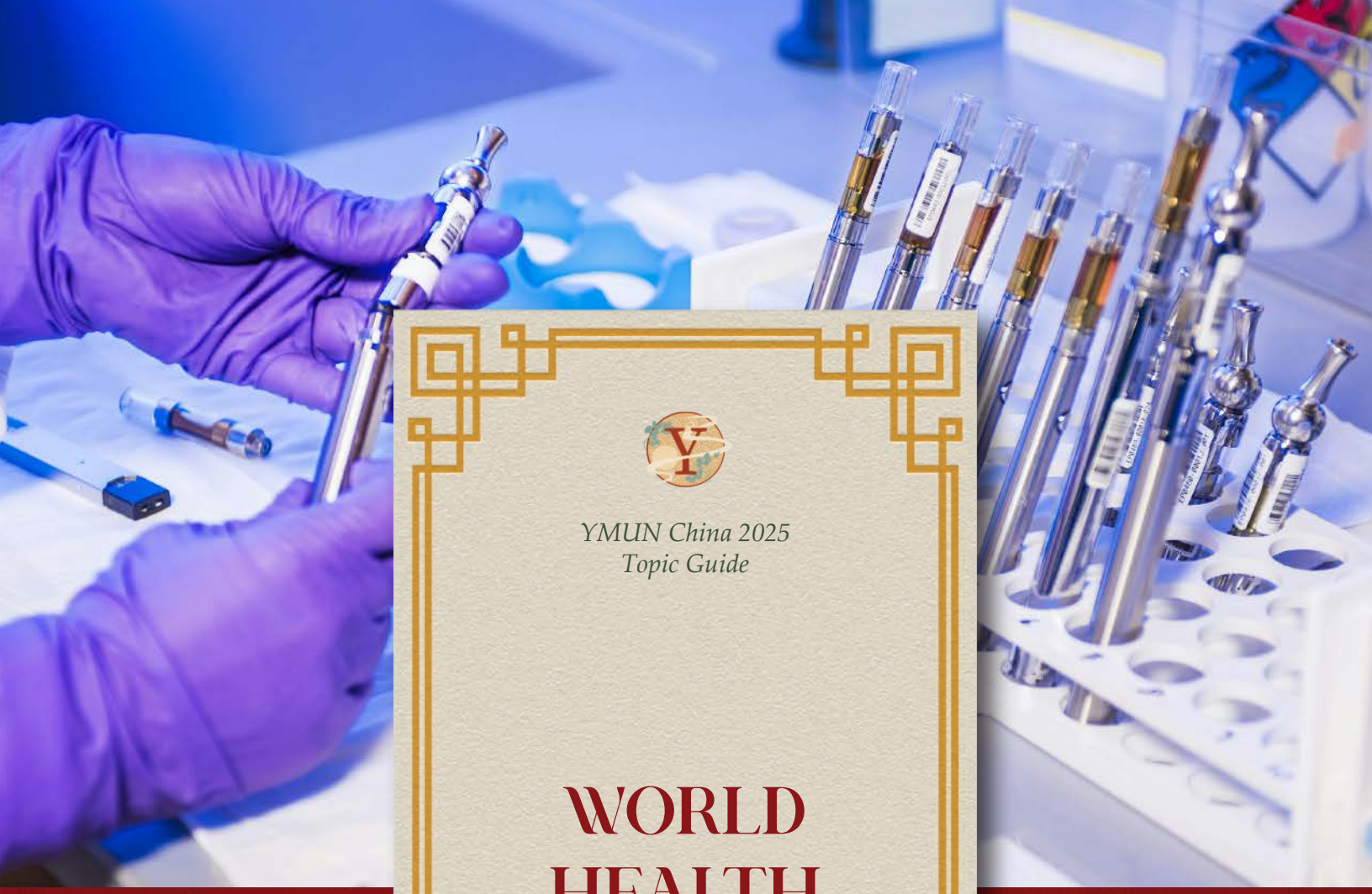

YMUN China 2025
Topic Guide

WORLD HEALTH ORGANIZATION

Lishore Kumar

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Letter from the Dais

Dear Delegates,

Welcome to the **World Health Organization**! Over the course of our three day conference, you'll embark on a journey to discuss two of the most pressing global health challenges. For over 70 years the WHO has subsisted off an unfettered mission to protect the health of the globe—vulnerable or not. To that end, the WHO has been keen on addressing issues before they become global emergencies, even searching for technologies and methods that can change the way we approach health. Together, you will explore and develop applicable, accessible, and lasting solutions. While delegates will lead the discussion, a successful committee experience will involve examining both the technical, scientific factors and the policy-based, integrative aspects of these issues. Above all, a productive and meaningful experience requires mutual respect among delegates to foster genuine discourse.

Now, a little about me—I am one of your secretariat members and committee director. My name is Lishore Kumar, and I'm a first-year at Yale majoring in Biomedical Engineering and Economics. I spent most of my childhood in Tomball, Texas, but I have also lived in Malaysia multiple times, where much of my family is from. My ultimate goal is to work in global economic policy with a focus on healthcare, and my studies in these two majors are designed to help me understand the intricate connections within healthcare systems.

Outside of my academic and career interests, I am an avid cellist and a member of a rock cello group called Low Strung. Additionally, I'm studying Chinese! Since arriving at Yale, I've immersed myself in Chinese courses and hope to impress you all by summer—though, admittedly, 你的中文比我的好多好!

Happy preparing,
Lishore Kumar

Committee History

The World Health Organization (WHO) was founded on April 7, 1948, as a successor to the League of Nations' Health Organization. While the WHO receives guidance and assistance from the Economic and Social Council (ECOSOC), it remains an autonomous organization, meaning this coordination does not infringe upon its independence.

Since its inception, the WHO's mission has been "to promote health, keep the world safe, and serve the vulnerable." In recent years, WHO's initiatives have been guided by three overarching principles: universal health coverage, health emergencies, and promoting well-being. In order to make strides towards the advancement of universal health coverage, the WHO has worked on sustainable healthcare financing, workforce training, and standardized medical record-keeping for global health data analysis.

When it comes to health emergencies, the WHO plays an essential role as a means of global communication in the case of health emergencies. From alerting member states about regional health and disease-related developments to eradicating smallpox through a global vaccination campaign, the WHO serves as a bridge for countries around the world.

As for promoting well-being, WHO addresses social determinants of health and conducts interdisciplinary research on disease prevention and treatment.

WHO's Funding:

Funding is critical for WHO's operations. About 25% of its budget comes from mandatory contributions by member states, calculated based on wealth and other factors. About 75% comes from voluntary contributions by member states and donations from private organizations, like the Bill & Melinda Gates Foundation.

WHO Governance:

The World Health Assembly (WHA), consisting of 194 member states, serves as the governing body of WHO. The WHA functions like a board of directors, setting global health priorities, while the WHO acts as the executive branch (like a CEO), implementing the WHA's decisions.

WHO's Role in AI and Fertility Research:

While WHO acknowledges the role of AI in healthcare, it has taken limited action, mainly publishing guidelines on AI ethics and considerations at present. On fertility rates, WHO has sponsored research on declining birth rates to raise awareness but has not proposed direct policy solutions.

TOPIC ONE

Addressing the safety concerns of AI in healthcare

Introduction

Since the creation of Artificial Intelligence (AI) in the 1950s, it has had widespread applications in healthcare. From its initial usage in aiding in the diagnosis of bacterial infections and recommending antibiotics, AI has been integrated into hospital systems, research institutions, and national healthcare for purposes such as medical scribing, drug discovery, and disease tracking, respectively.

Glossary

Artificial Intelligence in Medicine (AIM)-The use of computer systems to simulate human intelligence in healthcare tasks, such as diagnosis and treatment planning.
Black Box Effect–The phenomenon where the internal workings of complex AI systems are not transparent or understandable to users, making it difficult to interpret how decisions are made
Natural Language Processing (NLP)-A field of AI that enables computers to understand and process human language, allowing for tasks like speech recognition and text analysis
Electronic Health Records (EHR)-Digital versions of patients' medical histories, including diagnoses, treatments, and test results, which are stored and accessed electronically
Deep Learning Models-A subset of machine learning involving neural networks with multiple layers that can learn from large amounts of data, often used in image and speech recognition
Pharmacogenomics-The study of how an individual's genetic makeup affects their response to drugs, aiming to optimize drug therapy for each person

Artificial Neural Network (ANN)-A computing system inspired by the human brain's network of neurons, used in machine learning to recognize patterns and solve complex problems
True Positive–In diagnostic testing, a result that correctly indicates the presence of a disease or condition when it is actually present
Deep Learning-Type of machine learning that uses artificial neural networks with multiple layers to analyze complex data and recognize patterns

Topic History

AI has been incorporated into healthcare since the 1950s, despite facing many challenges in terms of cost and capability. However, in the 2000s, it became popularized due to the applications to many fields. For most of the 1950s–1970s, AI was primarily used to simulate human decision-making. Machines were programmed with hundreds of rules, where the rules represented a previously observed condition as well as the diagnosis from a doctor. While this was useful for speeding up the process for simple diagnoses, it didn't do much beyond that.

This changed in the 1970s when AI in medicine (AIM) was first introduced through a system known as MYCIN (please note here that MYCIN is not an acronym). MYCIN was designed to identify bacterial pathogens and recommend antibiotics. Unlike previous AI systems, MYCIN had predictive power, utilizing over 600 rules that could be compounded upon each other at the system's discretion and adjusted based on patient factors.

Say a physician is working to determine what bacteria were responsible for a patient's illness. The physician would be prompted with a series of mostly "yes" or "no" questions, along with some longer, textual ones. While this resembled the binary "if-then" nature of previous AI systems, MYCIN had interpretive power, understanding textual answers and ranking the importance of different questions. At the end of the query, MYCIN would generate a list of likely causes. Additionally, it provided a medicine recommendation, automatically adjusted for the patient's weight.

MYCIN's success reinforced AIM as a crucial tool in healthcare. In 1984, the University of Massachusetts developed DXplain, a system that allowed users to input laboratory results, symptoms, and other data to diagnose a patient with one of 2,600 diseases. This seemingly simple call-and-response nature became the crux of AIM, rapidly decreasing diagnostic timeframe and reducing human-error.

Following these clinical applications of AIM, AI became increasingly integrated into healthcare systems. Hospitals began using it to predict patient trajectories, optimize resource allocation—such as nursing staff placement—and anticipate patient demand. The use of AI for these administrative tasks surged in popularity around the 2010s. Not only did it promise a more efficient use of healthcare workers' time,

but in an era of rising patient wait times and a growing shortage of medical staff, it freed up their time to focus more on patient care.

Since then, various international bodies and organizations have pushed for AI's use in drug discovery as its developments continue to enable greater applications of it. With AI being used to map the spread of COVID-19 and other infectious diseases, enabling precise assessments of ongoing threats, targeted resource allocation, and informed predictions about future outbreaks, we can ask how these developments will take AI into its future applications in the healthcare industry.

Current Situation

In the following paragraphs, we'll discuss three of the ways AI has been used in healthcare while first showing how the situation looked without it. Following this discussion, we'll divide into the challenges to AIM implementation.

Application 1: Assisting Administrative Tasks

With no reduction in patient needs and a dwindling healthcare workforce, health workers are overworked. This has led to a decline in the quality of patient care. In fact, up to 30% of the work that nurses handle and an average of 15.5 hours per week for physicians is spent on administrative tasks. These include filling out paperwork in standardized formats, scheduling appointments, ordering tests, and interpreting results. In fact, in China, a study observed that the actual examination portion of a doctor's visit was significantly shorter compared to the time required for follow-up tasks, such as the aforementioned administrative duties and scheduling additional appointments (Li et. al., 2021).

It's in areas like this that AI in medicine has the potential to alleviate a significant burden faced by healthcare service locations around the world. Automating administrative processes have actually already proven effective, as that same previously mentioned Chinese study found that the use of AI for administrative tasks reduced patient wait times fivefold, from an average of 1.97 hours to just 0.38 hours.

Application 2: Drug Discovery

AIM has revolutionized drug discovery, addressing a process that was once slow, costly, and unreliable. Traditionally, developing a single drug required manual calculations and lab testing, often taking 3 to 6 years with no guarantee of success. These long development times increased costs for inputs and labor that were ultimately passed onto consumers.

Now, AIM has accelerated this process by leveraging permutation-based methods and rigorously trained neural networks to computationally analyze drug interactions. AI can assess drug-to-drug interactions, identify cytotoxic properties, and more, reducing the drug discovery timeline by an average of 1 to 2 years. However, while this application of AI is common in the Western world, it has yet to be widely utilized for diseases more prevalent elsewhere, such as HIV and malaria in Africa—diseases that claim over 1.1 million lives annually.

Application 3: Disease Surveillance

The discussion of global disease naturally leads to the importance of global disease management, a critical focus for organizations like the WHO and its member states. In today's interconnected world, an infectious disease can spread from a remote village to six continents in just 36 hours. Tracking the spread of illnesses is essential for allocating resources and preparing for outbreaks. Here, AIM has proven invaluable.

During the COVID-19 pandemic, AI played a crucial role in mapping the virus's spread. For instance, the company BlueDot used machine learning to detect a cluster of pneumonia cases and accurately predict the outbreak's trajectory and geographical spread. However, having the ability to fully leverage AI in future outbreaks requires global cooperation— an idea that not all member states are currently engaged in or fully sure of.

Though we have discussed and made clear the potential benefits of AI in healthcare, it is equally important to discuss the challenges. While AIM offers promising solutions, barriers to its adoption remain. The challenges can be categorized into three broad areas: (1) reliability, (2) logistical issues, and (3) data protection. Though they exist separately, each of these factors compounds the others, making it difficult to address any single challenge in isolation.

1. Reliability

As AI models have become more advanced and widely available, an AI model's own ability to explain the reasoning behind their decisions has diminished through a phenomenon known as the Black Box Effect. This is especially true for deep learning models that rely on complex scientific and mathematical analyses to parse vast amounts of data. Even when AI-generated explanations are provided, they are often highly unstructured and difficult to interpret.

This lack of transparency makes it difficult for both doctors and patients to trust AI-based diagnoses. After all, if a physician cannot interpret an AI-generated result, why would a patient trust it?

Furthermore, AI models are often trained on biased datasets. That is, the demographic data used to develop these models does not always reflect the populations they serve. A prime example of this is racial bias in healthcare AI. Many datasets are composed primarily of data from white, middle-aged men, leading to disparities in recommendations for minority patients. Geographic bias is another major issue, as most data collection efforts occur in urban areas near major institutions. This means that rural populations—who may have different health concerns—are often underrepresented in AI models. As a result, studies have found that AI-based diagnostic tools sometimes recommend the same treatments for far sicker minority patients as they do for less sick, non-minority patients.

Efforts to expand data collection are ongoing, but they are costly and difficult to implement. Encouraging participation from rural communities or populations historically harmed by biased AI models presents its own challenges, as skepticism toward these systems is difficult to dismantle.

Beyond data collection, standardization is another critical issue. For AIM to support international collaboration on disease tracking or drug discovery, data must be formatted in a universally accessible way. Expecting doctors to change the way they record patient information overnight is unrealistic. This is where Electronic Health Records (EHRs) become vital—they must be designed to extract and interpret data from diverse medical records in a way that is both consistent and usable across different healthcare systems. Governments and organizations, at both the regional and international scale, must allocate resources to ensure that such standardization efforts are both feasible and effective.

2. Logistical Issues

Professor Hattie Chung from the Yale School of Medicine succinctly describes some of the biggest challenges of AIM: storage and access.

Regardless of the medical field, AIM relies on terabytes to petabytes of data. In fact, healthcare accounts for 30% of the world's data, and it is growing faster than the overall average rate of data expansion. Every time a patient's outcome needs to be calculated, it must be cross-referenced with millions of other patient records. While having more data improves accuracy, it also increases storage demands that might struggle to keep up.

As this relates to the healthcare system, questions about ethics and security arise. Hospitals often prefer to store their patients' data within their own systems, effectively creating a firewall that prevents third parties from accessing it. While this enhances security, it is also costly and inefficient. Maintaining in-house servers requires expensive cooling systems, continuous maintenance, and significant IT resources, which is not something every hospital has the resources to do.

Shared data centers offer a potential solution by reducing costs and improving efficiency, but they come with risks. Data breaches can spread across multiple servers, affecting entire regional healthcare networks. With 78% of physicians using EHRs, a single hospital outage should not cascade into a widespread disruption—but without careful infrastructure planning, that remains a possibility.

Delegates must consider how best to balance security with accessibility when determining storage solutions for AI-driven healthcare systems. Additionally, researchers have emphasized that a global effort is required to optimize data retrieval, as healthcare data continues to grow exponentially.

3. Data Protection

Perhaps the greatest barrier to the widespread adoption of AIM is data security. The healthcare industry holds some of the most confidential and personal information about individuals. In 2019 alone, 41.2 million healthcare records were exposed, stolen, or illegally disclosed across 505 data breaches. Due to the high sensitivity of this data, healthcare breaches can cost nearly double the amount of a typical data breach. In the U.S., the average cost of a healthcare data breach is $15 million.

As countries seek to collaborate on AI-driven healthcare initiatives, cross-border data sharing becomes a significant concern. National-level task forces have been established to address domestic security, but international efforts remain vulnerable.

Beyond preventing breaches, ethical concerns arise: Who owns the data? If one country's healthcare data is used by another nation for research, who has the right to grant that access? Even if such data-sharing benefits the greater good, citizens' rights must be considered.

Questions to Consider

1. How can data sets better include underrepresented minorities?
2. Should all WHO member nations collaborate and adhere to a universal framework for data collection?
3. In the event of a data breach, who is to be responsible in light of new expansion efforts?
4. Given the differing and limited resources of nations, what drawbacks of AIM should this delegation prioritize in addressing?
5. How should we determine how much a country financially supports the expansion of AIM?
6. What are certain milestones this delegation should have for fixing/expanding AIM?
7. How can citizen's privacy be protected concerning their data amidst AIM expansion efforts?

Additional Resources

https://www.nature.com/articles/s41598-024-70073-7
https://academic.oup.com/trstmh/pages/globalhealthai
https://www.healthitanswers.net/why-do-hospitals-need-a-data-center-strategy-to-thrive-in-the-digital-era/
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https://www.google.com/url?q=https://pmc.ncbi.nlm.nih.gov/articles/PMC7966905/&sa=D&source=docs&ust=1743172738649627&usg=AOvVaw2hy7Vhon23xvtVNCzi5aSX

TOPIC TWO

Measures to increase birth rates globally

Introduction

Average global population growth may persist, but hundreds of countries are witnessing a drop in birth rates below the replacement level required to maintain their existing populations. This demographic transition jeopardizes economic stability and places pressure on existing infrastructures and systems—many of which are already overburdened.

Glossary

Demography: the field of scientific inquiry that delves into human populations, which includes the characteristics and changes across them over time.
Total Fertility Rate (TFR): The average number of children a woman is expected to have during her lifetime.
Replacement-Level Fertility Rate (RFR): The average number of children per woman required to perfectly replace each generation, accounting for natural life-and-death cycles.

Mortality Rate: The number of deaths in a given population during a specific period.
Urbanization: The process by which rural areas become urban, often associated with changes in family size and fertility rates.
Pronatalist Policies: Government initiatives designed to encourage citizens to have more children, such as financial incentives or parental leave.
Dependency Ratio: The ratio of non-working population (including children and the elderly) to the working-age population.
Youth Dependency Ratio: The ratio of the population aged 0–14 to the working-age population (15–64), affected by declining births.

Topic History

Over the last century, there has been a decline in the fertility rates across many countries of the world which has changed demographic patterns and challenged earlier assumptions about population growth. At the beginning of the 20th century, industrialization and urbanization started to reduce family sizes in Europe and North America because economic changes made child bearing and rearing an expensive burden. By the end of the twentieth century, this trend continued, and many countries in East Asia, Latin America and some countries in the Middle East experienced sharp decline in their birth rates. Hopes of having a big family have remained a dream for more than half of the population worldwide, with 63% of the world now residing in low birth rate countries, that is, their population will decrease if no measures are taken to increase it. It is important to note that many of these regions are also low-income areas as well, which relates to the universality of this issue though every region/circumstance witnesses it differently.

The effects of this phenomenon persist in everyone's lives. Governments around the world face increased social security strain from older populations, labor shortages, and increased pressure on public services. Additionally, urban planning is thrown into jeopardy, as declining populations lead to underused infrastructure, housing vacancies, and shifting demands for public transportation. The effects even transcend to the national level, with many nations struggling to maintain military recruitment levels, prompting discussions on the future of their defensive capabilities.

The causes behind falling birth rates are wildly complex. They include factors such as the high cost of childcare, rigid work-life structures, and unaffordable housing. Societal trends are at play as well, as more individuals forgo having children due to career ambitions, gender imbalances in the labor force, and changing cultural/societal norms. In response, various countries have implemented pronatalist policies, including financial incentives, subsidized child care, and extended parental leave. However, the effectiveness of these measures has been mixed, with many nations still experiencing below-replacement fertility rates.

Therefore, a comprehensive understanding of how birth rates intersect with various government sectors is crucial to developing effective solutions.

Current Situation

The global decline in birth rates has rapidly expanded, both in depth and breadth. That is to say that while birth rates are decreasing, the countries experiencing this trend in recent years have expanded, with nations like Mexico, Austria, and Germany added to the mix. Notably, even countries that traditionally maintained stable fertility rates, such as Turkey and Brazil, have begun to see significant declines, suggesting that this trend is no longer confined to highly developed nations alone.

As of 2023, the global total fertility rate (TFR) stands at approximately 2.3 births per woman, a substantial decrease from the mid-20th century average of 5 births per woman. This trend is particularly pronounced in developed nations. For instance, England and Wales reported a TFR of 1.44 children per woman in 2023, the lowest since records began in 1938. Similarly, countries like Japan and South Korea have experienced sustained low fertility rates, leading to population declines and an aging demographic. Meanwhile, China, which once maintained strict population control policies, has now seen its fertility rate drop to an estimated 1.09 births per woman in 2023, intensifying concerns about future workforce shortages and economic stagnation.

Several interrelated factors contribute to declining birth rates. These can be divided into largely two categories: economic and societal factors. As we explain the economic factors, we'll discuss relevant case studies to illustrate the concepts.

Economic Factors

The high cost of living, encompassing housing, education, and healthcare, discourages individuals from having larger families. In many urban areas, exorbitant housing prices and childcare expenses make raising multiple children financially challenging. Accordingly, financial strain has emerged as the number one reason (24.5%) women choose not to have children. In some countries, surveys have shown that couples feel they must choose between homeownership and having children, highlighting the direct economic pressures influencing fertility rates.

Case 1: Finland

Despite various incentives, governments worldwide are struggling to raise birth rates, acknowledging that financial bonuses are often ineffective. For instance, in the small town of Lestijärvi, Finland, policymakers offered women €1,000 annually per newborn for ten years if they had a child. After what is equivalent to nearly $400,000 of government expenditure, the result? A 20% reduction in the population.

Other countries such as Hungary, France, and Australia followed in Finland's steps, effectively providing checks with no restrictions on how they are to be spent. While that in itself isn't a problem, what is problematic is the fact that underlying issues aren't being addressed. In fact, as journalist Nowakowski put it, *"Having a child is a life-changing decision, one based on long-term stability, not short-term financial perks. People will not commit to parenthood if they face job insecurity, unaffordable housing, and economic uncertainty. Offering one-time bonuses or minor tax cuts fails to address these deeper concerns."*

Some argue that governments should shift from superficial incentives to policies that create real stability—secure employment, affordable housing, and predictable economic conditions. Inflation must be kept in check, taxation should be fair, and essential services should be reliable. When people feel economically and socially secure, they will naturally choose to have children. Instead of quick-fix solutions, members of the international community feel policymakers should focus on fostering a stable environment where family life is a viable and attractive option.

Outside of the method of unguided checks, some nations have decided to take a more tailored approach. Most notably, by subsidizing child care for children. Still, this comes with its challenges, and can be seen in the case of Sweden.

Case 2: Sweden

In the early 2000s, Sweden implemented a reform to cap childcare costs, significantly reducing costs for families. Research indicates that this reduction led to a 4-6% increase in birth rates over an 18-month period, suggesting that lower childcare costs can positively influence fertility decisions.

Despite the initial positive impact, Sweden's fertility rate has remained below the replacement level. Their failure stems from an inability to address the broader spectrum of factors influencing individuals' decisions to have children, including the cost of student loan debt and the increased cost of living. In short, Sweden illustrates the point that when one issue is resolved, the others only shine brighter. Scenarios like these highlight the need for a comprehensive solution that tackles every aspect.

Needless to say, this approach doesn't come without incurring substantial costs and is something that necessitates collaborative efforts. Fortunately, this framework has been developed before.

Case 3: The EU

In 2019, the EU created the Work-Life Balance Directive, a bill that sought to make it easier for people to balance a working career with a familial one. Under this legislation, it sought increased parental leave (both on the paternal and maternal side), flexible schedules, and mandated "carer" days for workers to leave when they need to care for someone. Though simplistic on the surface, this policy was the result of relentless planning from member states in the EU.

Societal Factors

Once the financial challenges of childbirth are tackled, the undeniable societal shifts and influences must be examined. Most notably, increased participation of women in the workforce and higher educational attainment have led to delayed marriages and childbearing. Additionally, evolving societal norms prioritize personal and professional development, often resulting in smaller family sizes. For many women, the decision to have children would jeopardize their own careers and aspirations, often forcing them to make a difficult choice. While not tied to a specific country, this can be seen clearly on a global scale. In a study by London Business School, researchers found that 70% of women felt anxious about taking a career break, with many worried about what having a child would do to their professional trajectory. This concept is known as the "motherhood penalty," a phenomenon that mothers often encounter in the workforce. With an estimated 5% wage penalty per child persisting for mothers compared to non-mothers, it's clear that a disparity is present. Even outside of wage penalties, the impacts can manifest in the form of hiring bias or career advancement struggles.

While seemingly applicable solutions have been passed, such as subsidized childcare and increased maternity leave, these solutions try to target the economics of this decision, not the societal factors. Moreover, they don't actually address the problem of workplace discrimination, something that numbers clearly show exists.

It should be noted that this challenge in particular is part of a far larger issue and nearly impossible to "solve." There are, however, solutions that can lessen the experience of this discrimination and help hopeful mothers have children. Some companies, for example, have begun implementing "returnship" programs—structured programs designed to help professionals re-enter the workforce after an extended break. Additionally, countries like Denmark have promoted cultural shifts that normalize parental leave for both men and women, reducing the stigma attached to mothers taking time off.

Ultimately, declining birth rates are a multifaceted issue, requiring both economic and societal solutions that address long-term stability, rather than temporary fixes. To that end, delegates have many questions that their research can aim to more clearly define. They are encouraged to develop solutions that push past the temporary, and aim to bring the global community together in order to bring forth a long-term solution. Whether that be through international collaborative efforts, or gaining a better understanding of the matter at a regional level, delegates are strongly encouraged to ponder the characteristics that would make a solution a long-term one.

Questions to Consider

1. What are some of the underlying reasons people are against increased access to childcare, or other monetary help against birth decline?
2. How might nations that don't have a declining birth rate assist others in addressing this problem and prevent their own birth rate decline in the future?
3. What cultural shifts need to occur to reduce the "motherhood penalty?"
4. Addressing this problem takes time. While policy unfolds, how should countries create an even landscape to address the birth decline problem? In other words, how can countries stabilize current problems with an overburdened healthcare system due to a rising population of elderly, and other such problems, in the meantime?
5. What are some goals/milestones that should be reached in the path to solving this issue?
6. In the process of unveiling economic solutions to this problem, how might they affect the social landscape? And vice-versa.
7. Let's say your policy goes to plan and you meet the goal of rising the birth rate. How might countries best prepare for the sudden rise?

Additional Resources

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https://www.nippon.com/en/in-depth/d00906/#:~:text=sign%20that%20comes%20just%20once,%E2%80%9D
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