

WORLD HEALTH ORGANIZATION

DELEGATE BACKGROUND GUIDE



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A Letter From Your Director...

Dear delegates,

Welcome to UTMUN! Whether this is your first committee, or your tenth, I hope that you get everything you're looking for out of a MUN experience.

My name is Navin and I'll be your director. I'm currently in my 1st year of study at university, pursuing a degree in Sexual Diversity Studies. I am a passionate member of the MUN community here at the University of Toronto and hope to create a dynamic and engaging committee for all of you.

Of course, I can't run a committee on my own. A dedicated team is behind every committee and we've been working hard to create an inclusive environment for you to improve your debate skills. However, your MUN experience is ultimately what you make of it. Bring your ideas to the table, research your position and speak to your fellow delegates. If you have any questions, please get in touch and I'd be happy to help.

It's going to be a fantastic conference and my team and I look forward to meeting you all this February!

Best Regards,

Navin Kariyawasam

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Photo: NBC

THE EBOLA CRISIS

Ebola: The Disease Itself

The Ebola virus disease (EVD), or formerly Ebola haemorrhagic fever, is a severe viral illness found primarily in primates. It has an average case fatality rate of 50%, and is one of the most easily transmittable infections.¹ It can even spread across species (from other animals to humans). For instance, the fruit bats from the Pteropodidae family are natural Ebola hosts.²

"Ebola is introduced into the human population through close contact with the blood, secretions, organs or other bodily fluids of infected animals such as chimpanzees, gorillas, fruit bats, monkeys, forest antelope and porcupines found ill or dead or in the rainforest."³

It then spreads through human contact via secretions, blood, organs, sexual activity, or other bodily fluids of those infected. The incubation period for the Ebola virus is anywhere from two to twenty one days, and humans are not infectious until they develop symptoms. The first symptoms of the virus are sudden fever, fatigue, sore throat, muscle pain, and headaches. These are followed by more severe symptoms, including: vomiting, rash, diarrhoea, and even impaired functioning of the liver and kidneys.⁴ In some cases, this is followed by both internal, and external bleeding. It can be difficult to distinguish Ebola from other illnesses such as malaria.

Some diagnostic tools for Ebola include antibody-capture enzyme-linked immuno-

1 Ebola virus disease [Internet]. World Health Organization. World Health Organization; [cited 2016, Nov 11]. 1 Available from: <http://www.who.int/mediacentre/factsheets/fs103/en/>

2 *Ibid.*

3 *Ibid.*

4 *Ibid.*

sorbent assay (ELISA), antigen-capture detection tests, serum neutralization test, reverse transcriptase polymerase chain reaction (RT-PCR) assay, electron microscopy, and virus isolation by cell culture.⁵ While the methods of these tests are fairly irrelevant to this committee, understanding how they can be used in a crisis is very valuable.

Ebola is an RNA virus which works by targeting immune system cells and disarming the vascular system. When it infiltrates the body's cells, it camouflages itself, thus, not allowing the body to fight against it. The Ebola virus takes over the dendritic cells (which control immune system function), and then proceeds to reproduce. The immune system is then disrupted, and the Ebola virus proceeds to infect other cells. This leads to an over-flux of fluid being released into the blood stream, and leads to internal bleeding, which results in the body's attempt to fight the infection. Finally, all this launches an attack from the immune system. However, since Ebola has infected the cells, which control the immune system, this is very damaging to the body.⁶ Often the collateral damage is too high, and is fatal. No FDA approved medication or drug exists for the virus. Ebola patients are usually treated by providing large quantities of intravenous (IV) fluids to the patient as well as attempting to balance the body's electrolytes, taking care of blood pressure and oxygen, and treating other infections as they arise.⁷ Some potential treatments include immune and drug therapies, as well as blood products. The first known cases of the Ebola virus were reported in 1976 in Yambuku, a northern village of the Democratic Republic of Congo, Nzara, South Sudan, and by the aptly named Ebola River.⁸ The recent outbreak is the most severe outbreak of Ebola we have ever seen in history.

THE WEST AFRICAN EBOLA CRISIS (2014-2016)

Tackling a more ambiguous topic, such as a large-scale outbreak, can be challenging, particularly in that it is hard to comprehend the events in a logical and sequential manner. The first step is to understand what goals need to be driving the research. This committee will be focusing on the Ebola outbreak in West Africa from August 2014 to June 2016. It is important to recognize that events related to this outbreak occurred outside of this framework. Cases of Ebola had been reported prior to August 2014, but the WHO only officially declared the outbreak at that time.⁹ Furthermore, impacts to infrastructure, policy, family, and personal lives still persist in afflicted countries, despite the end of the official outbreak. These are certainly areas to look into, but this preliminary guide to your research will focus on the outbreak of Ebola from the eyes of the WHO, namely how and when it was involved.

To understand the events of the recent Ebola outbreak in West Africa, it is immensely helpful to break up the crises into discrete sections. This is particularly useful (and possible) due to a research focus on the WHO and its response to the outbreak. The WHO recognizes three distinct phases within the outbreak.¹⁰

Phase 1: August - December 2014

Phase 2: January - July 2015

5 *Ibid.*

6 Servick, Kelly. What does Ebola actually do? [Internet]. Science. 2016 [cited 2016, Nov 11]. Available from: <http://www.sciencemag.org/news/2014/08/what-does-Ebola-actually-do>

7 Centers for Disease Control and Prevention, 22 June 2016. Web. 11 Nov. 2016. Available from: <https://www.cdc.gov/vhf/Ebola/>

8 Ebola virus disease [Internet]. World Health Organization. World Health Organization; [cited 8 2016, Nov 11]. Available from: <http://www.who.int/mediacentre/factsheets/fs103/en/>

9 "Event Background" 2016

10 "How WHO'S Ebola Response Unfolded" 2016

PHASE 1

The WHO became aware of the Ebola outbreak on March 22, 2014, when the Ministry of Health in Guinea notified it of an outbreak in south-eastern Guinea, including its capital, Conakry, which hold roughly fourteen percent of the population of Guinea.¹¹ Immediately, the strain of the Ebola virus was noted to be different.¹² Importantly, the clade of the virus was seen to not share strains of virus that had been studied in past African outbreaks.¹³ This was the first sign that the outbreak was to be taken seriously. While minor outbreaks of various viruses are relatively common, new strains, particularly those that belong to a different genetic clade have been especially nefarious in the past.

Another important aspect to note is the population density of Guinea. Guinea's population density has grown drastically in the past 50 years.¹⁴ In 2015, the World bank reported a population density of 51 people per square kilometer.¹⁵ For reference sake, Canada's population density (admittedly very low on the global scale) is a mere 4 people per square kilometer.¹⁶ This density has tremendous implications on how an outbreak need be assessed. Considering the population density of Guinea (and the ease with which the Ebola virus spreads), this initial outbreak was a clear sign of danger. This is compounded upon the analysis of population densities in nearby countries. For example, the next two infected nations, Sierra Leone and Liberia, have densities of 89 and 47 respectively. As a WHO delegate, it is imperative to research and understand the aspects of a region that impact its susceptibility to outbreak.¹⁷ This should be known not only of one's own country, but also of any nations of concern with regards to a specific crisis.

The WHO declared an outbreak of Ebola in West Africa on August 8, 2014. This was after the virus had spread from Guinea to Sierra Leone, Liberia, and Nigeria.¹⁸ By this point, Ebola had not only spread to four nations, but also had spread to larger regions, most notably in Guinea.¹⁹ Again, it is important to analyse the impacts this had on how the WHO could tackle this crisis. Despite the fact that much of the new regions of Ebola infection in Guinea were significantly less populated, this was still a necessary area to treat in order to contain the virus from spreading even further. What this meant was that infrastructure and outreach had to be set up not only in a densely populated, mostly urban area, but also in rural communities. This posed countless economic and logistical challenges that hindered the WHO's initial response to the crisis.

In the WHO's initial response to the outbreak (the official "Phase 1"), focus was placed on the rapid increase of infrastructure surrounding treatment and containment. The WHO invested the majority of its resources into the erection of treatment centres in afflicted areas, wherein existing health care frameworks were quickly becoming overwhelmed.²⁰ The WHO moved on to hire and train treatment teams to not only treat and contain the virus but also spread knowledge of how to prevent contamination to local health care workers and the general populous. The mobilization of this information is a key aspect of a response to outbreak. It is invariably imperative, in a time of outbreak, for health care organizations to invest great amounts of time and resources educating those affected. This was particularly

11 "Event Background" 2016

12 *Ibid.*

13 *Ibid.*

14 "Population Density (People Per Sq. Km Of Land Area) | Data" 2016

15 *Ibid.*

16 *Ibid.*

17 "Event Background" 2016

18 *Ibid.*

19 "How WHO'S Ebola Response Unfolded" 2016

20 *Ibid.*

important in West Africa, where, particularly in some areas, infrastructure was lacking to disseminate trustworthy, legitimate knowledge about how to combat the spread of Ebola, as well as how to recognize its symptoms.

Two final actions are worth noting in terms of Phase 1. Firstly, the education of health care providers sent to West Africa in the respectful disposal of infected bodies. This has often been a criticism of the WHO and organisations like it, in that, during times of crisis, cultural practices and priorities regarding death and the disposal of bodies are treated with ignorance and insensitivity. While, of course, certain limitations exist to how infected bodies are treated, it is always important to find methods that minimize cultural and religious insensitivity. Finally, the UN Mission for Ebola Emergency Response was initiated.²¹ While its impact on this initial stage bears little relevance to the WHO, it became more relevant later on in the outbreak.

PHASE 2

The World Health Organization and its partners decided to move to Phase 2 of the Ebola outbreak at the beginning of 2015. The phase lasted for about seven months, and emphasized increasing capacities for case finding and contact tracing, as well as promoting community engagement. Vaccinations were introduced within those seven months, and Guinea, who was the first to receive the vaccination, was tasked with bringing the outbreak under control. Additionally, more Ebola treatment centers were set up in the three of the more intense transmission countries, Guinea, Liberia, and Sierra Leone.²² After that, cases of new outbreaks dropped, and in the last three weeks of phase 2, there were only 64 new cases in those three countries.²³

Statistically, up to July 2015, there were 3,729 cumulative cases in Guinea, 10,666 in Liberia, 13,119 in Sierra Leone; this totaled up to 27,514, with 11,220 deaths.²⁴ The total number of confirmed cases had similar statistics for males and females, however people aged 15 to 44 years old were more likely to be affected in Guinea and Liberia, which was three times more likely than Sierra Leone.²⁵

In terms of outbreaks in other parts of the world, there had been cases reported in Mali, Nigeria, Senegal, Spain, the United Kingdom, and the United States of America.²⁶ In July itself, one health worker was diagnosed after travelling back to Italy, but was discharged in less than a month after being tested negative. The WHO also ensured that all countries were ready to be detected and investigated but most importantly report any new Ebola Virus cases. They sent support through preparedness-strengthening teams (PSTs) and performed visits in countries to provide technical guidance and tools.²⁷

In terms of support and training, the WHO had provided leadership and coordinated partners to support the fourteen priority countries, as well as their contribution to the International Health Regulations.²⁸ International meetings were held to discuss future actions and develop long-term strategies to provide security to global health. The WHO was responsible for managing cases, doing laboratory services and contact tracing, while the International Federation of Red Cross and Red Crescent Societies (IFRC) was in charge of

21 *Ibid.*

22 “Ebola Situation Report - 1 July 2015 | Ebola” 2016

23 *Ibid.*

24 *Ibid.*

25 *Ibid.*

26 *Ibid.*

27 *Ibid.*

28 *Ibid.*

safe and dignified burials.²⁹ As for the UNICEF, they promoted community engagement and social mobilization.

PHASE 3

By August 2015, the scope of the outbreak had been radically reduced, with a majority of cases isolated to Guinea, Sierra Leone, and Liberia. The 70/70/60 plan (see below) had been implemented successfully, but was not without its complications. Once phase 3 began, the WHO and its partners were under the impression that Ebola would soon be over, but an unexpected tail continued after the peak, pushing the goal of the resilient zero further out of reach.³⁰ Other than the resilient zero, there were two overarching objectives for phase three of the outbreak for the WHO, which were outlined in the September 2015 report.

The 70/70/60 plan was an ambitious plan implemented by the United Nations Mission for Ebola Emergency Response (UNMEER) in October of 2014. The plan was to have 70% cases isolated and 70% of victims safely buried within 60 days. The plan was put into place on the 1st of October, and the goal successfully reached in December. After the goal was achieved, experts believed that the road to zero would be soon approaching, but experienced an unexpected long tail after the peak, which, one year after the 70/70/60 success, was still being dealt with. The reason for this is believed to be, as stated by Dr. Bruce Aylward, special representative of the Director General for the Ebola Response and Assistant Director General of WHO, in November 2015: "This is not just an Ebola outbreak. This is an Ebola outbreak with all the baggage of a humanitarian international crisis, and that crisis in these countries was accompanied by a huge amount of mistrust".³¹ While the 70/70/60 plan was a success, there was much more to be done before zero would be reached.

One of the largest barriers faced during the Ebola outbreak was a disconnect between the citizens, the government, and international aid agencies. MSF's (Medecins Sans Frontieres) emergency coordinator Anja Wolz described country's unwillingness to work with foreign aid bodies, such as the hospitals and ministry of health in Sierra Leone both withholding crucial information on the virus and outbreak data.³² The WHO proposed in the establishment of Phase 3 that incentives be provided to individuals and communities for compliance with public health measures, as this was one of the main difficulties foreign aid agencies encountered.³³ Another post peak concern was maintaining the support of the WHO's partners, keeping them active within the affected countries to achieve zero cases rather than beginning to decrease support since the worst of the outbreak was considered over. The WHO had concerns once the tail became evident and needed to ensure that it was taken care of and not risk any further spread of the virus.³⁴ One measure about which the UN was adamant concerned stopping the possible spread of the virus through exit screenings so that all persons leaving affected areas were tested before being allowed to leave. The screenings had to include a minimum of a questionnaire and a temperature reading to look for the virus-induced fever.³⁵ Keeping the virus contained was crucial, especially once it seemed as though the spread of the virus had slowed.

29 "Ebola Situation Report - 1 July 2015 | Ebola" 2016

30 "EBOLA RESPONSE PHASE 3 - World Health Organization." World Health Organization. Page 3.

31 "WHO: The Ebola Crisis in November 2015, One Year after Its Terrifying Peak." YouTube. 2015. http://www.youtube.com/watch?v=_Lxh187oX_I.

32 Regan, Helen. "Slow Response to Ebola Outbreak 'Cost Thousands of Lives'" Time. March 22, 2015. <http://time.com/3753684/Ebola-medecins-sans-frontiers-west-africa-world-health-organization-slow-response-cost-lives/>.

33 "How WHO's Ebola Response Unfolded." World Health Organization. <http://www.who.int/csr/disease/Ebola/response/phases/en/>.

34 "EBOLA RESPONSE PHASE 3 - World Health Organization." World Health Organization. http://apps.who.int/iris/bitstream/10665/184693/1/Ebola_resilientzero_eng.pdf?ua=1. Page 11-12.

35 "Primary Focus of Response Must Be to Halt Spread of Ebola in West Africa – UN." UN News Center. <http://www.un.org/apps/news/story.asp?NewsID=49154#.WCUtwPkrLIU>.

In the September 2015 Ebola Response Phase 3 report, the WHO clearly outlined two objectives in the hopes of reaching the resilient zero. The first was "to accurately define and rapidly interrupt all remaining chains of Ebola transmission", and the second was "to identify, manage and respond to the consequences of residual Ebola risks."³⁶ Objective 1 included risk management, enhanced identification and case management³⁷, and Objective 2 included enhanced alert management, regional response capacity, and improved survivor support.³⁸ The WHO and other participating organizations such as MSF clearly stated that they needed to learn from their mistakes. In the following November 2015 report covering surveillance strategy, the WHO identified different types of alerts. The primary source were live alerts, which ranged from community-based surveillance to the monitoring of health care centers. Criteria for diagnostics were also clearly set.³⁹ No chances were going to be taken. Identification had to be quicker, and cross border cooperation was crucial. One final yet incredible important objective was emphasis on helping survivors. Ebola survivors suffer from long term effects such as chronic fatigue syndrome, joint pain, and permanent loss of vision. These symptoms are defined as "Post-Ebola Syndrome", which is still not fully understood by doctors. The WHO has confirmed that over 25% of Ebola survivors have experienced some form of vision loss, with many of them considered near blind now. The survivors require long term care and support, and it is important that both international aid organizations, local health care practices, and communities understand this. Survivors also face stigma when returning to their communities, as many communities did not understand that the survivors would not infect them and therefore treated them as though they were infected, leaving the survivors isolated.⁴⁰

Although the peak of the outbreak had passed, Phase 3 was far from the end of the international efforts needed to eradicate and deal with the outbreak.

LIMITATIONS OF THE WHO

The World Health Organization (WHO) has long been hailed for its apolitical and speedy response to international health epidemics. For example, in 1947, an outbreak of cholera claimed the lives of many in Egypt. The epidemic was effectively abolished in a matter of six short weeks thanks to the WHO's rapid and effective response time.⁴¹

However, in the past decade, the WHO has come under extensive criticism for its failure to act in international health crises, particularly in the Ebola virus outbreak in West Africa. Initially, the WHO's response seemed promising, as they deployed officials to the region of the outbreaks only six weeks after the outbreak was announced.⁴² However, criticism of the WHO's response began in May 2014, when the secretariat in Geneva announced at the 67th annual World Health Assembly (WHA) that the epidemic was largely abolished and the situation under control which, in fact, was far from the truth.⁴³ Soon after

36 "EBOLA RESPONSE PHASE 3 - World Health Organization." World Health Organization. Page 4.

37 "EBOLA RESPONSE PHASE 3 - World Health Organization." World Health Organization. Page 5-7.

38 "EBOLA RESPONSE PHASE 3 - World Health Organization." World Health Organization. Page 8-10.

39 "Emergency Guidance: Surveillance Strategy during Phase 3 of the Ebola Response." World Health Organization. November 5, 2015. Page 6-9.

40 "Ebola Bulletin - Humanitarianresponse.info." United Nations Office for the Coordination of Humanitarian Affairs (OCHA). September 2015. Accessed November 13, 2016. https://www.humanitarianresponse.info/en/system/files/documents/files/151001_Ebola_bulletin_september_2015.pdf.

41 Charles S. Ascher. "Current problems in the World Health Organization's program." *International Organization* 6, no. 1 (1952): 29.

42 Adam Kamradt-Scott. "WHO's to blame? The World Health Organization and the 2014 Ebola outbreak in West Africa." *Third World Quarterly* 37, no. 3 (2016): 404-409

43 *Ibid.*

the WHA, 16 more cases of the Ebola virus were reported and confirmed in Sierra Leone.⁴⁴ That number rapidly rose to 440 confirmed cases in Sierra Leone and Guinea by June 2014, and by mid-June, 88 more cases had arisen, bringing the total to 528.⁴⁵ The resulting response of the WHO to the alarmingly rapid outbreak was almost non-existent, save for several meetings that each ended without providing any further solutions on how to respond to the now widespread pandemic.⁴⁶ By the end of July, the number of EVD cases had risen to 1000+, with the virus spreading further throughout the African continent, causing outbreaks in Nigeria and Liberia.⁴⁷ It was not until August of 2014 that WHO officials declared the Ebola outbreak a public health emergency.⁴⁸

The WHO's nearly non-existent response to such a tragic epidemic that has infected more than 23,000 and claimed the lives of 11,300 victims has led to outrage against the organisation.⁴⁹ However, the WHO is limited in its ability to govern by its own constitution, which states that the WHO has no responsibility to act in any health crises unless asked to do so by the nation's leaders, a point to which the WHO has referred time and time again to defend its response towards the Ebola crisis.⁵⁰ At the 67th WHA, the Guinean Minister for Health emphasized that his "country was seeing tremendous progress in containing the outbreak" and that "the epidemic is effectively controlled."⁵¹ However, the WHO still appears negligent in their response as they did not try to challenge or investigate the Health Minister's claims that the epidemic was under control, despite overwhelming evidence to the contrary.⁵²

Additionally, a WHO report of the Ebola Interim Assessment Panel points out issues with the internal politics and culture of the WHO, stating that the "WHO does not have an organizational culture that supports open and critical dialogue between senior leaders and staff or that permits risk-taking or critical approaches to decision-making. There seems to have been a hope that the [Ebola] crisis could be managed by good diplomacy rather than by scaling up emergency action."⁵³ The WHO's organizational setup is not one of an emergency response team, and its response to the Ebola crisis emphasized that fact. This is largely due to the lack of funds available to support any emergency response actions, limiting the organization's ability to act rapidly, especially in a short amount of time.⁵⁴ According to a report of the Ebola Interim Assessment Panel, "less than 25% of WHO's Programme budget comes from assessed contributions (and the remainder from voluntary funds). There are no core funds for emergency response."⁵⁵ The report suggests that in order to aid this budget issue, each member state of the WHO provides a minimum donation in voluntary funds to allow for quicker response action to health crises in the future.⁵⁶

44 *Ibid.*

45 *Ibid.*

46 *Ibid.*

47 *Ibid.*

48 Tiffany Ap. "Ebola Crisis: WHO slammed by Harvard-convened panel over slow response." *CNN*. November 23, 2015. <http://www.cnn.com/2015/11/23/africa/Ebola-lancet-report/>

49 *Ibid.*

50 Adam Kamradt-Scott. "WHO's to blame? The World Health Organization and the 2014 Ebola outbreak in West Africa". *Third World Quarterly* 37, no. 3 (2016): 404-409

51 *Ibid.*

52 *Ibid.*

53 World Health Organization. "Report of the Ebola Interim Assessment Panel." July 2015. <http://www.who.int/csr/resources/publications/Ebola/report-by-panel.pdf?ua=1>

54 *Ibid.*

55 *Ibid.*

56 *Ibid.*



Photo: Doctor's Without Borders

A Guide to the Committee & Research

This committee will be interactive. Your first “topic” will focus on the first phase of the outbreak, your second will be the second phase, and your third will be the third phase and

the development of future health infrastructure in the region. The committee will be chronological in nature, and while the general historical timeline of the disease will be followed, actions you take in the first phase will affect the other phases, and the progression of the outbreak. While researching your nation’s role in what actually happened is important, this committee will ‘rewrite’ the history of the outbreak, and your position paper should reflect that. Your paper should focus on the initial outbreak, and your nation’s position regarding both their individual role, and the role of the WHO.

RESEARCHING YOUR NATION

1. What is your nation’s role in the WHO? In international politics in general? What powers does your nation have (both in terms of unilateral and multilateral powers)?
2. How does your nation relate to this crisis? Is it geographically linked to West Africa? Does it have significant travel connections there? If your nation isn't close, how else might it be relevant? For example, perhaps your nation would be an effective port for the shipping of materials and medical personnel.
3. What is the history of your nation’s policy with regards to outbreaks? In the past, has your country imposed strict travel restrictions very quickly? Has it become heavily involved in foreign crises, spending significant amounts of money?
4. What aspects are important to your nation’s government? What aspects are important to its people? For example, perhaps while your government has shown a tendency to donate a lot of money to such crises, the citizens disapprove.
5. How does your nation view the WHO? Is your nation heavily involved? Or does it prefer to simply be present? What other health-related organizations is your nation a part of?

RESEARCHING EBOLA

1. What is Ebola? How is it spread and how can this be combatted? How contagious is it? How fatal is it? Are deceased individuals infected with the disease still dangerous?
2. Are there any vaccines or treatments? How costly are they? How are they administered?
3. What Ebola outbreaks have happened in the past? How were they dealt with? How can this be improved?
4. How did the WHO respond to this outbreak? How was it different from how other organizations responded? How is it different (or the same) from how the WHO has responded to other outbreaks?
5. What information should citizens have about Ebola? How might that information be disseminated? What infrastructure is necessary for this?
6. How was outbreak in West Africa different from other Ebola outbreaks? Hint: research the genetic nature of this viral outbreak compared with others.

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