

FOURTEENTH ANNUAL
ALABAMA MODEL UNITED NATIONS



WHO TRAVELS BACK IN TIME

BACKGROUND GUIDE

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LETTER FROM THE **DIRECTOR-GENERAL**

Esteemed Faculty and Delegates,

Welcome to **ALMUN XIV**. My name is Catharine del Carmen, and I am serving as the Director-General. I am in my fourth year at the University of Alabama's Bachelor of Social Work (BSW) Program. Even after COVID-19 forced us to rain-check last year's conference, I am so excited that you chose to attend one of the Southeast's premier Model United Nations conferences for high school students! We are pleased to offer a diverse array of committees ranging from traditional General Assemblies to the International Court of Justices to a crisis committee based off a viral online video game with everything else in-between. I'm proud to announce that ALMUN XIV will also be implementing its first Plenary Session for the General Assembly during the last committee session on Sunday, February 6th. The fourteenth rendition of ALMUN's secretariat and staff have worked tirelessly to revamp our conference and provide an immersive, engaging, and realistic experience to all delegates who choose to attend.

This is my eighth year participating in ALMUN, and I cannot believe how much time has passed since I was a high school freshman freaking out over debating international policy in a room full of people. Model United Nations has become a passion of mine, and I enjoy joking about the irony of my previous statement with my friends and family. If you asked me eight years ago if MUN would be a key player in my college experience, I would laugh in your face, but it truly has shaped me into the young adult and aspiring professional I am today. The University of Alabama has paid for me to travel to Boston, Chicago, Washington, D.C., and even Montreal, Canada. My heart and mind are with international politics, advocacy, and diplomacy, and I do not believe I could confidently say so if it weren't for my experience as a Model United Nations delegate, staffer, and secretariat member all these years.

I hope you all obtain the same amount of passion, wisdom, and joy that I have from competing in MUN conferences, and I encourage you to take this past high school. My email will be listed below if you have any questions about the conference, your committee, or just Model U.N. in general. I wish you the best of luck in your research and preparation, and Roll Tide!

Best,
Catharine del Carmen
Director-General
almun.dg@gmail.com

a note on RESEARCH, PREPARATION, & POSITION PAPERS

Your experience as a delegate doesn't begin on the first day of the conference. Rather, the time you spend leading up to the conference is just as important as the debate and discussion that occurs therein. Proper research and preparation are key to a successful performance, but for new delegates, or those without much experience, the idea of a MUN conference and the preparation behind it can seem like an overwhelming task. The best place to start is this Background Guide written and prepared for you by your committee staff. This document is the perfect jumping off point for all of your research, and it will also help you understand the innerworkings, schematics, and purpose of your character/country assignment and role as a delegate during the conference.

The position paper is a delegate's first impression to the dais and is the final product of a student's preparation and research for any Model United Nations conference. It contains informed perspectives and histories of the state a delegate represents and is crucial to creating an authentic MUN experience.

All delegates are strongly encouraged to submit a position paper. Each country/character represented at ALMUN XIV must submit a position paper in order to be considered for awards. The best position paper within each committee will be awarded the Outstanding Position Paper award by the committee staff.

FORMAT

- The position paper will be two pages, so that each topic takes up space on one page. When finished writing positions for the first topic, add a page break and begin the second topic on the second page. Do not exceed two pages.
- The document will be single spaced, 12 pt., Times New Roman
- The document will begin with a three line header on the left side consisting of the following:
 - Name(s) of the delegate(s)

- State represented by the delegate(s)
- Committee in which the delegate(s) will participate
- After the header, center and identify the title of the first topic, such as in the following example:
Topic A: [Insert Title of Topic]
- References will be cited using footnotes in MLA format. Include the URL for electronic sources. We strongly encourage using solely electronic sources for ease of reference.
- **Position papers should be saved as a word document or PDF file with the title "ALMUNXIV_[committee]_[country]"**.

CONTENT

Position papers will have three paragraphs for each topic outlined as follows:

The first paragraph introduces the topic from the point of view of the nation represented. It discusses the history of the topic, specifically in relation to the country.

The second paragraph analyses the topic's context in the nation and expresses most of the research done on the topic. It discusses past action or inaction, success or failure, and the nation's current thoughts and feelings towards the issue.

The third paragraph consists of an informed discussion of solutions to be proposed by the delegate(s) at the conference. It uses the research done on the topic and synthesizes it into new and creative ideas based on the nation represented by the student.

OTHER TIPS & NOTES

- Do not write in first person; write as the character represented (e.g. "The New York Times leans...")
- Avoid the passive voice
- Write matter-of-factly rather than with embellished language
- Remember to cite your sources in-text if necessary

Please use example position paper provided on the ALMUN website for ideas on how the writing and style should look, as well as how to present the information needed to prepare for the conference

If you are looking for more information on how a committee runs and debate flows, please check out our [Delegate Resource Guide](#) and [Handbook for Rules and Procedures](#). These two documents will break down everything you need to know about awards, parliamentary procedure, and even offer a brief rundown and history of your committee's branch.

Please submit all position papers to [this google form](#), no later than February 3rd, 2022 at 11:59 p.m. CT

**DELEGATES THAT DO NOT SUBMIT
POSITION PAPERS WILL BE
INELIGIBLE FOR AWARDS.**

Letters from Dias

Dear Delegates,

I'm Turner Koch, one of your chairs for this year's iteration of ALMUN XIV, where I'll be overseeing the World Health Organization Travels Back in Time Committee. I'm currently a sophomore pursuing a degree in both Biology and International Studies with a minor in Chinese language here at the University of Alabama, and I truly could not be more excited for this committee.

I come from a small town in Northern Indiana, and my first experience with Model United Nations came last year. When I first arrived on campus, I joined the Alabama International Relations Club and quickly fell in love with MUN. Throughout my first year, I competed in seven conferences and helped to host AIRMUNC I, our collegiate conference, as a staffer. This year I'm not just competing, but also serving as the Director of External Affairs for AIRC as a whole, and pursuing MUN as a passion outside of that.

As a biology major, I was fascinated by the concept of hosting a World Health Organization committee that looks back in time at the failures and struggles of public health. COVID-19 has brought the WHO into the global spotlight, and understanding its roles and procedures are critical to improving global public health. The WHO was not present during one of the health crises we will be discussing, and still in its infancy during the other. It is my hope that throughout this conference, the need for cooperation and collaboration on issues of health more than anything will become apparent. Beyond health, these topics will tackle historical and contemporary issues of global conflict, discrimination, and systemic problems that demand your attention as representatives of public health.

I cannot wait to hear your novel solutions to these global crises, and I'm looking forward to seeing all of you in February! If you have any questions regarding this background guide or the logistics of "time travel", feel free to reach out to me at tjkoch3@crimson.ua.edu or any of the dias!

Best wishes and good luck,

Turner Koch

Chair

tjkoch3@crimson.ua.edu

Delegates,

Welcome to ALMUN XIV. My name is Nikhil Salian, and I will be serving as the co-chair for the World Health Organization Travels Back in Time Committee. I am a senior at the Capstone, looking to earn a Bachelor of Science in Biology with a minor in General Business with the intention of pursuing a career in dentistry after graduation. I am very excited for this committee and the opportunity to create this experience for y'all.

My background in MUN started my sophomore year of high school. I joined the MUN team and was quickly engrossed in the experience. Our team only attended the same local conference each year, and each year I was a delegate in the World Health Organization Committee. When I came to UA, I spent my freshman year exploring some other organizations, but I quickly realized how much I missed being around MUN. I joined the Alabama International Relations Club my sophomore year and promptly got my MUN fix in. I competed in two conferences and staffed the first AIRMUNC on the Clone Wars Committee.

Having competed in the WHO committee each year in high school, I sought to get a real-world WHO experience. The summer after my freshman year, I volunteered at the WHO Collaborating Center for Influenza at St. Jude Children's Research Hospital in Memphis. I learned valuable information about the spread of the influenza virus and saw how the WHO works to create a flu vaccine each year as well as trace new mutations and viruses on a global scale. The WHO has a massive influence on global public health, and the past two years have shown how important having such an organization is to improving it.

I look forward to your solutions to the crises Turner and I have created for this committee, in addition to your perspective on the time travel aspect. Please do not hesitate to contact me at nksalian@crimson.ua.edu if you have any questions regarding any background information or the committee as a whole. I cannot wait until February to see y'all in person for this committee!

Good luck,
Nikhil Salian

Co-Chair

nksalian@crimson.ua.edu

Committee Details

The World Health Organization (WHO) Travels Back in Time committee will be run as a specialized agency, with a heavy focus on general assembly style debate. The topic of debate will be set during the first session and serve as the source of debate for the majority of the committee. No crisis notes or arcs will be used throughout the course of the conference. This means that the goal of the weekend will be to produce longer working papers after dividing into blocks, followed by debates, merging, and eventual voting procedure on longer documents aimed at tackling every facet of the selected topic.

Delegates should however expect updates during the course of debate with new global events, research, outbreaks, or mutations to discuss. Following these updates, delegates should be prepared to alter their debate strategies or working papers to accommodate the ever shifting world of public health policy.

The dias acknowledges that many of the countries represented did not exist in their current form during the time period of Topic II, as well as some from Topic I. In either case, assume that you as a delegate maintain your role as an advisory member to your country, irrespective of the borders during the selected time period. Effectively, the modern map of advisors and medical personnel from the World Health Organization will be overlaid over the chosen Topic. The dias understands that time travel is a potentially confusing process, and any questions regarding the logistics of your role are more than welcome.

In light of the ongoing COVID-19 Pandemic, the dias recognizes that many of the topics, updates, and debates may closely mirror real life events. Delegates should keep this in mind when approaching this committee, as when discussing any public health crisis, the personal circumstances of those at the table are not known. If at any point delegates feel uncomfortable with the topics, before, during, or after the conference, please do not hesitate to contact the dias so that we can address those concerns as soon as possible. The dias and the University of Alabama also strongly condemns the use of racist, sexist, ableist, or generally discriminatory language during this committee, and will not stand for the use of this rhetoric both in and out of debate.

WORLD HEALTH ORGANIZATION OVERVIEW AND HISTORY

Mission and History

The World Health Organization (WHO) is the directing and coordinating authority on international healthcare issues within the United Nations (UN) system. Its mission is to advocate and catalyze global and country actions to resolve the human resources for health crisis, to support the achievement of the health-related millennium development goals and health for all (“About WHO”, 2021). The WHO’s vision is promoted through this charter of values:

The infographic consists of five horizontal bars, each with a circular icon on the left and text on the right. The icons are: a hand holding a heart with a pulse line, a ribbon award, a scale of justice, two hands shaking, and a hand holding a heart. The text for each value is as follows:

- Trusted to serve public health at all times**
We put people’s health interests first
Our actions and recommendations are independent
Our decisions are fair, transparent and timely
- Professionals committed to excellence in health**
We uphold the highest standards of professionalism across all roles and specializations
We are guided by the best available science, evidence and technical expertise
We continuously develop ourselves and innovate to respond to a changing world
- Persons of integrity**
We practice the advice we give to the world
We engage with everyone honestly and in good faith
We hold ourselves and others accountable for words and actions
- Collaborative colleagues and partners**
We engage with colleagues and partners to strengthen impact at country level
We recognize and use the power of diversity to achieve more together
We communicate openly with everyone and learn from one another
- People caring about people**
We courageously and selflessly defend everyone’s right to health
We show compassion for all human beings and promote sustainable approaches to health
We strive to make people feel safe, respected, empowered, fairly treated and duly recognized

Promote health | Keep the world safe | Serve the vulnerable

During the initial conference of the United Nations in 1945, representatives from Brazil and China proposed that an international health organization be established. On April 7 of 1948, the World Health Organization Constitution was drafted and signed by 51 UN members and 10 other nations (Charles, 1968). The World Health Assembly, the governing body of the WHO, incorporated the assets and personnel of the former League of Nations' Health Organization. Some of its first objectives were to control the spread of diseases such as malaria and tuberculosis. In addition, the WHO sought to improve mental health in mothers and children, hygiene and nutrition.

Today, the World Health Organization has expanded to include 194 states, including all but one United Nations member (Lichtenstein) and an additional two non-UN states (Cook Islands and Niue). The scope of the WHO's authority needs no introduction given recent developments in the COVID-19 Pandemic. The World Health Organization has played an instrumental role in coordinating research and formulating policy recommendations during the Coronavirus Outbreak, but the extent to which WHO has been involved in recent health crises does not stop at COVID-19. Zika, Ebola, and frequent monitoring of the annual flu are just a few examples of how the WHO has been responsible for shaping the public health sphere in recent years ("About WHO", 2021).

Structure

The World Health Organization in the modern era can be divided into two separate bodies: the World Health Assembly and the Executive Board.

The Executive Board is an exclusive group composed of 34 experienced medical personnel who are elected for three-year terms. The Executive Board serves as the basis for the delegate list in this committee. Each of the members are selected from a diverse group of six geographical regions, including Africa, Americas, South-East Asia, Europe, Eastern Mediterranean, and Western Pacific, with proportional representation being key to establishing the World Health Organization as a non-biased party. The 34 elected professionals are responsible for providing technical expertise to the World Health Assembly, and for constructing the agenda on public health issues for discussion ("WHO Executive Board", 2021).

The World Health Assembly functions as the primary body for most of the activities conducted by the WHO. It is composed of a representative from each member nation who attends, discusses, and votes on the agenda proposed by the Executive Board ("World Health Assembly", 2021). The WHO Assembly is also responsible for setting and approving the annual budget and managing finances, as well as electing the Director-General of the World Health Organization. The Director-General is appointed

by vote through a secret ballot and serves as the presiding officer over the Assembly, communicating with both the Assembly and Executive Board and ensures proper functioning of the World Health Organization (“The Election of WHO director-general”, 2021).

Powers and Responsibilities

The World Health Organization, much like the United Nations itself, serves as more of a public forum on health issues than a true legislative body. While the World Health Assembly can vote on and pass documents that call for action by member states, those actions are often voluntary and serve primarily as recommendations (“World Health Assembly”, 2021). As seen during the COVID-19 Pandemic, the World Health Organization lacks any true enforcement mechanism other than restriction of its services in public health aid. Enforcement of public health recommendations largely falls to the local and regional governments being addressed. That being said, the World Health Organization maintains a pivotal role as the world’s main forum on any issues of public health that extend beyond borders.

In that sense, the WHO’s main responsibility is to serve as an advisor, mediator, and advocate for issues in public health. WHO also allows nations that would otherwise not communicate to collaborate on research or developing solutions to ongoing crises. Collaboration and cooperation is critical to overcoming any public health crisis that extends beyond the borders of a single state, and as such the successes of the WHO cannot be overstated.

Budget and Funding

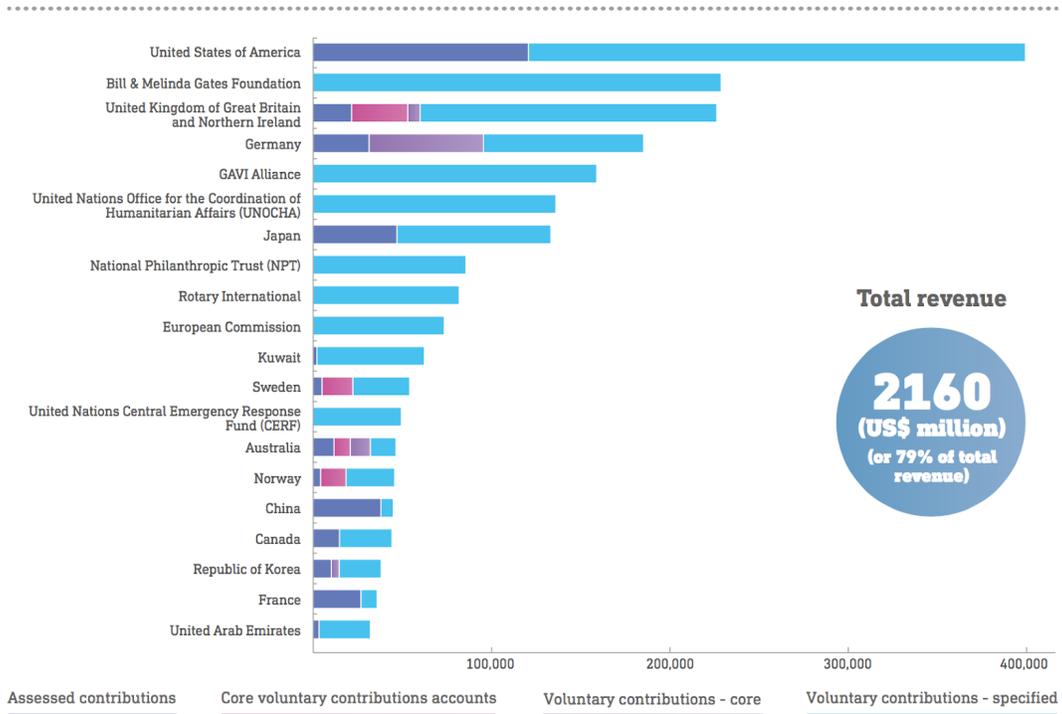
The World Health Organization has two main sources of funding: assessed contributions and voluntary contributions. Assessed funding is determined as a percentage of each member nation’s gross domestic product. This percentage is approved on a biannual basis by the United Nations General Assembly, the overarching organization that watches the World Health Organization. Unfortunately, these membership costs only make up 20% of the World Health Organization’s total budget, so additional funding must be taken into account (“Our Contributors”, 2021).

Voluntary contributions are where this difference is made up. This comes primarily from donations of member states, with other funding coming from the United Nations general budget, private sector donations, and philanthropy from non-governmental organizations. Of these, the United States serves as the largest donor, followed by the United Kingdom of Great Britain and Northern Ireland, the Bill and Melinda Gates Foundation, and Germany (Moulds, 2020). Throughout history, the

largest contributors to the World Health Organization have remained relatively constant, with a large concentration coming from Europe and the Western World.



Top 20 contributors to the Programme budget 2018 (US\$ thousands)



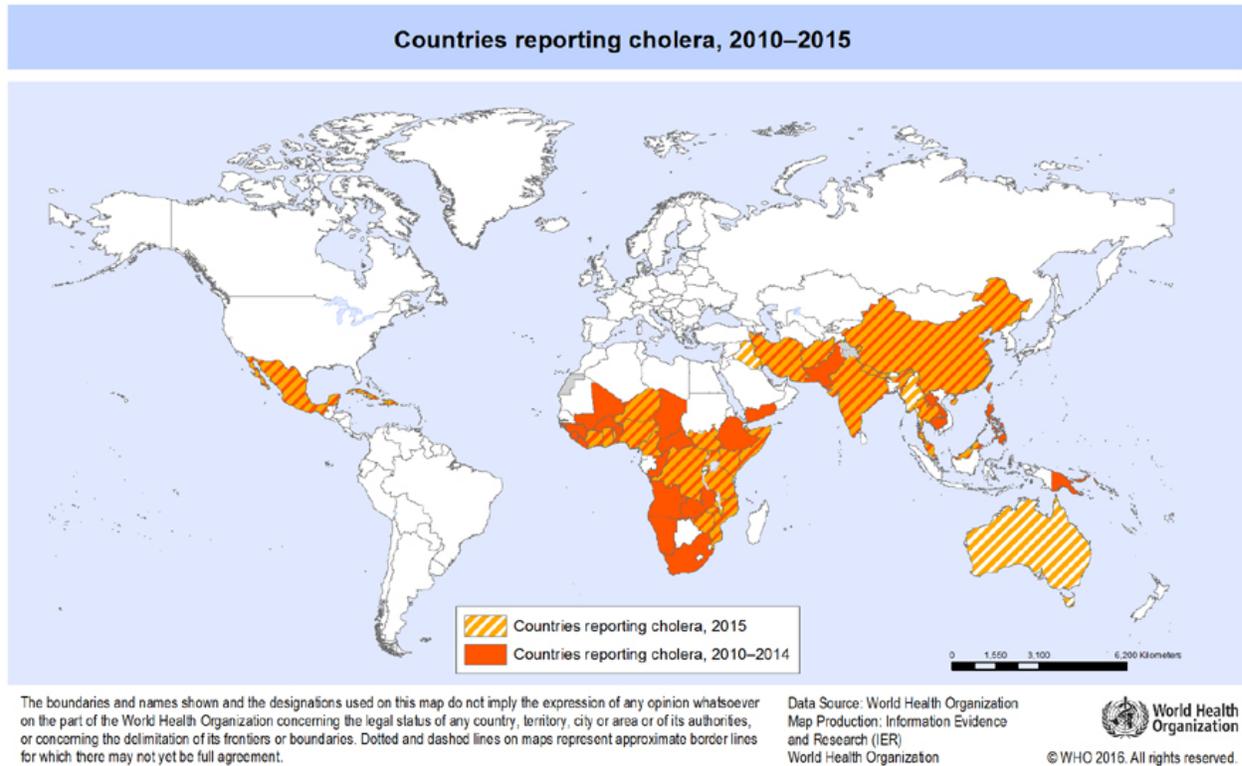
Topic I: THE CHOLERA EPIDEMIC OF 1961 AND GLOBAL DEVELOPMENT

Introduction

Cholera has been a near constant uphill battle in the world of public health since it first appeared on a large scale in the early 19th century. Since that first emergence, cholera has undergone seven separate pandemic outbreaks, with the current pandemic emerging in 1961 and continuing to this day (“Cholera”, 2017). One of the greatest challenges facing the battle against cholera is the lack of sanitation infrastructure in underdeveloped regions of the world, resulting not only in often discussed wealth inequalities but also in the perpetuation of a disease that spreads through sewage and bodily fluids. Today, it is estimated that there are between 1.3 million and 4.0 million cases of cholera, leading to between 21,000 and 143,000 deaths globally each year (“Cholera”, 2021). The wide variability in those numbers points to a similar trend: unequal development has allowed many viruses, cholera specifically, to continue existing in public health.

What is Cholera?

According to the World Health Organization, “Cholera is an acute diarrhoeal disease that can kill within hours if left untreated” (“Cholera”, 2021). It is a viral disease that causes acute diarrhetic symptoms, though symptoms may take between 12 hour and 5 days to appear after consuming any contaminated material. Cholera does not distinguish between adults and children, it affects all age groups and demographics similarly. Interestingly, infection by the bacteria *V. cholerae* does not guarantee the evolution of symptoms. However, even in the absence of symptoms, the bacteria is often present for days following exposure, which can result in infection of others in the local area. Symptoms can range from mild to severe, with major diarrhetic symptoms resulting in dehydrations serving as the primary cause of death. While many serogroups, or substrains of the bacteria, exist, the O1 serogroup is the main source of all recent outbreaks. A secondary serogroup, O139, has also caused an outbreak localized to Asia, with no major differences in mode of transmission or symptoms (WHO Cholera, 2021).



Cholera is spread through contaminated bodily fluids and other liquids. This most often is seen through contaminated water sources that are used communally, or in regions where wastewater is not treated properly. In many places where the disease is endemic, a lack of sanitation systems only exacerbates the issue. WHO describes the most at-risk communities as, “peri-urban slums and camps for internally displaced persons or refugees” (“Cholera”, 2021). As a direct result, the epicenter of most cholera outbreaks have been historically underdeveloped areas that lack advanced sanitation measures or water treatment options, often in Southeast Asia, Africa, or South America.

Issues in underdevelopment extend beyond infection. Treatment options are typically lacking in the most heavily affected areas, where rapid treatment with intravenous fluid to prevent dehydration combined with antibiotics to halt the infection are the best option. More recently, oral vaccinations for cholera have been developed to enhance resistance to the disease in areas where access to clean water and a working sewage system may be at risk (“Cholera”, 2021). Diagnosis is similarly difficult, as the only true method to ensure symptoms are truly the result of cholera is through the use of rapid diagnostic tests that flag samples to be sent for culturing and monitoring at a laboratory. These tests are often only conducted, however, in cases where the symptoms are severe, despite mild and no-symptom infections allowing for continued

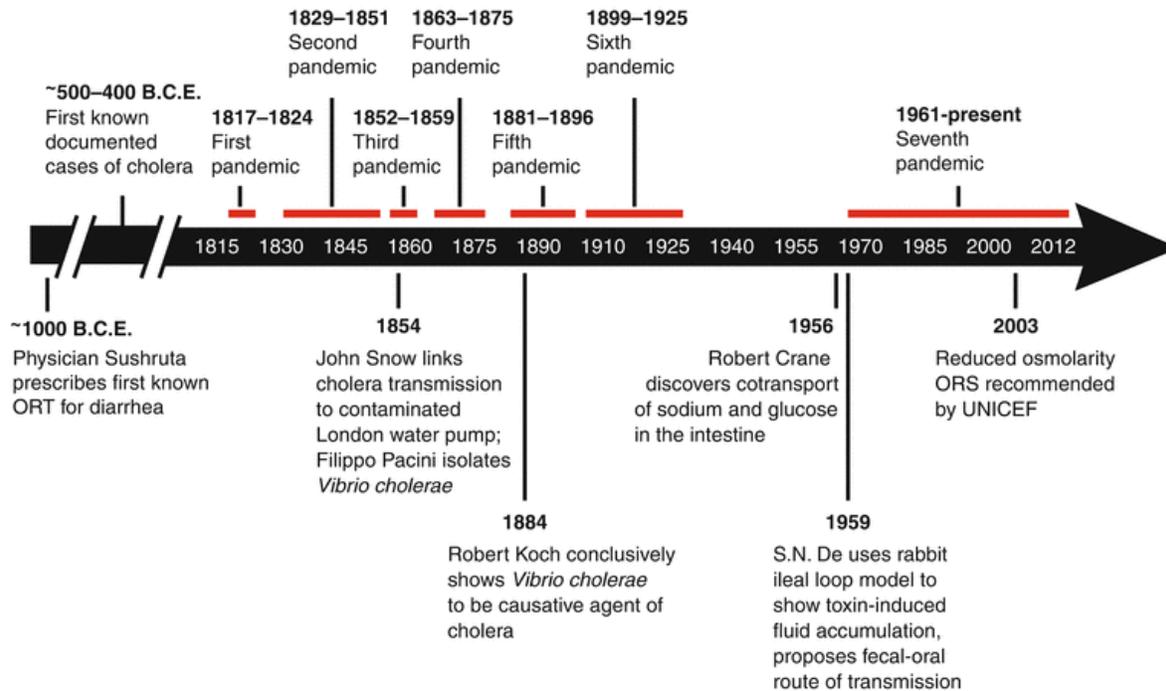
transmission. Nations or regions are also often hesitant to report full data reports on cholera outbreaks for fear of trade, tourism, or global reputation repercussions (“Cholera”, 2021). This can produce a cycle of cholera outbreaks, where low development produces a high risk for cholera, which can reduce trade through fear of transmission, reducing the funds present to develop suitable infrastructure and in turn creating an even higher risk for cholera.

Global State of Affairs in 1961

The world in 1961 was a volatile place, not only for the renewal of a cholera outbreak but also due to the global political conflicts of the Cold War. As conflicts reached a fever pitch between the United States and the Soviet Union, the impact on public health management cannot be overstated. While no direct warfare took place between the two global superpowers, the outbreak of proxy wars maintained a steady stream of health crises in wartime. The development of war produces situations that demand the attention of regional health officials, such as large numbers of injuries, outbreaks of treatable diseases on the battlefield, and even the presence of fallen soldiers or civilians that must be properly taken care of. Not only that, but the mere existence of a global conflict that had created proxy wars in Asia, Africa, and Eastern Europe resulted in a dampening effect on all attempts at global cooperation, regardless of the issue (Jakovljevic et al., 2018).

Beyond the issues of tensions and wars, the issue of priority also presents itself in 1961. While public health crises may be of grave concern to some, namely those in the World Health Assembly, it is important to remember that the Bay of Pigs Invasion and Berlin Crisis both took place in the same year as cholera’s resurgence. World leaders are facing a variety of issues on the global stage that extend beyond your purview as public health officials that also need addressing by this committee. This is perhaps one of the primary questions presented by the World Health Organization, of how to convince world leaders to care about public health on a global level. Navigating a crisis of international relations is a task often undertaken by global health officials, and the world in 1961 was as volatile as one could imagine, to say nothing of the Cholera outbreak itself.

The 1961 Outbreak Timeline



While outbreaks in cholera have been occurring for centuries, the majority of the scientific understanding on the disease was gained within the last 200 years. The linkage of cholera outbreaks to faulty water pumps was the first key to unlocking the puzzle of the disease, and future research demonstrated the specific biochemical mechanisms by which cholera progresses. Despite this growth in knowledge, however, cholera persists as a major disease in the global sphere. The seventh outbreak of cholera began in 1961 and still continues today, which has been marked by the growth of treatment and diagnosis options despite ongoing issues in sanitation and unequal development, which will be discussed further later.

The Cholera Outbreak of 1961 began in Indonesia, an unique starting location for Cholera pandemics to that point. From there, it quickly spread across Southern Asia to eventually reach Africa in 1971. The disease soon spread beyond Eurasia and Africa to reach the Americas in 1991 (“Cholera”, 2021). By 1990, nearly all reported cases to the World Health Organization were from Africa (“Cholera”, 2017). Since the beginning of the outbreak, the disease has, as expected, become a disease of largely impoverished and less-developed nations.

Sanitation and Unequal Development

As previously discussed, unclean water and sewage is the primary mode of transmission of cholera and serves to perpetuate the disease when it reaches an area. In that context, lack of water treatment infrastructure, and thus development, is the main problem facing cholera prevention, treatment, and ultimately, eradication. Yet, Africa has long suffered and continues to suffer from failures of international development and systemic economic inequality. A 2017 study conducted by the United Nations Development program found that despite adoption of the Millenium Development Goals and other international aid programs, over half of Africa's population continues to live on less than \$1.25 a day (Harsch, 2017). Beyond economic misfortune, the continent of Africa suffers from severe economic inequality, with 10 of the top 20 most unequal countries being African despite increased focus on broadly reducing poverty and improving quality of life (Harsh, 2017). While Southeast Asia and South America have generally fared better in recent history, the 1960's stand as similarly economically challenging periods in history (Elias and Noone, 2011).

In general, nations suffering from economic depression cannot be expected to maintain high quality infrastructure, and this case is no different. One study found that from 1960 even to today, some rural African borehole wells experienced large degrees of both chemical and pathogenic contamination. The suggestion was that regulation and management be used to reduce the possibility of failing water systems, but legislation has accomplished relatively little during that time frame (Lapworth et al., 2020). In 1950's South Africa, for instance, water scarcity and low water quality resulted in the passage of the Water Act, which enabled government control of water resources and allowed for the racialization of water. In turn, quality water access was reduced to those with power in the South African system (Tempelhoff, 2017). Legislation therefore did little to curb the ongoing water crisis, with improvement to water quality seemingly occurring in spite of legislation, rather than because of it.

As a result of these problems, much international aid for development has moved toward Africa, especially given South America and Southern Asia's dual rises to economic growth in recent history. However, a variety of challenges to infrastructure and aid present themselves when discussing sanitation and development. While each state undergoes individual crises, the general trend of problems preventing international development remains the same. Issues such as rampant political and economic corruption reduces the effectiveness and availability of funds, systemic discrimination eliminating access to improvements for all civilians, and armed conflicts halting progress in nearly every regard constantly challenge ongoing aid (Harsch, 2017). As a result, new aid is hesitant to flow to the region. Failure of attempts at aid on the

ground can also be attributed in part to failure of implementation by international development agencies, with misidentified goals and failed attempts and social improvement leading to misuse of funding (Ajeagbo, 1984). Ultimately, aid and investment in Africa and Southeast Asia has been overall positive, but multifaceted failures have resulted in development in sanitation and infrastructure being unequal at best. The presence of cholera in the region continues to serve as an indicator that not enough has been done to stimulate development and establish lasting water infrastructure.

Early and Current Mitigation Attempts

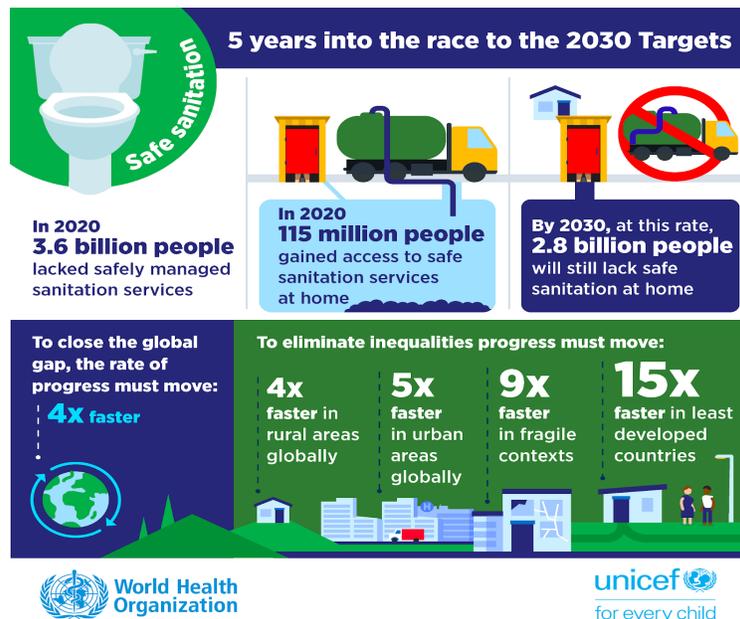
Despite multiple attempts to mitigate the cholera epidemic, the seventh outbreak of cholera still continues to this day. The success rates of these treatment and mitigation strategies vary, and may serve as a template for any novel ideas into reducing the severity of the outbreak.

Chiefly among the mitigation strategies used in the early stages of the outbreak were the use of health education campaigns, hosted by the World Health Organization and other local health agencies. The WHO aimed to encourage the use of basic hygiene practices, such as washing hands with soap and water following using the restroom or handling potentially contaminated materials, disposing of human waste properly, and safe preparation or storage of food and beverages. Additionally, these health campaigns sought to destigmatize cholera on a global level while educating the local public on symptoms, transmission, and treatment options. By breaking the global stigma and encouraging development in areas that suffer from cholera outbreaks, the outbreak could potentially be halted in the future. The success rate of the health education campaigns is hard to measure, though education is generally viewed as a critical step to mitigating health crises (“Cholera”, 2021).

Beyond education, the WHO encouraged the growth and development of water sanitation practices, arguing to this day, “The long-term solution for cholera control lies in economic development and universal access to safe drinking water and adequate sanitation” (“Cholera, 2021). For this reason, the World Health Organization adopted a policy of encouraging water, sanitation, and hygiene solutions (WASH) in all cholera hotspots. This strategy was and is believed to not only reduce the spread of cholera but a plethora of other water borne illnesses, in turn reducing hospital capacity and enabling an eventual end to the epidemic. Encouraging infrastructure and development in WASH solutions is considered to be the ultimate solution and eventual goal, in compliance with the United Nations Sustainable Development Goals SDG 6 (“Water, Sanitation, and Hygiene”, 2021).

Other than education and treatment, however, few measures were taken to halt the spread at the start of the outbreak. The quick spread from Indonesia to Africa and South America is evidence of that. Treatment materials were moved to cholera hotspots, but no overarching goal of cholera elimination was fully realized and acted on until recent history.

In 2014, the Global Task Force on Cholera Control (GTFCC), a network of more than 50 non-affiliated partners working to stop the spread of cholera, was revitalized by the World Health Organization in an effort to mitigate the current situation. Today, the GTFCC seeks to provide a forum on cholera specific issues and donors to fund novel research and development into cholera treatment and reduction measures. Furthermore, the GTFCC aims to bring cholera into the global spotlight by bringing media attention to the lack of development and growing public health crisis, in turn bringing more funding and research to the issue (“Cholera”, 2021).



Finally, the World Health Organization has drafted a series of proposals and policy guidelines moving forward, with the goal of reducing cholera deaths by 90% and eradicating cholera in at least 20 countries. This Roadmap to 2030 was adopted in 2018 and features three primary strategic axes based on the WASH guidelines. First, it aims to improve monitoring and surveillance measures to allow for earlier detection of new outbreaks and better data collection on ongoing outbreaks. Second, it seeks to reduce and stop instances of cholera recurrence by encouraging states to develop heavily in already known cholera hotspots, preventing outbreaks in areas that have already been hit. Third, it sets the goal of embellishing the GTFCC, establishing it as the primary forum on cholera control and research and bringing additional funding and media attention to the issue of cholera. In this sense, the Roadmap to 2030 works to further

develop existing infrastructure and plans on reducing cholera, simplifying solutions and providing technical experience to those already in the field. Through this plan, the World Health Organization believes the seventh outbreak of cholera can finally approach an end after 80 years of existence (“Global Roadmap”, 2018).

Questions to Consider

1. Does the lack of fair and equal development in public health facilities such as sanitation and water purification constitute a public health crisis, and if so, what steps can the World Health Organization take to create more equal development?
2. How can the World Health Organization ensure that all nations are receiving equal treatment as diseases are researched and treated?
3. What steps can be taken to prevent the spread of diseases like cholera beyond their local regions, thus producing endemic outbreaks in other nations?
4. How can public health and medicine be conducted free of political affiliation in light of conflicts between the United States and the Soviet Union?

Topic II: WAR, PEACE, AND DISEASE: THE SPANISH FLU

Introduction

The 1918 influenza pandemic was the most severe pandemic of the 20th century. It was caused by an H1N1 virus with genes of avian origin. It is estimated that about 500 million people or one-third of the world's population became infected with this virus. The number of deaths was estimated to be at least 50 million worldwide with about 675,000 occurring in the United States ("1918 Pandemic", 2019). While the 1918 influenza pandemic eventually reached an end, where the virus began to regress in intensity, the impact of one of the deadliest viruses in history continues to reverberate today. Measures taken during the COVID-19 pandemic reflect many of the concerns from 1918, and variants of the flu today can be traced back to the 1918 ancestor.

For this topic, delegates will place themselves in the middle of the pandemic and have to deal with the growing number of cases along with the struggles of a global war. While some of the countries represented were not in their current form or may not have existed during this time period, it is assumed that they do exist for this committee.

World War I

The First World War was a global war fought from July of 1914 to November of 1918. Many factors such as nationalism, expansionism, and political alliances were brewing leading up to the war; however, the event that sparked the war was the assassination of the Archduke Franz Ferdinand of Austria-Hungary by the Serbian Gustavo Princip on June 28, 1914. A month later on July 28, 1914, Austria-Hungary declared war on Serbia. European countries like Britain and France expanded their empires greatly leading up to the war, and it resulted in increased tensions between them. Opposing empires such as the Ottoman and Austria-Hungary began forming alliances within themselves. These alliances were informal and were based on former pacts between the empires. The two major alliances were the Triple Entente (Russian Empire, British Empire and French Empire) and the Triple Alliance (Germany, Austria-Hungary and Italy). When the war began, these alliances led to the formation of the Allied and Central Powers. Political forces such as nationalism were another factor leading to the war. Serbian nationalism, in particular, was a driving force in creating tensions between the empires.

The end of the war came in November of 1918 when Germany signed an armistice agreement with the Allies. Germany reached this point following some key changes in the war effort. American forces did not enter the war until 1917, and once they did, the Allied Powers were too strong for the Central Powers. In 1919, the Treaty of Versailles was signed, forcing Germany into some unfavorable terms which in the years to come unintentionally caused the second world war. The war brought technological changes to warfare, fall of empires, new nations and redrawn boundaries. Some countries were prosperous, while others entered recessions. Social and economic reform also came about globally. Modern surgery was born in the First World War, where civil and military hospitals acted as theatres of experimental medical intervention. Millions of veterans survived the war but were left maimed, mutilated and disfigured (Cameron, 2014). Class structure was challenged post-war, and representation of the lower class in politics increased. Globally, tensions were high resulting in minimal cooperation between combative nations.

Spanish Flu and its Epidemiology

The origin of the Spanish flu has no universal consensus. The first known case was in Kansas, USA in March of 1918. In the following month, more cases began to be recorded in countries such as France, Germany and the United Kingdom.

The virus itself had some unique characteristics that made it one of the most deadly pandemics in history. Most influenza viruses affect the younger (under 5 years) and older (over 65 years) populations. The mortality for the H1N1 virus, however, was much higher than normal. In particular, the mortality of those aged 20-40 years old was particularly high. Even today, the properties of the virus which made it such a terrible one are not fully understood (Jordan, 2019). The effect of the influenza epidemic was so severe that the average lifespan in the United States was lessened by 10 years. The death rate for 15 to 34-year-olds of influenza and pneumonia were 20 times higher in 1918 than in previous years (Billings, 2005).

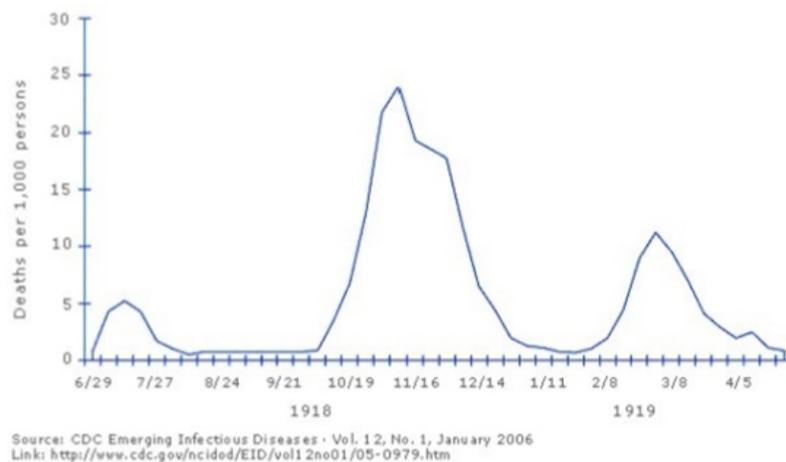
While common medicine is able to diagnose the flu relatively quickly, physicians in this time were forced to rely on signs and symptoms rather than a test. Many of the symptoms of this strain were similar to past flu viruses, but they were more severe. They included:

- Sudden, and sometimes very high, fever
- Dry cough
- Headache and body aches
- Sore throat
- Chills
- Runny nose

- Loss of appetite
- Extreme tiredness (fatigue)

The pandemic came in four waves; the first wave's (early 1918) symptoms were similar to the common flu viruses. The second wave (late 1918), however, was much more serious. Bacterial pneumonia (a bacterial infection of the lungs) complicated cases and often resulted in death. Reports of skin spots covering bodies followed by fluids filling lungs arose. Other new signs and symptoms included nosebleeds, loss of hearing and smell, impaired vision, and teeth and hair loss (Spinney, 2017). The third (1919) and fourth (1920) waves were more cases of the second wave but on a larger scale. Mortality rates were highest in the second and third waves, with the fourth wave being mostly isolated cases in different cities around the globe.

Pandemic Waves (1918-1919)



Misinformation

Ways information spread in the early twentieth century grew by a large margin. Electricity was growing as a global source of power, and communication methods such as telegraphs, radio, and telephones grew with it. This massive increase in communication methods allowed for more information-whether true or false-to spread faster. World War I is one of the first instances where misinformation plays a large part in the outcomes of the war.

The name Spanish flu itself is a misnomer. The origin of the virus was not in Spain, but misinformation was spread. This started in England when a paper published an article using the name “Spanish Influenza.”

**SPANISH INFLUENZA--A NEW NAME
FOR AN OLD FAMILIAR DISEASE**

**Simply the Same Old Grip That Has Swept Over the
World Time and Again—The Last Epidemic
in the United States Was in 1889-90.**

ORIGIN OF THE DISEASE.
Spanish influenza, which appeared in Spain in May, 1889, swept over the world in numerous epidemics as far back as history runs. Hippocrates refers to an epidemic in 412 B. C. which is regarded by many to have been influenza. Every century has had its attacks. Beginning with 1831, this country has had five epidemics, the last in 1889-90.

THE SYMPTOMS.
Grip or influenza as it is now called, usually begins with a chill followed by aching, feverishness and sometimes nausea and dizziness, and a general feeling of weakness and depression. The temperature is from 100 to 104, and the fever usually lasts from 3 to 5 days. The germs attack the mucous membrane, or lining of the air passages—nose, throat and bronchial tubes—there is usually a hard cough, especially bad at night; oftentimes a sore throat or tonsillitis, and frequently all the appearances of a severe head cold.

THE TREATMENT.
Go to bed at the first symptoms—take a purgative, eat plenty of nourishing food, remain perfectly quiet and don't worry. Nature herself is the only "cure" for influenza and will

heat of the body liberates the ingredients in the form of vapors. These vapors, inhaled with each breath, carry the medication directly to the parts affected. At the same time, VapoRub is absorbed through and stimulates the skin, attracting the blood to the surface, and thus aids in relieving the congestion within.

NO OCCASION FOR PANIC.
There is no occasion for panic—influenza or grip has a very low percentage of fatalities—not over one death out of every four hundred cases, according to the N. C. Board of Health. The chief danger lies in complications arising, attacking principally patients in a run down condition—those who don't go to bed soon enough, or those who get up too early.

HOW TO AVOID THE DISEASE.
Evidence seems to prove that this is a germ disease, spread principally by human contact, chiefly through coughing, sneezing or spitting. So avoid persons having colds, which means avoiding crowds—common drinking cups, roller towels, etc. Keep up your bodily strength by plenty of exercise in the open air, and good food.

KEEP FREE FROM COLDS.

A couple of factors played a role in the spread of propaganda and lies surrounding the outbreak. Because of the large casualty numbers, media control was needed to keep morale up. Many countries failed to inform its people of the disease in order to keep said morale high; they developed a central command office for propaganda and censorship. The United States entered the war in April 1917, fully two-and-a-half years into the conflict, and created its own Committee on Public Information and its own Censorship Board (Chorba, 2018). Furthermore, in May of 1918, Woodrow Wilson signed the Sedition Act. It was an extension to the Espionage Act of 1917, which forbade the use of "disloyal, profane, scurrilous, or abusive language" about the United States government, its flag, or its armed forces or that caused others to view the American government or its institutions with contempt (Kessler, 2018). Similar preventions occurred in European countries. In Austria-Hungary, the War Press Office (*Kriegspressequartier*) was founded as a central censorship and propaganda institution. The institution contained over 750 writers, journalists, photographers and filmmakers who all would prepare pictures or writings of the frontlines for the public but leave out key aspects of the war like disorder, carnage and disease (Chorba, 2018). Unlike many of the combative countries the Spanish press were covering the growing pandemic. As a result, Spain was one of the only countries to spread true information regarding the virus and its spread. Some accounts in the United States show that the paper and other

press outlets would report the halt of the disease, even though cases grew by 1,500 the night before.

Public Health Crisis

The war brought the spread of many new diseases, and quick responses were required in order to treat these diseases. Widespread use of treatments and vaccinations increased, and innovations to medical technology came about. New antiseptics were developed to clean wounds, and improved personal hygiene was encouraged for soldiers (Clarke, 2014). The treatment of wounded and sick needed to be more organized and controlled. Militaries would draft surgeons and other medical professionals and bring them closer to the frontline. In hindsight, this proved to be a misguided decision as healthcare at home became more limited. A crisis was afoot, with infectious disease spreading quickly. In fact, research shows that infectious diseases resulted in more casualties than war-inflicted wounds (Chorba, 2018). Water purification and improved sanitation were implemented to mitigate the spread of diarrheal and dysenteric diseases on the frontline. These methods would prove useful when the influenza outbreak occurred.

What proved to be a key factor to the spread was the return home of soldiers. While the war ending was good for the global political scene, it was harmful to the global health scene. Many soldiers would return to their homes with the disease, and some estimates place 30% of transmission occurring in the household (Ferguson et al., 2006). The global spread of the disease was quick with the first known case in March of 1918. By the late spring of 1918 three quarters of French troops and more than half of British troops contracted the disease. By July, cases had appeared in North Africa, India, China, and Australia (Martini et al., 2019). Within six months, the Spanish flu had reached every continent on the globe. Many non-pharmaceutical inventions such as isolation, quarantine, good personal hygiene, use of disinfectants, and limitations of public gatherings were used in response to the pandemic (Jordan, 2019). The global spread was quick and the number of mortalities was even quicker. With European politics reforming, access to care became difficult, and the countries that survived the war had their own cases to treat. Without a global force for healthcare, a coordinated treatment plan was difficult to achieve. The World Health Organization not having been created, the global response to the pandemic was brackish and inadequate.

Mitigation

Currently, the best treatment for the influenza virus is a vaccine. However, the nature of the virus is to mutate quickly, preventing a single vaccine from completely

preventing all influenza infections. Each year, the influenza vaccine must be modified to the strains circulating the globe; the WHO is responsible for the study and creation of the yearly vaccine (World Health Organization, 2000). When the H1N1 virus spread in 1918, a vaccine against the flu did not exist. Because of this other methods of prevention were implemented by different countries across the globe. Research has shown that measures like school, church, and theater closings were implemented. In the United States, weddings and funerals with an attendance over 20 were banned; a face mask requirement and curfew were also introduced in some cities (Bardi, 2015).

Unfortunately, not many other forms of mitigation were used globally. The strain of this virus never truly was eradicated, most notably making appearances in the Russian flu pandemic of 1977 and swine flu pandemic of 2007. The overall cases dropped after a few years, and research into the virus was not conducted in the years following.

Spanish Flu Pandemic Timeline

A TIMELINE OF THE 1918 PANDEMIC

This one was different.

The 1918 influenza pandemic killed more than 50 million people around the world. The H1N1 flu virus strain, also known as 'swine flu,' targeted healthy adults and the usual flu victims - the very young, the very old and people with existing health conditions.



MARCH – AUGUST 1918
Influenza Surfaces in Numerous Military Camps Worldwide
Flu spread quickly through military training camps in the U.S. The first reported outbreak was at Camp Funston, Kansas, and it spread through military units in the U.S. and Europe. At that time, the illness was mild and did not cause much alarm.

MAY 1918
Spain's King Alfonso XIII Falls Ill With Flu
Since Spain stayed neutral during World War I and therefore did not implement wartime censorship restrictions on the press, King Alfonso XIII's illness was reported widely. This reporting resulted in the term 'Spanish flu,' although it is unlikely that the pandemic began in Spain.

AUGUST 1918
Flu Reappears in Military Camps, More Lethal Than in the Spring
People who caught pneumonia as a secondary infection to flu were the most likely to die. Some died within hours of the first symptoms. Several outbreaks of the lethal strain occurred in late June, but not until August was the problem widespread.



OCTOBER – NOVEMBER 1918
Flu Kills Millions Worldwide

As within the military camps, flu quickly kills civilians who contract pneumonia as a secondary infection. The illness triggered a massive immune response, causing the lungs to fill with fluid. Patients tended to develop cyanosis (a bluish cast to the skin) due to a lack of oxygen, and they drowned from the excess fluid in their lungs.

SEPT. 28, 1918
Philadelphia Holds Liberty Loan Parade
Philadelphia holds the largest parade in the city's history to raise money for the Liberty Loan campaign. Two days later, the illness was widespread throughout the city.

SEPT. 26, 1918
Military Cancels October Draft
Army Provost Marshal Enoch Crowder cancels the October draft to reduce the spread of flu in military camps.



SEPTEMBER 1918
Milton Rosenau Takes Commission in Boston
Lieutenant Commander Dr. Milton Rosenau had left his position on the Harvard faculty to serve in the Navy. In early September, he oversaw an outbreak of flu at Boston's Chelsea Naval Hospital. Navy authorities in Philadelphia took Rosenau's warnings seriously, especially given that troops from Boston were being dispatched to Philadelphia. Despite isolation of the transferred men, more than 600 became ill in Philadelphia within one week of the transfer. [John M. Barry, *The Great Influenza: The Story of the Deadliest Pandemic in History* (New York: Penguin Books, 2004).]
Rosenau came to UNC in 1936 as director of the School of Medicine's Division of Public Health. When the division became a school in 1940, he was its first dean.

OCT. 26, 1918 – JAN. 21, 1919
Edward Kidder Graham and Marvin Hendrix Stacy Die
UNC President Edward Kidder Graham died from pneumonia on Oct. 26, 1918, at age 42. Stacy became acting president after Graham's death, but died from flu complications three months later at age 41.



APRIL 3, 1919
Woodrow Wilson Contracts Flu During Paris Peace Conference
Wilson's illness forced him to miss several days of negotiations. Although he recovered, many point to this illness as the beginning of a decline in his health. He died about five years later (Feb. 3, 1924), at age 67.

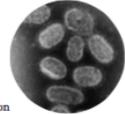


DECEMBER 29, 1919
William Osler Dies
Sir William Osler, known as a pioneer of modern medicine, dies at age 70 from flu complications. Most deaths occurred in late 1918 and early 1919, but deaths continued into the early 1920s.



Photo courtesy of McMaster University

1933
Discovery of Human Flu Virus
After an intense quest and competition among various individuals, National Institute for Medical Research scientists C.H. Andrews, Patrick Laidlaw and Wilson Smith isolate the pathogen that causes human influenza. During the 1918 pandemic, the cause of flu was unknown.



Thanks to Dawne Lucas and others at the UNC Health Sciences Library for the library's online exhibit, where this timeline first appeared. Learn more at: go.unc.edu/HSL-flu-exhibit.

Questions to Consider

1. When nations are at war, what factors should be considered when a disease infects all? Should an organization such as the WHO serve patients on one side over the other or should a neutrality be established? What other problems should be solved when a new form of war influences the spread of this disease?
2. Modern medicine has changed the landscape for treating illness quickly and effectively. How do you solve issues in public health where such measures do not exist or are too hard to reach? How do you give effective care on a global scale?
3. Should one country receive a different care than another? If not, how can you ensure equality for all during this time?
4. Misinformation can harm the treatment of disease. Additionally, it can prevent effective methods for stopping the spread of a virus. What methods should be used for combating misinformation on illnesses and their treatments? Who should be responsible for obtaining and presenting the vital information to the public?

Delegation List

Delegates will comprise the 34 countries currently sitting on the World Health Organization Executive Board, acting as representatives of both their state and of global public health.

1. Africa
 - 1.1. Botswana
 - 1.2. Burkina Faso
 - 1.3. Ghana
 - 1.4. Guinea-Bissau
 - 1.5. Kenya
 - 1.6. Madagascar
 - 1.7. Rwanda
2. Americas
 - 2.1. Argentina
 - 2.2. Columbia
 - 2.3. Peru
 - 2.4. Grenada
 - 2.5. Guyana
 - 2.6. Paraguay
3. Southeast Asia
 - 3.1. Bangladesh
 - 3.2. India
 - 3.3. Timor-Leste
4. Europe
 - 4.1. Austria
 - 4.2. Belarus
 - 4.3. Denmark
 - 4.4. France
 - 4.5. Russian Federation
 - 4.6. Slovenia
 - 4.7. Tajikistan
 - 4.8. United Kingdom of Great Britain and Northern Ireland
5. Eastern Mediterranean
 - 5.1. Afghanistan
 - 5.2. Oman
 - 5.3. Syrian Arabic Republic
 - 5.4. Tunisia
 - 5.5. United Arab Emirates
6. Western Pacific
 - 6.1. Japan
 - 6.2. Malaysia
 - 6.3. Republic of Korea
 - 6.4. Singapore
 - 6.5. Tonga

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