is evident, and the co-infection rates are increasing. Additionally, co-infection faces many treatment problems. While there are several approaches currently being taken, such as the DOTS treatment, VCT, and ART, more collaboration efforts need to be made between HIV programs and TB programs. Both HIV and TB have a profound impact individually on global health, and together they pose a serious threat to a significant percentage of the world’s population.

Questions to Consider
As you prepare for UGAMUNC and this topic in particular, you would be well served to analyze the following questions:

1. How should the United Nations approach this co-infection problem?

2. How could collaboration efforts be improved?

3. What can be done to address the several treatment concerns?

Suggestions for Additional Reading
World Health Organization:
   http://apps.who.int/tdr/svc/diseases/tb-hiv

Doctors Without Borders:
   http://doctorswithoutborders.org/publications/topten/story.cfm?id=3241
Topic II: The Social and Humanitarian Crises in Zimbabwe

Background
Zimbabwe is a country of 13.5 million people, and it is located in southern Africa. During the European colonization of the Africa in the late 1800’s, Zimbabwe became a colony of Great Britain. The British named the country Southern Rhodesia. In 1965 the people of Rhodesia declared their independence from Great Britain. The four-year Chimurenga II War broke out following the declaration. Free elections were not held until 1979. Robert Mugabe, who was a pro-independence campaigner, has dominated politics in the country since 1980. Upon gaining independence, the name of the country changed from Southern Rhodesia to Zimbabwe.

Twenty years ago, Zimbabwe’s thriving farming industry, based on tobacco crops, led many to praise the country as an African success story. However, in 2000, Mugabe’s government began redistributing land to the majority black population with a publicly stated purpose of assisting landless black Zimbabweans. This led to “white flight” of white farmers and professionals, severely damaging the economy. Land reforms significantly decreased the country’s gross domestic product. The country, which once served as the breadbasket for the region, began facing serious food shortages.

These food shortages caused by the emigration of Zimbabwe’s farmers are only part of the problem. The country was also hit by long-running drought, which worsened Zimbabwe’s food crisis. As a result of the decreased crop yields from commercial farmers in Zimbabwe, the country began importing most of its food products.

Current Situation
The Zimbabwean economy is in a state of crisis due to uncontrolled hyperinflation, disappearing food sources due to shrinking agricultural production, very high unemployment rates, a devalued currency, and high HIV/AIDS rates. Agricultural production is the most important element of Zimbabwe’s economy, but years of drought, government land reforms, and HIV have crippled the country’s farming abilities. While Zimbabwean farmers harvested 130 percent more maize in 2009 than in 2008 due to increased levels of rainfall, a large percentage of the population continues to rely on food aid. Cereal shortfall for the current consumption year is approximately

677,000 tons. An estimated 45 percent of the population faces malnourishment. Life expectancy for males in Zimbabwe is only 44 years old, and it is only 43 years old for females. Zimbabwe also has over 500,000 internally displaced persons (IDPs) as a result of the economic crisis, land reforms over the last decade, and political violence.

The crisis in Zimbabwe worsened in March of 2008 during the country’s political elections. After several years of rigged political elections in Zimbabwe, the Zanu-PF party lost the majority in parliament. President Mugabe won the presidential elections in March 2008 because Morgan Tsvangirai, his only political challenger in the election, decided to withdraw from the political race because his supporters were facing considerable amounts of violence. The international community condemned the political elections due to strong evidence of corruption and vote tampering. However, in September of 2008, a power-sharing deal was signed between Zanu-PF and the opposition. While this appeared to be a good sign at the time, Mugabe still remains head of state, head of the cabinet, and head of armed services. Since Mugabe has agreed to share power, Tsvangirai became the prime minister in February 2009, which is a newly created political position in the country.

The United States and the European Union supply food support to Zimbabwe on humanitarian grounds. The European Union is attempting to boost grain production in Zimbabwe by contributing $22.73 million worth of seed and fertilizer to small-scale farmers in the country, while still maintaining sanctions against President Mugabe. Mugabe has heavily criticized Western countries for imposing sanctions against Zimbabwe. Furthermore, Mugabe has stated that he believes Zimbabwe’s problems are strictly internal, and he would prefer that the United Nations not prescribe solutions to the country’s issues.


![GDP Growth Graph]

Source: World Bank and IMF. 2005 is an IMF estimate.

Zimbabwe, a country that was once considered an African success story, now faces several social, economic, and humanitarian crises. Long-running droughts coupled with controversial governmental land reforms have decreased both the country’s food sources and its GDP. To make matters worse, the country’s population has a low life expectancy due to high HIV/AIDS rates and malnutrition. The economy is suffering due to hyperinflation, a devalued currency, and soaring unemployment rates. Zimbabwe has experienced years of political instability marked by rigged elections and corruption. All of the country’s problems have combined to cause huge humanitarian concerns throughout the country.

Questions to Consider
As you prepare for UGAMUNC and this topic in particular, you would be well served to analyze the following questions:

1. How can the United Nations improve the humanitarian crisis in Zimbabwe? How can the UN provide relief to the people of Zimbabwe without impeding on the nation’s sovereignty?

2. How can the UN work with regional bodies in Africa towards finding a solution to this problem?

3. Of the many issues that Zimbabwe faces (hyperinflation, high levels of unemployment, food shortages, etc), which is the most pressing?

Suggestions for Additional Reading
CIA World Factbook

BBC Country Profile: Zimbabwe
http://news.bbc.co.uk/2/hi/europe/country_profiles/1064589.stm

World Health Organization
http://www.who.int/countries/zwe/en/
**Introduction**

Dracunculiasis, also known as guinea worm, is a preventable parasitic disease that is contracted through the ingestion of stagnant water contaminated with dracunculiasis larvae. There is unfortunately no immediate cure for the disease; instead patients that contract this affliction must go through a painful extraction process of the parasitic nematode worm. This disease often times breeds a deadly cycle of infection and contamination as victims of the disease seek to sooth the burning sensation as the worm emerges in a painful blister by soaking their affected appendage in water. This stimulates the parasite to release more eggs into the water source, and thus contaminates the water supply as a whole.

**Background**

Historically speaking, Egyptian records documenting cases of guinea worm date as far back as the second millennium BC. Referenced in many biblical texts as the “fiery serpent,” dracunculiasis has proved its endurance through the ages. Plutarch even noted that the disease was endemic throughout the countries bordering the Red Sea. The first early conjectures made on the disease believed that the exposed worm was a reaction of dead tissue to exposed nerves. It was actually the Swedish naturalist Carlus Linnaeus who first suggested that it was an emerging parasite and not in fact many of the other proposed ailments. This disease spread over the centuries mainly to both Africa and Asia and remained endemic in both areas until the 20th century. In the 1950’s there were an estimated 50 million documented cases of guinea worm occurring throughout the Eastern Hemisphere, but due to concentrated eradication efforts, dracunculiasis is slowly being eliminated.

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34 “Dracunculiasis Eradication: Historical Background and Important Dates,” World Health Organization.
Current Situation

Current infection rates have been declined drastically over recent decades. The 1980’s saw a widespread infection rate with over 3.5 million people carrying the disease. By 1999 only an estimated 96,000 cases remained.36 Today, guinea worm is alarmingly prevalent in 13 African countries. With the continued efforts of international organizations, that number has strong hopes of declining in the future.

The efforts of organizations like the Carter Center show promising results for the complete eradication of guinea worm without any vaccines or medicines. With emphasis on both water filtration and education, cases of infection have dropped drastically. The Carter Center’s Guinea Worm Eradication Program work in Ghana is an excellent example of eradication effort results. The Carter Center started to implement programs in Ghana in 1987 when there were 180,000 documented cases of guinea worm. In 2008 there were just 501.37

While this disease is painful, it is also debilitating to families and communities. Once a member of a community contracts guinea worm, there is a high risk of that person contaminating the community’s water supply. In this event, an entire workforce of an area can be infected, rendering the group incapable of labor. Dr. Emmanuel Baya, a UNICEF Resident Project Officer, states that “Children just become bedridden. If the rest of the family has the disease, there is no one to care for them. So it affects the whole productive capacity of the community.”38 This can be especially devastating to agriculturally based communities in which manual labor is the predominant mode of income.

Safe drinking water is thus a pertinent requirement for combating the contraction and spread of guinea worm. Since water is a large portion of the nematode’s life cycle, sanitation is pertinent to both the UN’s and many non-governmental organizations’ goals. Both Iran and Saudi Arabia

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saw the elimination of guinea worm from their population after significant improvement in their respective water supplies.39

**Conclusion**
Guinea worm shows promising signs of being one of the first eradicable parasitic diseases. This would be a great accomplishment not only for the improvement of global living conditions but also towards achieving the Millennium development goals. The international community can play a significant role in preventing the spread of this disease. How can your country contribute to the dracunculiasis eradication agenda?

**Questions to Consider**
As you prepare for UGAMUNC and this topic in particular, you would be well served to analyze the following questions:

1. How does the question of water sanitation as well as education play a role in preventing the spread and contraction of dracunculiasis?

2. Is eradication of guinea worm feasible for the United Nations to accomplish in the future?

3. What other efforts can be made by the international community besides education and sanitation programs to prevent the contraction of dracunculiasis?

4. In which countries is guinea worm still considered endemic?

5. What specific efforts have countries taken in order to prevent further infection?

**Suggestions for Additional Reading**
http://www.cartercenter.org/health/guinea_worm/central_african_republic.html

http://www.cartercenter.org/health/guinea_worm/mini_site/current.html

http://www.cartercenter.org/health/guinea_worm/central_african_republic.html

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39 “Dracunculiasis Eradication: Historical Background and Important Dates,” World Health Organization.