

WHO

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STRATEGIES TO PREVENT AND CONTROL THE PROLIFERATION OF DISEASES IN REMOTE INDIGENOUS AND AFRICAN COMMUNITIES

Guías de Estudio





STUDY GUIDE WHO LETTER FROM THE SECRETARY-GENERAL

Estimados delegados:

¡Bienvenidos a la decimoctava edición de **San Ignacio Model of United Nations**! De parte de todo el comité organizador, nos complace muchísimo que puedan asistir a nuestro preciado modelo, el cual hemos preparado con gran esfuerzo y dedicación. Este año, la temática central será "**La ruptura del consenso y el desorden global**", un espacio donde ustedes podrán trabajar en problemáticas tanto actuales como históricas. En SIMUN nos regimos por cuatro valores fundamentales: **empatía, responsabilidad, integridad y compromiso**. Por ello, esperamos que durante estos tres días de debate demuestren ser delegados íntegros que honren estos principios. Recordemos siempre que, aunque representen a naciones o personajes, al final del día todos somos seres humanos; medir nuestras acciones para no herir al otro es esencial. Personalmente, siempre llevo conmigo una frase que espero los inspire: *"Es mejor fracasar con honor que triunfar mediante el fraude"*.

A pesar de ser simulaciones, los Modelos de Naciones Unidas nos permiten crecer personal y académicamente. Nos brindan técnicas de negociación para defender nuestras ideas con firmeza, herramientas de oratoria para expresarnos con claridad, liderazgo para inspirar a través del ejemplo y, sobre todo, amistades con personas que nunca imaginamos. Desde el comité organizador de **SIMUN 2026**, deseamos que puedan adquirir o reforzar todas estas habilidades, pues si lo logran, habremos cumplido nuestra tarea: formar hombres y mujeres capaces de estar a la altura de sus sueños.

Por último, disfruten tanto como lo haremos nosotros. Entreguen su mayor esfuerzo y dedicación para que cada segundo valga la pena. Más allá de los reconocimientos, el simple hecho de haber asistido y atreverse a debatir ya los convierte en ganadores.

¡Esperamos con ansias verlos en **SIMUN 2026**!

Sofía García Pérez
Secretaria General SIMUN 2026



STUDY GUIDE WHO LETTER FORM THE PRESIDENT

Dear SIMUN delegates,

It is a true honor and privilege to extend a warm welcome to this new edition of the San Ignacio Model of United Nations, specifically within the World Health Organization (WHO). My name is Ana Poleo, and I will be serving as your committee's president this weekend!.

We gather at a critical juncture in history. While humanity celebrates rapid and remarkable medical advancements, digital health revolutions, and technology that are transforming lives; a sobering reality remains. Many communities have been excluded from the promise of "global" health. That's why our focus for this committee is on developing Strategies to Prevent and Control the Proliferation of Diseases in Remote Indigenous and African Communities, populations constantly mentioned, but not really prioritized.

This challenge unfolds at the time where the international consensus is fracturing with global disorder, where multilateral organizations and WHO face tests to their force, unity, and effectiveness. As future diplomats and decision-makers, your task is to confront these realities head on with creativity, critical thinking, and empathy.

In this committee, we seek more than just knowledgeable delegates. We seek visionaries capable of proposing innovative, realistic, localized, and culturally grounded solutions that balance scientific logic and diplomatic understanding.

I encourage you to debate with enthusiasm, but negotiate with kindness seeking to commit yourselves fully from the very first moment. I'm sure it is going to be a great and fun weekend where all of us will have a good time and live memorable experiences. I hope you're as excited as I'm!

If you have any doubt about anything, remember that you can count on me and on Rodri, Ana, and Gustavo. We will be willing to help and support you with anything you need so feel free to ask whatever you want.

Good luck, see you soon!

Warm regards, Ana Poleo



STRATEGIES TO PREVENT AND CONTROL THE PROLIFERATION OF DISEASES IN REMOTE INDIGENOUS AND AFRICAN COMMUNITIES- RABIES AND MALARIA

History and Powers of the Committee

The World Health Organization, as the United Nations specialized agency for health, has been at the center of international health cooperation for over 60 years. With origins dating from the nineteenth century, the WHO's mandate is the attainment by all people of the highest possible level of health. The huge challenge of fulfilling this objective has not only required high-level technical skills, but has led the organization to engage with a broad range of political and economic interests.

The WHO has enjoyed many high-profile successes such as the global eradication of smallpox and control of SARS, and ongoing campaigns against polio and other diseases. On other issues, such as essential drugs, tobacco control, and diet and nutrition, efforts to tackle the broader determinants of health have brought the organization into contact with issues such as globalization, poverty, social justice, and human rights. (Lee, 2009)

In the 1800s, markedly increased trade and travel with the East led to outbreaks of cholera and other epidemic diseases in Europe. In response to cholera epidemics in 1830 and 1847,

which killed tens of thousands in Europe, the first International Sanitary Conference was convened in Paris in 1851. At the time, the cause of cholera was unknown and due to political differences little was accomplished at this or the next several meetings. Nonetheless, the conferences were the first attempt at establishing a mechanism for international cooperation for disease prevention and control. The effort finally paid off with the adoption in 1892 of the International Sanitary Convention for the control of cholera and 5 years later with a Convention that addressed control of the plague.

In the Americas, the forerunner of the Pan American Health Organization (PAHO), the International Sanitary Bureau, was established in 1902, making PAHO the oldest international health agency in the world. In Europe, L'Office International d'Hygiene Publique was established in 1907, and in 1919 the League of Nations established the Health Organization of the League of Nations in Geneva. In 1926, the International Sanitary Convention was revised to include provisions against smallpox and typhus. The last International Sanitary Conference was held in Paris in 1938 on the eve of World War II. Immediately after World War II, in 1945, the UN Conference on International Organizations in San Francisco voted to establish a new international health



organization and a year later the International Health Conference in New York approved the Constitution of the World Health Organization.

Between 1946 and 1948 an Interim Commission, with 18 states, took over the work of L'Office International d'Hygiene Publique, the Health Organization of the League of Nations, and the Health Division of the UN Relief and Rehabilitation Administration. In 1948, the WHO Constitution obtained enough signatures to bring it into force. The Pan American Health Organization became one of WHO's six regional organizations.

The First World Health Assembly met in Geneva in the summer of 1948 and established priorities for the organization: malaria, tuberculosis, venereal diseases, maternal and child health, sanitary engineering, and nutrition. WHO was involved in wide-ranging disease prevention and control efforts including mass campaigns against yaws, endemic syphilis, leprosy, and trachoma.

The World Health Assembly is the decision-making body of WHO. It is attended by delegations from all WHO Member States and focuses on a specific health agenda prepared by the Executive Board. The main functions of the World Health Assembly are to determine the policies of the Organization, appoint the

Director-General, supervise financial policies, and review and approve the proposed programme budget. The Health Assembly is held annually in Geneva, Switzerland.

All countries which are Members of the United Nations may become members of WHO by accepting its Constitution. Other countries may be admitted as members when their application has been approved by a simple majority vote of the World Health Assembly.

WHO collaborates with our Member States to provide on-the-ground planning, implementing and monitoring of health programmes. Today, more than half of WHO staff work in country offices.



WHO regional offices map- WHO (2025)

Activities Over the Years

Smallpox eradication: In 1958, the USSR proposed a WHO-led smallpox



eradication programme. By 1977, the last confirmed case of smallpox was identified in Somalia. In 1980, the Global Commission for Certification of Smallpox Eradication recommended a halt to routine smallpox vaccination.

Disease control and eradication: In the 1960s WHO promoted mass campaigns against yaws, endemic syphilis, leprosy, and trachoma and helped control a major cholera pandemic in Asia and the Western Pacific and the large epidemic of yellow fever in Africa.

Childhood immunisation: In 1974, WHO launched its Expanded Programme on Immunization, which aimed to vaccinate children worldwide against diphtheria, pertussis, tetanus, measles, poliomyelitis, and tuberculosis. This goal remains unachieved but is now being pursued by the Global Alliance for Vaccines and Immunisation.

Alma-Ata: In 1978, WHO adopted the Declaration of Alma-Ata, calling on all governments to make high-quality primary health care an essential feature of their national health systems. Following this declaration, in 1981 WHO adopted a global strategy for achieving health for all by 2000. The key to achieving this goal was to make primary health care the “central function and main focus of the country's health system”.

Environment and health: Following the 1992 UN Conference on Environment and Development (the “Earth Summit”) in Rio de Janeiro, WHO launched initiatives addressing the health hazards posed to environmental degradation.

Functions of the World Health Organization by its constitution:

- A. To act as the directing and co-ordinating authority on international health work.
- B. To establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate.
- C. To assist Governments, upon request, in strengthening health services
- D. To furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments.
- E. To provide or assist in providing, upon the request of the United Nations, health services and facilities to special groups, such as the peoples of trust territories.
- F. To establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services.



- G. To stimulate and advance work to eradicate epidemic, endemic and other diseases.
- H. To promote, co-operation with other specialized agencies where necessary.
- I.
- J. To promote the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene.
- K. To promote co-operation among scientific and professional groups which contribute to the advancement of health.
- L. To propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objective.
- M. To promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment.
- N. To foster activities in the field of mental health, especially those affecting the harmony of human relations
- O. To promote and conduct research in the field of health
- P. To promote improved standards of teaching and training in the health, medical and related professions.
- Q. To study and report on, in co-operation with other specialized agencies where necessary, administrative and social techniques affecting public health and medical care from preventive and curative points of view, including hospital services and social security.
- R. To provide information, counsel and assistance in the field of health.
- S. To assist in developing an informed public opinion among all people on matters of health.
- T. To establish and revise as necessary international nomenclatures of diseases, of causes of death and of public health practices.
- U. To standardize diagnostic procedures as necessary.
- V. To develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products.
- W. Take steps for the prevention of accidental injuries.
- X. Take all necessary action to attain the objective of the Organization

Aims of the Committee

The World Health Organization proposes to coordinate and support policies and strategies to enhance global access to interventions for the prevention, control, elimination and eradication of neglected tropical diseases, including some zoonotic diseases like Rabies and Malaria.

1. Malaria:



- 1.1. Playing a leadership role in malaria, effectively supporting member states and rallying partners to reach universal health coverage and achieve goals and targets of the Global Technical Strategy for Malaria.
- 1.2. Shaping the research agenda and promoting the generation of evidence to support global guidance for new tools and strategies to achieve impact.
- 1.3. Developing ethical and evidence based global guidance on malaria with effective dissemination to support adoption and implementation by national malaria programmes and other relevant stakeholders.
- 1.4. Monitoring and responding to global malaria trends and threats.
- 1.5. Preventing a resurgence of malaria in all countries that are malaria-free.

2. Rabies:

- 2.1. Prevent and respond to by improving awareness and education, reducing human rabies risk through expanded dog vaccinations, and improving access to healthcare, medicines and vaccines for populations at risk.
- 2.2. Generate and measure impact by implementing proven effective guidelines for rabies control, and encouraging the use of innovative surveillance technologies to monitor progress towards “Zero by 30” (Collaborative strategic plan impulsed by WHO, FOA, WOA and GARC to eliminate human deaths from dog-mediated rabies by the year 2030).
- 2.3. Demonstrate the impact of the “United against Rabies” collaboration in national, regional, and global rabies elimination programmes, in order to ensure continued stakeholder engagement at all levels and sustained financing to achieve “Zero by 30”.

Shigeru Miyamoto once said: ***“A great idea solves multiple problems at the same time”.***

The proliferation of zoonotic diseases comes from the absence of



primary healthcare knowledge around the world, which leads to questioning the effectiveness of supposedly suitable health systems that were sidelined and relegated to a secondary role in underdeveloped territories due to the deficiency of economical resources. The world is in a state that forbids us from continuing wasting more time. This situation requires quick and impactful collaborative solutions that embrace all punctual problems at the same time, ensuring that no problem is underestimated along the way to success.

Background

Malaria and rabies remain persistent health challenges in Africa and South America. While Africa bears the highest global burden of malaria, South America has made significant strides toward elimination. In contrast, rabies transmission in South America has shifted from dogs to wildlife (primarily bats), whereas dog-mediated rabies remains the leading cause of human deaths in Africa. But to understand the current situation in each continent, and how we got here, there are two crucial things you need to know.

1. The Geographic and Climatic Challenge

Climate change is often seen as a Human Factor due to the fact that illegal mining, water

floods and contaminated bodies of water that may carry these diseases and move them from animal-animal to human making this mostly caused by human population. **“This surge is no coincidence,”** says Dr Memory Mapfumo, an epidemiologist at the Africa CDC.

“Prolonged rains have fuelled mosquito breeding, while activities like gold panning, fishing and artisanal mining are exposing more individuals to risk, especially during peak mosquito activity hours.”

A contributing factor is the interconnectedness of the countries, which drives transmission. Throughout the years, malaria has been spread by female *Anopheles* mosquitoes, carrying Plasmodium parasites that cause the disease. Higher temperatures and higher levels of humidity reduce the overall duration of a mosquito's reproductive cycle; also, the development time of the *Plasmodium* parasite within the mosquito is also decreased, therefore increasing the rate of transmission time between humans via the vector of the infected mosquito.



As an example of the effects on geographic location, malaria is becoming more prevalent in previously cool, high altitude areas such as in Kenya due to the increasing viability of mosquitoes to survive in these cool, high altitude areas; which is why countries in Europe and North America tend to lack these diseases.

And in rabies, it has been linked to the northward movement of vampire bat populations in Latin America, thus spreading the geographical range of rabies virus in the local population.

Geographic changes, such as population and deforestation caused by climate change alter the host animal behavior, by increasing interaction rates between species, and the change on environmental barriers; in some cases it can accelerate the virus in new regions while simultaneously making control measures like vaccinations less effective.

2. **Malaria and Rabies Transmission**

The transmission cycles of malaria and rabies are distinct biological processes, each involving specific animal vectors

that have adapted to thrive alongside human populations. Malaria is primarily transmitted through the bite of an infected female *Anopheles* mosquito, which injects *Plasmodium* parasites into the bloodstream while taking a blood meal.



In contrast, rabies is a viral zoonosis typically spread through the saliva of infected mammals. While bats serve as a natural reservoir for various rabies virus strains, the most significant public health threat occurs when the virus switches into domestic dog populations. This transition is often facilitated by environmental overlap where unvaccinated dogs encounter infected wildlife; once established in canine populations, the virus spreads through bites, making dogs the primary source of human rabies infections globally.



3. Previous vaccines invented for malaria and rabies and why animals are becoming immune

Rabies vaccines have evolved from Louis Pasteur's 1885 nerve tissue vaccines to modern cell-culture, recombinant, and oral wildlife vaccines. Malaria vaccines, particularly for animal models, include radiation-attenuated parasites and antibody-inducing models, rather than widespread natural immunity. Animals are not becoming universally "immune" to malaria or rabies, but rather developing higher resistance through intensive vaccination campaigns and, in some cases, natural selection after surviving infections.

Animals are not becoming universally immune to these diseases through natural selection alone, but rather via controlled exposure and, specifically for rabies, massive vaccination efforts like the widespread use of oral vaccines in wild populations (foxes, raccoons) is designed to create herd immunity, making them immune to the virus, animals that survive a first, severe infection (like malaria in some

instances) may develop antibodies, leading to a form of acquired immunity for subsequent infections. New-generation rabies vaccines, including recombinant and subunit vaccines, provide more potent immune responses, allowing animals to generate stronger protection. Basically, the more vaccines and antibodies you inject into one of these species like mosquitoes, bats or dogs, the more immune they become to it, and the more likely you are to.

Previous Vaccines Invented for Rabies and Malaria

- *Rabies Vaccines:*
 - Nerve Tissue Vaccines (NTVs): Developed by Pasteur in 1885, using rabies virus from infected sheep, goats, or rabbit brain tissue.
 - Attenuated Live Vaccines: Developed in the mid-20th century, such as the Flury low-egg passage (LEP) and high-egg passage (HEP) strains, to reduce side effects in dogs.
 - Oral Rabies Vaccines (ORV): SAD Berne strain developed in 1969 to immunize wildlife vectors.
 - Modern Vaccines: Cell culture-based vaccines (HDCV, PCECV) and newer



recombinant DNA vaccines that are safer and more immunogenic.

- **Malaria Vaccines :**
 - Radiation-Attenuated Vaccines: Experimental vaccines like PfSPZ (Plasmodium falciparum sporozoites) show high efficacy in animals by attenuating the parasite, offering durable, protective immunity.
 - Antibody-Based Vaccines: Studies on penguin malaria identified antibodies that, if applied via a vaccine, could protect against the disease.

Study Cases

With **rabies**, the incubation period is typically 2-3 months but may vary from one week to one year, once the virus infects the central nervous system and clinical symptoms appear, rabies is fatal in a 100% of cases, where offering comprehensive and compassionate palliative care is recommended. However, the deaths are preventable with Prompt Post Exposure Prophylaxis (PEP) by stopping the virus from reaching the central nervous system consisting of a thorough wound washing, administration of a course of human rabies vaccine and, seeking immediately a PEP care.

On the other hand, **malaria** cases in countries like Botswana, which since epidemiological weeks 1-23 of 2025 has recorded 2,223 cases and 11 deaths, compared to 218 cases and no deaths in the same period in 2024. Okavango has been hit hardest, accounting for 69% of the cases. Since the outbreak began in November 2024, a total of 2,344 cases have been reported, with sporadic outbreaks appearing in non-endemic districts.

Across Zimbabwe, 115 out of 1,705 health facilities have been affected, highlighting the widespread impact of the disease on healthcare infrastructure



Since late 2024, countries like Nigeria, Mozambique and Ghana who hold the highest global malaria burden, accounting for more than 30% of all cases, have seen a rise of 39% in deaths in the last year, experiencing a severe rise in drug-resistant **malaria**. Cases of



malaria have increased, particularly with high resistance to treatments since 2022. Nevertheless, vaccination efforts expanded, with 28.3 million doses distributed across 24 countries after these statistics were reported by the African Leaders Malaria Alliance.



The epidemiologic situation in these countries for early 2026 shows a regional contrast: while **rabies** remains a critical concern primarily linked to wildlife (bats) and isolated urban canine outbreaks, malaria is heavily concentrated in the Amazon basin, with Brazil, Colombia, and Venezuela accounting for nearly 75% of all cases in the Americas. Brazil remains a regional supplier of vaccines, donating 5,000 doses of rabies vaccines to Venezuela in 2025. As of April 2026, there is an active urban outbreak in Zulia State, with laboratory positivity rates at 77% for animal samples. Three new human cases were confirmed in early 2026 in Barinas and Portuguesa. Colombia confirmed 25 rabies cases (including 13 deaths) and confirmed 2 human cases in the first seven weeks of 2026. The primary threat remains

vampire bat transmission in the Amazonian jungle

Actual Situation

William Faulkner once said: “**The past is never dead. It’s not even past**”. Malaria has been with us for thousands of years, the symptoms described in ancient Chinese medical texts from 2700 BCE are the exact same symptoms doctors treat in South Africa today. Our past issues have not been tackled already, so the current professionals are the ones who have to seek to avoid more malaria & rabies outbreaks, but the humans are the ones who have to seek survival which isn't properly delivered by the UN. The ethnic health organizations along the borders can be adapted in order to make them capable of delivering this help that is needed and they should be supported by international organizations to do that.

According to the World Malaria Report 2025, the major study highlights the extreme weather events now accounting for nearly 80% of additional malaria cases. Warmer temperatures are pushing malaria into higher altitudes and regions previously considered free of malaria outbreaks such as Ethiopia and Madagascar. The increasing resistance to Artemisinin-based treatments, particularly in the WHO African Region, has made the disease harder to control.



The only real way to provide care is through malaria preventive therapy, so the UN and the other players are going to have to work with ethnic health organizations because nobody else has access to these areas. Unstable healthcare systems and the immutability from the mosquitoes to vaccines existing have led to an important rate of civilians dying from both of these illnesses.

Past Actions

Creation of rabies vaccines 1885

On July 6, 1885, Louis Pasteur and Émile Roux used a “weakened” version of the virus obtained by drying the spinal cords of infected rabbits to cure Joseph Meister, an 9 year old child bitten by a rabid dog. This was the first time a vaccine had been successfully used on a human for the disease.

The 2000 outbreak

South Africa experienced a massive malaria epidemic during this period, peaking in the year 2000 with approximately 459 deaths and over 64,000 notified cases. Due to the emergence of resistance to the then-standard drug (sulfadoxine-pyrimethamine) and the comeback of a specific mosquito species (*Anopheles funestus*) that was resistant to certain insecticides, the outbreak began.

Following the crisis, the country implemented more effective treatment protocols such as: Artemisinin-based combination therapies and improved indoor spraying programs. The results of the enhancement of these protocols led to an impressive decrease in mortality rates over the following decades.

Massive Dog Vaccination Campaigns 2024

Under the “Zero by 30” initiative, countries in Southeast Asia and Latin America launched aggressive dog vaccination drives in 2024 to avoid the virus reaching the humanity

The 2025 outbreak

In early 2025 a mystery illness erupted in The Democratic Republic of the Congo. Starting in January, hundreds of people in the Bolomba and Basankusu clusters fell ill with what local officials initially feared was a new “mystery hemorrhagic fever” because patients were suffering from: High fevers, vomiting blood, and rapid deaths.

By March 2025, the DRC’s National Institute of Public Health confirmed that the primary killer was severe malaria. There were nearly 1,100 confirmed cases and over 60 deaths in only a few months. The high fatality rate



was blamed on a “perfect storm”: a lack of available medicine

Massive Vaccination Rollouts

At the end of 2025, over 24 countries (primarily in Africa) integrated the R21/Matrix-M and RTS,S/AS01 vaccines into their routine childhood immunization programs. Effective results happened, this prevented an estimated 170 million cases

Crux of the Debate

The proliferation of infectious diseases such as malaria, rabies, ebola, tuberculosis, and cholera in remote areas in remote Indigenous communities represents a challenge that goes beyond a lack of medicine; it is often a lack of infrastructure, trust, and accessibility due to geographic isolation and socio-economic barriers that aren't directly related to the diseases themselves, but they support the maintenance of them.

Given the context of the situation, where limited access exacerbates vulnerabilities, the current challenge for this committee regarding disease proliferation in isolated Indigenous and African communities is the clear intersection of the following:

- ***An aggravated resource scarcity with a poor use of external aid and a***

weak strategy to target all the people needing the help;

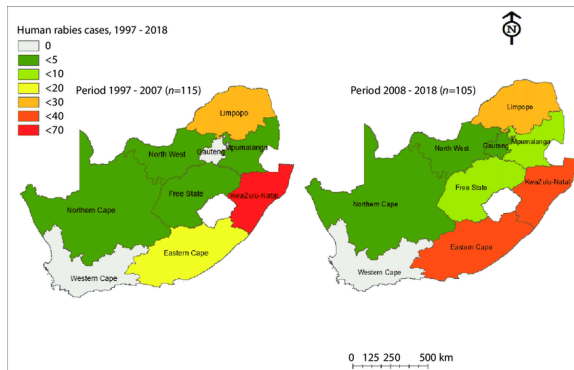
- ***A clear geographic isolation with a lack of infrastructure that is leaving individuals without any sanitation opportunities at all;***
- ***The zoonotic challenges of the pathogens, including vector-borne threats such as malaria and zoonotic risks like rabies that work with the hand of weak targeted strategies.***

In these specific isolated communities, the “Last Mile” concept of healthcare delivery exists, where it is not only a medical failure but a systemic one that is affected by the points previously stated, mostly the geographic isolation that works with resource scarcity, making it unable to create new helping infrastructure. This creates a medical vacuum where preventable diseases decimate whole populations that are already economically marginalized; that's why the committee has to take into consideration these problems and aim your resolutions not just at rabies and malaria, but also at other important diseases such as tuberculosis, HIV, and neglected tropical diseases (NTDs), taking into consideration the important death rates that they deliver annually.

Additionally, while urban areas constantly benefit from centralized healthcare infrastructures, remote regions face “vacuums” of infection where the endemic disease is not the



only problem, as it is compounded by broader issues such as poverty, sexual insecurity, crumbling infrastructure, and unhealthy living conditions empowering the presence and proliferation of these diseases.



Geographical Patterns- (ND)

Organizations such as the United Nations and the African Commission of Human Rights use the term “indigenous” for African communities to identify marginalized communities or those whose survival depends on the preservation of their ancestral lands. For example, in the Congo Basin, the Baka, Batwa, and Mbuti, who live in dense tropical forests and have malaria as a primary threat in their youngest population; in East Africa, the Maasai and Samburu, who are semi-nomadic pastoralists, living in constant proximity to dogs and rabid wildlife; the Fulani, the Tuareg, the Himba, and the San People, and much more.

Framing the issue on contemporary communities:

Registered rabies percentages by the WHO state that the disease takes more than 70,000 lives yearly; this number is much bigger, but due to unreporting, documented case numbers often differ from the estimate, where many victims die at home without even reaching a clinic, as there are some communities that are located days apart from them. 50% of this quantity occurs in remote indigenous African communities even though it is a vaccine-preventable viral disease and can also use immunoglobulins. These are often inaccessible and unaffordable, much more so to marginalized communities, taking into consideration that the average cost of rabies post-exposure prophylaxis (PEP) is approximately US \$108 (Ridder, 2024) along with travel costs and loss of income, which represent a financial burden to those African living communities whose earnings are US \$1-2 per person daily, so the cost becomes an insurmountable barrier. (Balaram, 2016)

In 2026, rabies remains a neglected zoonotic disease because it mainly affects poor rural communities, and while the WHO is aiming for a “Zero by 30,” or zero human deaths by 2030, the death rates in remote African and Amazonian villages only increase, and their down reality is based on a lack of Integrated Bite Case Management (IBCM) and a blind use of treatments such as the PEP, which can be used unnecessarily or is not available at all,

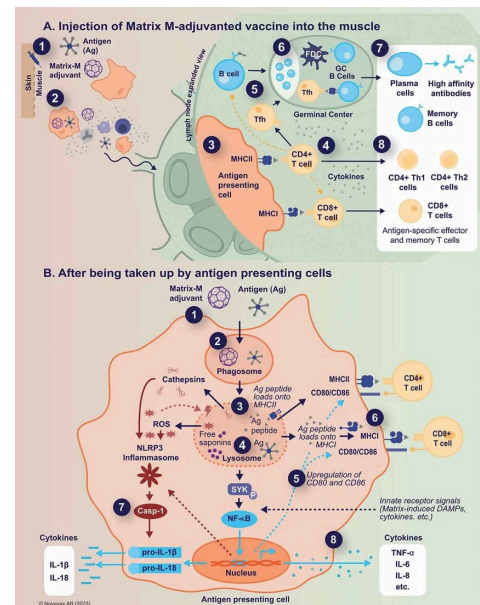


leading to a 100% mortality rate once symptoms appear. (Coetzer, 2016)

The malaria situation shifts as there's now the presence of biological resistance and climate change. *Anopheles stephensi* mosquitoes are each time more resistant to the insecticides used in bed nets, growing *partial artemisinin resistance*, while the *Plasmodium parasite* constantly shows resistance to frontline drugs (ACTs) in Africa and South Asia. This evolution of the diseases is influenced by the constant climate change and is creating new breeding grounds in areas that previously had zero malaria, catching isolated Indigenous health systems off guard. (Ritchie, 2024) This is making the debate between distributing Long-Lasting Insecticidal Nets (LLINs) versus investing in the new R21/Matrix-M malaria vaccine an important debate point due to all the healthcare-related transformations that this disease is developing and the constant climate change that is making communities face year-round transmission without the infrastructure to support complete year medical supplies.

The R21/Matrix-M vaccine represents efficacy rates of 63%-78% (Ogoma, 2021) in controlled infection trials, and the WHO reported that the R21 vaccine reduced symptomatic malaria cases by 75% in the 12 months following a 3-dose series, where the SII has established a production capacity of

100 million doses annually, making this vaccine an easy solution with a price range of \$2-\$4 per dose and a four-dose requirement per person. (Sharma, 2021)



Geographical pattern
R21/Matrix-M- Novavax (2023)

Despite the low cost and efficacy that it can present, the high temperature sensitivity of the vaccine mandates cold chain facilities, which aren't applied in actuality because of the remote subjugation of the communities that need it the most. As it is a reliable solution, it is important to debate on how it can be applied effectively without rising expenditures. (Collins, 2017)

Theoretical lenses:

Understanding that while there exists the main problem with the disease proliferation, the living situation in these rural communities is also a factor that has



to be considered is the key to understanding the whole panorama. That's why delegates must debate whether limited WHO resources should be prioritized for preventative measures for the long term, immediate clinical treatment for the short term, or if they should be managed in both ways.

1. Preventative measures: This approach prioritizes saving lives in actuality as the only moral imperative by looking up to work mainly on long-term solutions; focusing on sanitation, vaccinations, preparation strategy for the management of the aid, and community education to stop diseases even before they start with massive investments in Post-Exposure Prophylaxis (PEP) for rabies and Rapid Diagnostic Tests (RDTs) for malaria, looking to take quick action and help in actuality the biggest quantity of people as they can. (Wallace, 2022)

Nevertheless, critics have mentioned that this type of solutions doesn't help much to stop viruses in animal populations in the case of rabies, nor does it build tangible infrastructural projects for the future in order to maintain out of a vicious cycle marked by the purchase of treatments and an unregulated use of them, taking into consideration the high costs and the limited accessibility in these rural areas. (Schaefer, 2023) Reforming well-planned

and organized long-term programs can be more effective.

2. Clinical Treatment: This perspective looks up to stopping the diseases at the source to ensure they never reach the human population or reduce their impact to the minimum as is possible. By working with short-term solutions that focus mainly on mobile clinics, rapid diagnostic tests (RDTs), emergency stockpiles of PEP and antimalarials to save lives, Mass Dog Vaccinations (MDVs), and Seasonal Malaria Chemoprevention (SMC) with vaccinations such as the R21/Matrix-M. (Wang, 2025)

It has to consider and apply one of the main problems, which is the improper use of external aid, as it can be a really useful tool in the long term for the development of most of the projects looking to not just give temporary relief but to develop trust and tangible results. Even so, critics also argue that preventative measures can take years to actually show any result at all, taking into consideration all the quantity of deaths that these diseases are bringing now into our communities, explaining that quick measures are going to save more lives (Bhatti, 2012). Studies such as Prakash's mention that focusing on "Zero by 30" goals with logistical, financial, and biological challenges of maintaining 70% vaccination coverage in dog populations is unnecessary as rabies and malaria are 100% preventable and argue that current strategies struggle



with supply chain issues and high costs in low-resource settings.

3. *The integrated model:* This viewpoint is willing to create a “hybrid” system. Here delegates have to debate if strategies should shift from eradication to management and how to do it without neglecting one of the parts. It looks to build local capacities to do both of the parts; examples such as Liberia and Ethiopia can be used to adapt to the situation with other examples such as the WHO Global Strategy for Infection Prevention and Control. Malaria's measures aim to target multiple stages of the development of the parasite's life to prevent infection and transmission (Malar, 2023), while rabies aims to follow the One Health Approach (Mahulu, 2025).

Socio-economic and cultural barriers

Urbanization often leaves remote regions behind, and without a cold chain infrastructure, the best vaccines are useless. This brings high costs of transport and a lack of local health insurance, which cannot be sustained in actuality. This brings a trust deficit, as many indigenous communities view external medical intervention with skepticism due to colonial histories. The lack of reliable electricity, high costs of transport, which can't be covered by the individuals, and lack of trust in new measures create clear socio-economic and cultural barriers.

It is important to also stop the assumption that Western medicine should be forced upon a community, for a strategy to be effective, it needs to be culturally competent. Delegates will have to build trust in the population by addressing historical trauma or past medical exploitation that can lead to a hesitation on vaccines and finding ways to work alongside these remote communities (Herbert, 2020).

QARMAS

- Is it better to prioritize WHO-led tools like preventive chemotherapy, vector control, and veterinary public health for quick wins against the diseases or insisting on tackling root causes, infrastructure investments, poverty alleviation, and gender security even if they take more time?
- Is the total eradication of the diseases feasible in these remote communities? If so, how could all that process be managed without neglecting any part of the project?
- Is it better to invest the available funds on short-term applications or in long-term preparation?, why?
- How can the WHO balance the urgent need for Rabies and Malaria treatments with the necessity of building permanent healthcare infrastructure not



necessarily directed to these diseases in remote regions?

- To what extent can member states and the WHO implement cold chain infrastructure for the effective delivery of vaccines in remote regions with no access to a centralized electrical grid?
- How can the resolution ensure a structural balance between funding for short-term clinical treatments and long-term preventative measures?
- What innovative technologies or frameworks can be adapted in order to improve the surveillance and development of the projects in remote areas without violating the privacy or sovereignty of the residents?

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