Royal Model United Nations
2026

H-UNFPA

SELİN
AYAZ

PRESIDENT CHAIR

CANSU
USLU

DEPUTY CHAIR

GÖLGEM
GÖBEL

ACADEMIC ASSISTANT

BOSPHORUS
COLLECTIVE

Royal Model United Nations 2026

LETTER FROM THE SECRETARIAT

Dearest participants of ROYMUN'26,

It is the greatest honor to welcome you to the first edition of Royal Model United Nations 2026 and our H-UNFPA committee.

While shaping the ideas from the very beginning, our main goal was to ensure an extensive experience with both academic and organisational perfection.

In this prestigious committee, you will be raising impeccable ideas, debating about the current and the upcoming process, building new structures and turning the non-integrated actions and solutions to a masterpiece. Your board members will be guiding you to reach perfection in any situation.

While preparing, you will be discovering every single step about your topic and you may even find yourself in the middle of this sequence of events. It will be clear that you embrace your role in the committee.

Keep in mind that every speech you deliver, every motion you give, every question that you ask will gain a new perspective for everyone. The key point is to remain active and work confidentially while shaping the decision-making process with your colleagues.

As the Secretary-General, I am impatiently waiting to see your intelligent work and looking forward to sharing this royal experience with you.

Sincerely,
İmge Belgin
Secretary-General of ROYMUN'26

LETTER FROM THE CHAIRBOARD

Dear delegates,

Welcome to ROYMUN'26 and H-UNFPA Committee! We are Selin Ayaz and Cansu Uslu, your committee board members. We are having the honor to serve as the board members of this committee. On behalf of the Committee Board for the H-UNFPA Committee, we extend our warmest welcome to all delegates. We are thrilled to have you participate in this prestigious Model United Nations conference. UNFPA deals directly with sexual health, contraception, and gender dynamics. As delegates, you have a unique opportunity to engage in meaningful debate, negotiation, and problem-solving to address these pressing issues. This study guide contains many prominent information about the agenda while giving an open space for you to also do your own research. Remember, regardless of your country's position in the agenda, you are all equal in the committee and you have all the resources in your hands to come up with great solutions and innovative ideas to achieve the goals set by the committee.

We wish you all the best in your preparations and look forward to seeing you at ROYMUN'26.

Sunshine and Rainbows,
Selin Ayaz, Cansu Uslu

TABLE OF CONTENTS:

I. Welcoming Letters

A. Letter from the Secretary General

B. Letter from the Committee Board

II. Introduction to the Committee: H-UNFPA

A. History and Mandate

B. Powers and Limitations

III. Agenda Item: Global AIDS Epidemic

A. Historical Background of the AIDS Crisis

1. Emergence of HIV/AIDS

2. Initial responses

3. Scientific progress timeline

B. Demographic and Population Dimensions

1. Population Growth and Public Health Capacity

2. Youth and Reproductive Health

3. Women and the Feminization of the Epidemic

4. High-Risk and Marginalized Populations

C. Sociopolitical Dimensions

1. Stigmatization and moralization

2. Criminalization and Legal Exclusion

3. Religion and Conservatism

4. Public health incapacity and structural vulnerabilities

TABLE OF CONTENTS:

D. International and Institutional Response

1. UN Response

2. Major stakeholders

i. World Health Organization

ii. United Nations Population Fund

iii. National governments and ministries of health

iv. NGOs and activist organizations

3. Funding and Resource Allocation

i. Global disparities in healthcare funding

ii. Foreign aid and dependency

iii. Access to prevention infrastructure

4. Data Collection and surveillance

E. Regional Overview of the Epidemic

1. Sub-Saharan Africa

2. North America and Western Europe

3. Latin America

4. Eastern Europe and the Soviet Sphere

5. Middle East and North Africa

II. Introduction to the Committee: H-UNFPA

A. History and Mandate

The United Nations Population Fund (UNFPA) began its operations in 1969 as the United Nations Fund for Population Activities under the management of the UN Development Programme (UNDP). In 1971, the UN General Assembly designated its specialized role, and by 1972, it was placed under the direct authority of the General Assembly, establishing it as a distinct body within the UN system. The name was changed to the United Nations Population Fund in 1987, but the historic acronym UNFPA was kept.The UNFPA is an organization with the United Nations system that works to deliver a world where every pregnancy is wanted, every birth is safe, and every young person's potent is fulfilled. The organization works for various objectives including but not limited by ensuring universal access to comprehensive reproductive health care, including safe family planning, maternal health services, preventative sexual health education,assisting countries in collecting, analyzing, utilizing population data, promoting and protecting the human rights of women and youth, specifically focusing on gender equality and eliminating harmful practices.

B. Powers and Limitations

The delegates are expected to keep in mind the powers of the committee along with the limitations that are going to be stated in order to propose realistic solutions.UNFPA operates directly in over 140 countries. It possesses the power to allocate financial resources, distribute medical supplies such as contraceptives, testing kits, and sterile equipment and fund local healthcare infrastructure. The committee can draft comprehensive frameworks and standards for sexual education, maternal care, and epidemic prevention that member states use to build national laws. It trains local, doctors and community health workers, reinforcing local health systems to combat crises like HIV/AIDS independently. UNFPA can deploy technical teams to help countries track epidemic demographics, finding exactly where infection rates are spiking.

However UNFPA resolutions are strictly non-binding. The committee cannot force any member state to alter its domestic laws, criminal codes, or healthcare systems.The committee has no military or economic enforcement mechanism. It relies entirely on international cooperation,diplomacy and state consent. Because UNFPA deals directly with sexual health, contraception, and gender dynamics, its field operations are legally bound to respect national sovereignty. If a host government bans specific forms of sexual education or contraceptive distribution due to religious or cultural norms, UNFPA cannot bypass those restrictions. UNFPA is funded entirely by voluntary contributions from governments and private donors. It has no guaranteed budget, meaning its powers are tightly restricted by the political will of donor nations.

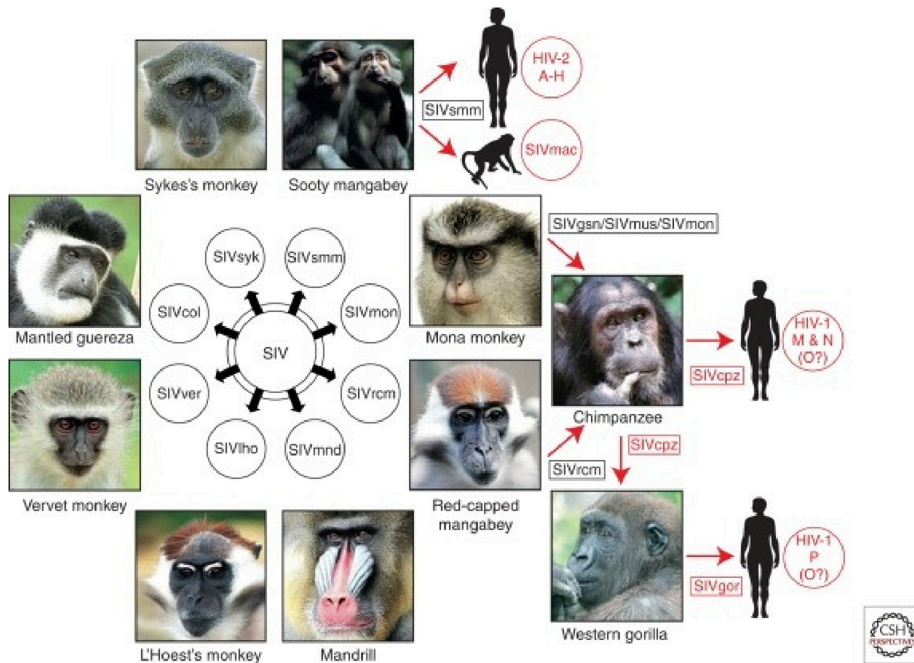
In conclusion, yes UNFPA possesses powers like distributing supplies and drafting frameworks however these powers are sometimes limited because of economical or cultural concerns.

III. Agenda Item: Global AIDS Epidemic

A. Historical Background of the AIDS Crisis

1. Emergence of HIV/AIDS

Human immunodeficiency virus (HIV) was started by zoonotic transmission(which means a virus jumping from animals to humans)in West-Central Africa during the early 20th century, where Simian Immunodeficiency Virus (SIV) mutated into HIV after humans hunted chimpanzees for meat. However it didn’t become an epidemic all of a sudden the virus spread silently for decades before emerging globally.



The official timeline of the modern epidemic began in 1981 when the US Centers for Disease Control and Prevention (CDC) published a report detailing five cases of a rare lung infection, Pneumocystis carinii pneumonia (PCP), among previously healthy young gay men in Los Angeles.The disease is initially called Gay-Related Immune Deficiency (GRID) because it is thought it only affects gay men. This clinical tunnel vision proved catastrophic: it ignored infections spreading rapidly through heterosexual populations, injection drug users, and hemophiliacs relying on blood transfusions. In September 1982, the CDC officially replaced GRID with the term AIDS (Acquired Immunodeficiency Syndrome), acknowledging that the disease did not discriminate based on sexual orientation.

2. Initial Responses

The early decades of the crisis were defined by fear, systemic neglect, and the urgent mobilization of civilian activists.

i. Government Inaction & Political Silence

Major world governments initially treated the epidemic as a moral issue rather than a public health emergency. In the United States, President Ronald Reagan did not publicly use the word "AIDS" until 1985, four years into the crisis, by which time thousands had died. This pattern of denialism played out globally, as many nations labeled the syndrome a "foreign" or "marginal" problem, severely delaying state-sponsored prevention campaigns, research funding, and resource allocation.Inaction reflects a political denial, an unwillingness to engage in sensitive issues, such as those inextricably linked to HIV transmission. Even though the positive political action during the later years at both the grassroots and governmental levels has greatly enhanced the global response to AIDS and Political action on AIDS also being an opportunity to correct underlying injustices and mobilize positive political momentum around issues such as gay rights. On the other hand, politics has been a negative force at times, blocking important policy developments and evidence-informed action on AIDS, particularly access to anti-retroviral treatment in poor countries, prevention of sexual transmission of HIV, and harm reduction in injection drug users.

ii. Media Sensationalism and Public Panic

Early media coverage amplified societal prejudices. News networks frequently referred to AIDS as the "gay plague." Sensationalist coverage stoked deep public panic, leading to widespread discrimination. HIV-positive individuals were fired from their jobs, evicted by landlords, and refused service by funeral homes. Children with the virus, such as teenager Ryan White in Indiana who was infected with HIV from a contaminated blood treatment , were banned from attending public schools due to the baseless fear of casual transmission. This shows how deep was the discrimination keeping people from their very basic human rights such as working and getting education.

iii. Medical Systems

Healthcare institutions were overwhelmed and under-prepared. Due to a profound lack of understanding regarding how the virus spread, and lack of state-supported research, some doctors and nurses refused to treat AIDS patients, while hospitals isolated patients in conditions that deepened their psychological trauma. Also the global blood supply remained contaminated for years because commercial blood banks resisted the implementation of costly screening protocols.

iv. Civilian Mobilization and Activism

Because institutions failed them, the affected communities started the mobilizations. Grassroots organizations provided palliative care, food, and emotional support to the dying. Groups like ACT UP (AIDS Coalition to Unleash Power) revolutionized public health activism through direct, disruptive action. They protested at Wall Street and the Food and Drug Administration (FDA), demanding shorter drug-approval processes, lower medicine prices, and an end to clinical discrimination. Their slogan, SILENCE = DEATH, became the defining rally cry of the era.

3. Scientific Progress Timeline

The scientific trajectory of HIV/AIDS fortunately and with the biggest contributions of the previously mentioned civilian mobilizations, shifted from complete medical helplessness to the development of life-saving, long-term management therapies.

i. Discovery of the Pathogen (1983-84)

Researchers led by Luc Montagnier at the Pasteur Institute in France and Robert Gallo at the National Cancer Institute in the US independently isolated the retrovirus responsible for AIDS. Initially given different names, it was internationally standardized as HIV (Human Immunodeficiency Virus) in 1986.

ii. The First Diagnostic Test-1985

The FDA approved the first commercial ELISA blood test. This milestone allowed blood banks to screen donations(however unfortunately as mentioned before the blood banks didn't want to use the test because of time and money concerns which led to a catastrophe) , cutting off transmission via transfusions, and made it possible for individuals to learn their status for the first time.

iii. The Monotherapy Era (AZT)-1987

The first antiretroviral drug, Zidovudine (AZT), was approved in record time. Originally developed as a failed cancer treatment, AZT worked by inhibiting the reverse transcriptase enzyme the virus uses to replicate. However, when used alone (monotherapy), the virus rapidly mutated against it. Unfortunately AZT also carried toxic side effects, including severe bone marrow suppression.

iv. Transmission Debates and Global Spread (1988-1993)

Intense international debates focused on transmission mechanics. While scientists proved that HIV could only be transmitted via specific bodily fluids (blood, semen, vaginal secretions, and breast milk), theories and denialist policies appeared. Most notably, the South African government under Thabo Mbeki rejected the viral link, attributing AIDS to poverty and malnutrition; this stance delayed antiretroviral rollout and cost hundreds of thousands of lives.

v. The HAART Breakthrough (1995-1996)

The introduction of Protease Inhibitors revolutionized treatment. Doctors developed HAART (Highly Active Antiretroviral Therapy), often called the "triple-drug cocktail." By combining three different classes of medications, HAART attacked the virus at multiple stages of its life cycle simultaneously, preventing it from mutating or developing resistance.

vi. The Great Global Divide

The HAART breakthrough transformed AIDS from a direct death sentence into a manageable chronic condition virtually overnight. However, this medical miracle cost upwards of $10,000 to $15,000 per patient annually in 1996. While mortality rates decreased in wealthy Western nations, the epidemic continued to devastate Sub-Saharan Africa and developing regions where healthcare systems could not afford the patent-protected, high-cost pharmaceuticals. This profound inequality sets the stage for H-UNFPA's historical interventions regarding reproductive health and access to care.

B. Demographic and Population Dimensions

1. Population Growth and Public Health Capacity

By 1995, the AIDS crisis had become both a public health emergency and also a major demographic and developmental challenge for many communities across the globe. Unlike many infectious diseases that disproportionately affected infants or the elderly, HIV/AIDS primarily targeted younger individuals in their most economically productive and socially active years. This gave the epidemic a uniquely disruptive demographic impact specifically. In heavily affected regions, especially as seen in Sub-Saharan Africa, rising HIV-related mortality reduced life expectancy, altered age structures, increased dependency ratios, and placed unprecedented strain on households and communities. Families often lost their primary income earners as adults became ill or died, children were withdrawn from school to work or provide care. As a result, communities faced growing numbers of orphans and vulnerable dependents. Thus, AIDS was not merely a health issue; it started to shape labor markets, educational outcomes, economic productivity, and long-term population development.

The epidemic also exposed the relationship between population health and state capacity. Effective responses to HIV/AIDS required functioning healthcare systems capable of providing testing, counselling, blood screening, epidemiological surveillance, public education, and long-term treatment and care. This meant a comprehensive and well-functioning healthcare system which was capable of delivering its contents to a wide range of people had to be present. However, many countries which were affected from the

vi. The Great Global Divide

The HAART breakthrough transformed AIDS from a direct death sentence into a manageable chronic condition virtually overnight. However, this medical miracle cost upwards of $10,000 to $15,000 per patient annually in 1996. While mortality rates decreased in wealthy Western nations, the epidemic continued to devastate Sub-Saharan Africa and developing regions where healthcare systems could not afford the patent-protected, high-cost pharmaceuticals. This profound inequality sets the stage for H-UNFPA's historical interventions regarding reproductive health and access to care.

B. Demographic and Population Dimensions

1. Population Growth and Public Health Capacity

By 1995, the AIDS crisis had become both a public health emergency and also a major demographic and developmental challenge for many communities across the globe. Unlike many infectious diseases that disproportionately affected infants or the elderly, HIV/AIDS primarily targeted younger individuals in their most economically productive and socially active years. This gave the epidemic a uniquely disruptive demographic impact specifically. In heavily affected regions, especially as seen in Sub-Saharan Africa, rising HIV-related mortality reduced life expectancy, altered age structures, increased dependency ratios, and placed unprecedented strain on households and communities. Families often lost their primary income earners as adults became ill or died, children were withdrawn from school to work or provide care. As a result, communities faced growing numbers of orphans and vulnerable dependents. Thus, AIDS was not merely a health issue; it started to shape labor markets, educational outcomes, economic productivity, and long-term population development.

The epidemic also exposed the relationship between population health and state capacity. Effective responses to HIV/AIDS required functioning healthcare systems capable of providing testing, counselling, blood screening, epidemiological surveillance, public education, and long-term treatment and care. This meant a comprehensive and well-functioning healthcare system which was capable of delivering its contents to a wide range of people had to be present. However, many countries which were affected from the

crisis had healthcare infrastructures which were already overstretched. Rural areas frequently lacked clinics and trained medical personnel, urban hospitals struggled with overcrowding, and many governments possessed limited administrative capacity to monitor and respond to rapidly evolving health threats. The crisis demonstrated that public health infrastructure should not be understood only as hospitals and medical equipment but rather as including trained professionals, public trust, data collection systems, transportation networks, pharmaceutical supply chains, and the ability of governments to coordinate large-scale prevention campaigns.
The epidemic also highlighted profound inequalities in the global distribution of healthcare resources. During the 1980s and early 1990s, many developing countries were undergoing economic crises, debt burdens, and structural adjustment programs promoted by international financial institutions (such as the International Monetary Fund and the World Bank). These reforms most often encouraged governments to reduce public expenditures and privatize state services. This meant limited social spending to be able to stabilize the countries' macroeconomics. While the impact of such structural adjustment varied across the countries, critics argued (and still do) that reductions in public healthcare spending weakened national capacities to respond to emerging health crises. In many low-income countries, governments struggled to finance preventive healthcare programs, maintain adequate staffing levels, or expand access to essential services. As HIV/AIDS spread, such pre-existing weaknesses became increasingly visible.

The crisis also revealed the unequal relationship between wealth and health outcomes on a global scale. It was seen that wealthier states generally possessed stronger healthcare infrastructures, harbored more advanced research institutions, and had greater access to pharmaceutical innovation. On the other hand, many poorer countries depended heavily on foreign aid, international organizations, and donor-funded programs to support their responses. This of course created significant disparities in prevention and care. While some governments could invest in public awareness campaigns and advanced research and medical treatment, others struggled to even provide basic services.

Another important nuance to note is, the governments which recognized the crisis earlier without any fear of stigmatization or any other political concern, had better outcomes in terms of their response. Capacity should be understood as a question of both funding and also one of political willingness, as it is an interconnected issue. States that openly acknowledged the crisis managed to mobilize public institutions more rapidly, which led to more effective response.

2. Youth and Reproductive Health

Young people occupied a particularly important position within the epidemic because they represented both one of the most vulnerable populations and one of the most critical targets for prevention efforts. By 1995, a significant proportion of new HIV infections worldwide were occurring among adolescents and young adults. This wasn't due to younger people being inherently more reckless or irresponsible than other ages, but because adolescence and early adulthood are periods characterized by major social, biological, and behavioral transitions. During these years, individuals begin forming sexual relationships, entering the labor force, migrating to urban areas, pursuing education, and gaining greater independence from their families. These transitions often increase exposure to situations in which HIV transmission can occur, while simultaneously placing young people in environments where access to reliable information and healthcare services may be limited.

One of the greatest challenges facing policymakers during the AIDS crisis was the widespread lack of accurate knowledge about HIV transmission among young people. Although awareness of AIDS had increased significantly since the early 1980s, information was often incomplete, inconsistent, or heavily influenced by social and political taboos. Since it was a sexually transmitted disease, in many countries discussions were seen as highly controversial, especially when they were targeted towards adolescents. Governments, schools, religious institutions, and parents frequently disagreed over whether sexual education should be provided at all, and if so, what form it should take. As a result, many young people entered adulthood without a clear understanding of how HIV was transmitted, how condoms functioned as a preventive measure, or how to access reproductive health services. Misinformation, myths, and fear often filled the gaps left by inadequate education.

The AIDS epidemic then exposed the limitations of approaches that relied exclusively on abstinence-based or morality-centered messaging. Such campaigns aim to discourage behaviors perceived as risky, but they frequently fail to provide practical information for individuals who are already sexually active, and turn a blind eye to this reality. In this time public health experts increasingly argued that effective prevention required comprehensive education that combined discussions of relationships, consent, contraception, sexually transmitted infections, and HIV prevention. By the mid-1990s, many international organizations were beginning to emphasize this perspective by arguing that young people should be treated as informed participants in public health efforts rather than passive recipients of moral instruction. This represented a significant shift in thinking, particularly in societies where youth were traditionally excluded from discussions regarding sexual and reproductive health.

After the 1994 International Conference on Population and Development (ICPD) in Cairo, the topic of reproductive health gained significant attention. By shifting away from previous strategies that prioritized limiting population increase and toward reproductive rights, individual choice, gender equality, and access to healthcare, the Cairo Conference signaled a significant shift in global population strategy. HIV/AIDS was widely recognized within this perspective as being inextricably linked to more general issues related to reproductive health. In addition to disease-specific therapies, access to contraception, sexual health education, maternal healthcare, counseling services, and information that empowered people to make educated decisions about their bodies and relationships were all necessary for preventing HIV transmission.

During the outbreak, young women were especially vulnerable. As will be discussed in the next section, gender inequality already hindered their ability to access healthcare independently and increased conditions of vulnerability. Young women often lacked the social or economic authority to put preventative strategies into practice, even if they were aware of them.

Youth vulnerability was also significantly shaped by economic factors. Rapid urbanization, unemployment, and poverty forced young people into dangerous circumstances in many developing nations. Migration to cities in pursuit of employment frequently increased exposure to hazardous situations and undermined established support systems. Young people who were struggling financially occasionally turned to transactional sex or other survival techniques that increased their risk of infection. Because of this, a number of academics and decision-makers started to contend that HIV prevention and more general development issues were inextricably linked. Young people's capacity to defend themselves against infection was impacted by social support networks, work prospects, and educational chances.

3. Women and the Feminization of the Epidemic

One of the most significant developments in the global AIDS epidemic by the mid-1990s was the growing recognition that HIV/AIDS was increasingly affecting women. During the early years of the epidemic, especially in North America and Western Europe, public discussions mostly associated the disease with gay men, intravenous drug users, or other groups identified as being at heightened risk. While these populations were heavily affected, such narratives obscured the reality that HIV was rapidly spreading among women in many parts of the world. By 1995, international organizations, public health experts, and policymakers were increasingly warning that the epidemic was becoming feminized, particularly in regions such as Sub-Saharan Africa where women represented a growing proportion of new infections. The term feminization of the epidemic refers to the fact that gender inequality was becoming an effective mechanism in the spread of the disease.

It's necessary to be able to go beyond purely biological reasons in order to comprehend the feminization of the epidemic. Women's vulnerability was largely influenced by social, economic, and political disparities, even while biological variables enhanced the risk of HIV transmission from men to women during heterosexual intercourse. Women had less influence over decisions about healthcare, family planning, and sexual relationships in many countries. They frequently lacked the capacity to resist risky sexual behavior, negotiate condom use, or end relationships that put them in danger. As a result, while participating in socially acceptable behaviors, many women became susceptible to HIV, indicating that vulnerability was frequently caused by unfair social institutions rather than personal decisions.

Numerous manifestations of gender inequality contributed to the HIV epidemic. Compared to men, women often had less access to healthcare services, less economic prospects, and lower levels of education. Women's financial reliance on male partners frequently hindered women's capacity to independently seek medical care or confront risky behaviors. Many women contracted the infection even though they continued to be in long-term monogamous partnerships because of cultural norms that accepted male infidelity while requiring female fidelity. Simultaneously, sexual assault, coercion, and abuse created further obstacles to healthcare and assistance and greatly increased susceptibility to infection. HIV prevention could not be successful without tackling more general concerns of gender inequality and violence against women, according to public health experts.

Significant demographic and developmental ramifications have resulted from the increasing impact of HIV/AIDS on women. In families, women were frequently the primary caregivers for children, older family members, and AIDS-affected family members. The consequences of women's illnesses went well beyond the individual; they weakened household stability, increased financial difficulty, and decreased support for dependents and children. Given that HIV can spread during pregnancy, childbirth, or nursing, the problem of mother-to-child transmission further reinforced the link between women's health and overall population results. Maternal health and HIV prevention could no longer be viewed as distinct policy domains by 1995.

Early beliefs that AIDS was predominantly concentrated among particular high-risk populations were challenged by the feminization of the pandemic. The increasing number of HIV-affected women showed how deeply ingrained the disease was in larger social and demographic institutions. Therefore, addressing the factors that made entire groups more vulnerable; such as unequal access to economic opportunity, education, reproductive healthcare, and legal protection; was necessary for effective prevention. This development brought to UNFPA's attention the intimate connection between gender equality, reproductive health, and population policy. The outbreak showed that social hierarchies and power dynamics influence health outcomes in addition to medical causes. As a result, the global response to HIV/AIDS increasingly focused on empowering women, boosting access to healthcare and education, and fighting prejudice.

4. High-Risk and Marginalized Populations

The AIDS epidemic's disproportionate effect on groups that were already socially disenfranchised prior to the onset of HIV/AIDS was one of its most politically sensitive features. Men who have sex with men (MSM), sex workers, people who inject drugs (PWID), prisoners, migrants, and underprivileged urban neighborhoods were among the groups with greater infection rates during the 1980s and early 1990s. Although these groups were frequently referred to as "high-risk groups," many public health professionals contended that the real problem was not identity per se, but rather the social, legal, and economic factors that made them more vulnerable and limited their access to treatment. Discussions thus began to move away from "high-risk populations" and toward ideas like structural vulnerability and high-risk situations.

During the early stages of the epidemic, men who have sex with men were among the groups most impacted, especially in Western Europe and North America. AIDS was frequently portrayed as a "gay disease," which fueled prejudice and gave the erroneous impression that most people were immune. However, LGBTQ+ people were frequently deterred from seeking testing and treatment due to legal constraints, societal stigma, and exclusion from healthcare institutions, which made prevention measures more challenging.
Sex workers faced similar challenges. In many countries, criminalization, violence, economic insecurity, and limited legal protections reduced their ability to negotiate safer practices or access healthcare services. Likewise, people who inject drugs experienced high infection rates due to needle sharing, yet many governments approached the issue primarily through criminal justice policies rather than public health measures. Debates over harm reduction initiatives such as needle exchange programs reflected broader tensions between punitive and health-centered approaches to social problems.

Risks were higher for other marginalized groups as well. Increased susceptibility was caused by a number of factors, including overcrowding in jails, poor healthcare, migration, unstable housing, and restricted access to information. Particularly, immigrants frequently experienced social marginalization, legal uncertainty, and language challenges while also being held accountable for the disease's spread. These instances brought to light a crucial aspect of the epidemic: social exclusion may turn into a risk factor for public health. Infections spread more readily and go unnoticed because those who were afraid of discrimination, incarceration, or stigma were less likely to seek testing, treatment, or prevention services.

At the same time, marginalized groups emerged as some of the key players in the international response. LGBTQ+ groups, associations for sex workers, advocates for harm reduction, and networks of individuals living with HIV/AIDS frequently mobilized before governments did, offering advocacy, support services, and education. Governments and pharmaceutical firms were effectively persuaded by groups like ACT UP to expedite research and increase treatment access. These campaigns showed that impacted communities were vital allies in the fight against the epidemic rather than just its victims.

The experiences of excluded groups, according to UNFPA, demonstrate the intimate connection between social inclusion, human rights, and public health. The AIDS pandemic showed that social standing, legal safeguards, and resource availability all influence vulnerability in addition to disease exposure. Therefore, identifying high-risk people is only one aspect of effective interventions; another is addressing the structural factors that initially cause vulnerability. In addition to being social justice issues, reducing stigma, increasing healthcare access, and making sure that prevention initiatives reach the most impacted communities are crucial elements of effective public health policy.

C. Sociopolitical Dimensions

1. Stigmatization and Moralization

Stigma may have had the biggest impact on how the AIDS epidemic developed. Although HIV/AIDS was primarily a public health concern, it soon became entwined with societal anxieties, moral judgments, and political discussions about sexuality, homosexuality, drug use, and sex work. As a result, cultural concerns frequently influenced public responses just as much as scientific data. By 1995, it was becoming more and more obvious that stigma was actively causing the epidemic to expand rather than just being one of its effects.

The public's fear and terror during the early stages of the epidemic were exacerbated by widespread disinformation and a lack of scientific knowledge. HIV-positive individuals were socially isolated as a result of the widespread misconception that the virus might spread through casual contact. People with HIV/AIDS were routinely discriminated against in the workplace, in schools, in healthcare facilities, and even in their own families because they were perceived as hazardous, careless, or morally dubious. An HIV diagnosis has serious societal repercussions in many civilizations that went well beyond its medical ramifications.

A larger process of moralization was intimately associated with the stigmatization of AIDS. The disease was frequently presented as proof of moral decay rather than a public health issue because it first impacted already marginalized populations, such as gay men, sex workers, and injecting drug users. Instead of preventing transmission, discussions often centered on placing blame and making differences between victims who were allegedly "guilty" and "innocent." This view supported the idea that some people were deserving of pity while others were to blame for their own circumstances.

These attitudes were reinforced in large part by the media. Sensationalist coverage of AIDS during the 1980s and early 1990s frequently highlighted danger, terror, and societal chaos, depicting the disease as a plague or existential threat. In addition to raising public awareness, these narratives fueled fear and strengthened preconceived notions about the impacted communities. However, because doing so necessitated talking about sexuality, drug use, homosexuality, and reproductive health, political leaders in many nations were hesitant to confront the epidemic head-on. Because of this, some countries postponed preventive programs or relied on moralistic messaging that emphasized personal responsibility and abstinence while avoiding realistic conversations about safer sex and HIV prevention.

Public health results were directly impacted by stigma. Many people were deterred from being tested, declaring their status, or using healthcare services out of fear of discrimination. An HIV diagnosis may result in the loss of family support, work, housing, or educational possibilities in certain regions. This led to a vicious cycle where stigma discouraged testing and treatment, which allowed illnesses to spread unnoticed and increased public anxiety. Regardless of how they got the virus, women frequently faced particularly harsh kinds of stigma, including accusations of promiscuity, social rejection, or even violence. In a similar vein, marginalized groups like LGBTQ+ persons, sex workers, and drug injectors were often depicted as threats to public morals rather than as groups in need of protection and healthcare.

At the same time, these narratives faced strong opposition due to the epidemic. People living with HIV/AIDS, healthcare professionals, community organizations, religious leaders, and activists have been challenging discrimination and calling for more compassionate responses. Advocacy groups promoted evidence-based preventative and care strategies, humanized impacted communities, and educated the public. Even while stigma was still a significant issue in 1995, these initiatives had started to change public discourse from blame and fear to compassion, inclusivity, and public health.

In the end, the AIDS crisis proved that stigma is a public health issue as well as a social one. Fear of discrimination or exclusion undermines trust, education, and access to healthcare, all of which are necessary for effective prevention. As a result, lowering stigma became a crucial part of the global response to HIV/AIDS, emphasizing the intimate connection between social attitudes, public health, and human rights.

2. Criminalization and Legal Exclusion

The influence of state institutions, criminal justice systems, and the law on HIV susceptibility was one of the most important social aspects of the AIDS pandemic. Instead of using public health tactics, several governments used punitive legal frameworks to target the communities most impacted by the pandemic during the 1980s and early 1990s. A fundamental conflict between public health goals and legislation intended to control socially stigmatized behaviors resulted from the development of HIV/AIDS in cultures where some people were already disadvantaged, criminalized, or disenfranchised from political activity.

Before the epidemic started, many of the groups most impacted by HIV/AIDS were marginalized groups so they already faced legal discrimination. People were frequently deterred from obtaining testing, treatment, or prevention services because of fear of being arrested, prosecuted, exposed to the public, or harassed. Because of this, criminalization often drove susceptible groups deeper underground, making it more challenging to track and stop HIV transmission through public health initiatives.

This dynamic was particularly visible in relation to homosexuality. In many countries, same-sex relations were criminalized and this reinforced social stigma and discouraged openly discussing HIV prevention. Governments that viewed homosexuality primarily as a criminal or moral issue often struggled to develop effective prevention programs because acknowledging affected communities carried significant political costs. Similar tensions emerged around sex work, where criminalization, police harassment, and legal insecurity limited access to healthcare and prevention services. Public health advocates increasingly argued that exclusion from healthcare and legal protection contributed directly to HIV vulnerability.

Another significant point of contention was drug policy. Despite the fact that sharing needles was known to be a very efficient way for HIV to spread, many governments continued to place a higher priority on arrests and incarceration than on public health initiatives. As a result, discussions about harm reduction initiatives like needle exchange programs and addiction treatment services grew. Opponents saw these strategies as promoting criminal activity, while supporters said they decreased transmission and safeguarded public health. These disagreements mirrored larger discussions about whether public health initiatives or punishment should be used to solve societal problems.

Discussions regarding the criminalization of HIV itself were also triggered by the epidemic. Some nations passed legislation making it illegal for anyone to conceal their HIV status or intentionally expose others to the virus. Critics cautioned that by introducing legal risks connected with knowing one's HIV status, such regulations could discourage testing, while advocates argued that they safeguarded public safety. Concerns about immigration laws and travel restrictions that target those living with HIV/AIDS have also surfaced. Despite being frequently justified on the basis of public health, these actions reinforced stigma and isolation while typically having little effect on transmission rates.

Perhaps most importantly, legal responses to AIDS often created a distinction between so-called “innocent” and “guilty” victims. Children infected at birth or individuals infected through blood transfusions were frequently viewed as deserving sympathy, while gay men, sex workers, and drug users faced blame and discrimination even though from a public health perspective these distinctions were deeply counterproductive.

3. Religion and Conservatism

The global reaction to HIV/AIDS was shaped by social conservatism and religion in a complicated and frequently conflicting way. In contrast to many public health emergencies, the AIDS epidemic was intimately linked to problems with substantial moral, cultural, and religious significance, including drug use, family dynamics, homosexuality, sexuality, and reproductive health. As a result, reactions to the outbreak were frequently influenced by broader moral and ideological convictions in addition to scientific data.

In many countries, religious organizations had a significant impact and were frequently seen as reliable sources of direction, especially in areas with weak state structures. As a result, religious leaders had a significant influence on how the general people perceived HIV/AIDS. While some advocated for empathy, care, and assistance for those impacted, others presented AIDS as a result of moral decay linked to actions like drug use, sex work, or homosexuality. In many instances, the illness was even depicted as a kind of divine retribution, which increased stigma and took focus away from public health strategies that prioritize treatment and prevention.

In discussions on HIV prevention and sexual education, the impact of conservative attitudes was especially noticeable. Increasingly, public health specialists contended that candid conversations about sexuality, contraception, and condom use were necessary to reduce transmission. Many conservative and religious organizations, on the other hand, were against these strategies and supported education focused on abstinence and traditional family values. Condoms emerged as a particularly prominent source of controversy. Some religious institutions contended that their marketing could promote promiscuity or compromise moral principles, despite the fact that health organizations saw them as one of the best ways to stop HIV transmission. These discussions were a reflection of larger conflicts between conservative social ideals and scientific public health approaches.

However, religion was more than just a barrier to the AIDS response. In areas where healthcare institutions lacked resources, faith-based organizations frequently played crucial roles in providing care for individuals living with HIV/AIDS. When many governments were unable or unwilling to offer medical care, emotional support, housing, and social services, religious charities, hospitals, and community organizations did. Despite widespread stigma and fear, religious institutions were among the first in many communities to offer support to AIDS sufferers.

Religious reactions also differed greatly between nations, groups, and specific leaders. While some religious groups focused on moral discipline and social control, others became ardent supporters of compassion, inclusivity, and public health initiatives. This variety emphasizes how crucial it is to resist making oversimplified assumptions about how religion plays a part in the pandemic. Instead of outright hostility, the relationship between religious and public health was frequently marked by compromise and adaptability.

Government policy was also impacted by conservatism. Due to the considerable political risks associated with discussing sexuality, homosexuality, and reproductive health, many political leaders were reluctant to publicly address HIV/AIDS. As a result, some governments shied away from discussing HIV-related topics in public, restricted teaching materials, or postponed preventative initiatives. Because conservative attitudes may restrict access to sexual education, reproductive healthcare, and preventative information, women and young people were frequently disproportionately impacted.

4. Public Health Incapacity and Structural Vulnerabilities

The notion that diseases do not only spread due to biological factors was one of the most significant lessons learned from the AIDS epidemic. Although mother-to-child transmission, tainted blood, unprotected sexual contact, and sharing needles are some of the specific ways that HIV is spread, broader societal, economic, and political factors have a significant impact on infection patterns. Policymakers began to realize by 1995 that HIV/AIDS was more than just a medical issue. Rather, the epidemic revealed how social exclusion, prejudice, poverty, and inequality might make people more susceptible to illness and impede efforts to prevent it.

During this time, structural vulnerability arose as an important notion. This is the elevated risk that people experience because of their place in social, economic, and political systems as opposed to only their own decisions. Even when a woman is aware of how HIV spreads, she may not have the authority to demand condom use. Although a migrant worker may be aware of how to defend themselves, they may not have access to trustworthy information or treatment. A sex worker may want to engage in safer sex, but their options are restricted by violence or financial demands. In each instance, vulnerability is influenced by larger societal institutions that limit opportunity and choice in addition to individual conduct.

One of the biggest causes of susceptibility was poverty. In addition to experiencing more economic instability, impoverished communities frequently had fewer access to public health information, healthcare, and education. Poverty may have played a role in migration, transactional sex, or hazardous employment that raised HIV exposure. Another significant element was gender disparity. Even when they had accurate information about prevention, women's ability to protect themselves from infection was often compromised by their unequal access to economic opportunities, healthcare, and education. These instances showed that if people lacked the social and economic clout to put their knowledge into practice, it was frequently insufficient.

D. International and Institutional Response

1. UN Response

The international response to HIV/AIDS emerged gradually, not immediately following the first reported cases in the early 1980s. This fragmented response was due to limited scientific knowledge, widespread stigma, and political hesitation of governments and international institutions. As the disease spread across the world, it became increasingly clear that the epidemic wasn't a localized health issue but a global challenge which required coordination. By 1995, the UN became one of the leading global actors in that sense which framed AIDS not only as a medical problem but also as a developmental, demographic, and social issue.

The World Health Organization (WHO) played a central role in the early stages through the establishment of the Global Programme on AIDS (GPA) in 1987. GPA aimed at improving surveillance systems, supporting national AIDS programs, promoting public awareness, and facilitating international scientific cooperation. At a time when many governments were reluctant to confront the epidemic openly, WHO helped establish HIV/AIDS as a legitimate global concern and became an important source of scientific guidance and technical expertise.

As the epidemic expanded, policymakers increasingly recognized that the disease had broader implications than only biology or healthcare, as it expanded into labor markets as well. This realization encouraged greater cooperation among different UN agencies and pushed the international response beyond a purely medical framework.

The UN also played an important role in challenging stigma and promoting inclusive approaches to the epidemic. However, despite the efforts, the UN still faced important limitations. While international organizations could mobilize resources and coordinate efforts, they still depended on effective coordination of the member states. Some governments embraced international recommendations while others remained reluctant to address politically sensitive issues related to the disease due to political concerns. Funding also remained insufficient due to this, especially in developing countries, compared to the scale of the crisis.

2. Major Stakeholders

By 1995, the crisis became a truly global challenge by affecting a wide range of fields. The international response, consequently, depended on the cooperation between international organizations, national governments, and civil society actors. Each stakeholder had unique capabilities and limitations that they brought to the stage.

i. World Health Organization (WHO)

The World Health Organization (WHO) occupied a central position in the international response to HIV/AIDS during the first decade of the epidemic. Through the aforementioned GPA), WHO became the primary source of scientific expertise, technical guidance, and international coordination. The organization assisted governments in developing national strategies, improving epidemiological surveillance, and promoting public awareness campaigns. At a time when misinformation and public fear remained widespread, WHO played a critical role in establishing scientific consensus regarding HIV transmission and prevention.

Beyond its technical functions, WHO helped frame HIV/AIDS as a global issue requiring international cooperation rather than a problem confined to particular countries or populations. By collecting and publishing epidemiological data, the organization demonstrated the transnational nature of the epidemic and encouraged governments to view AIDS as a shared international challenge. However, WHO's effectiveness remained dependent on the cooperation of member states, limiting its ability to enforce recommendations or compel governments to adopt particular policies.

ii. United Nations Population Fund (UNFPA)

For UNFPA, HIV/AIDS represented more than a public health crisis. As the UN agency responsible for population issues, reproductive health, and gender equality, UNFPA approached the epidemic through a broader developmental perspective. Following the 1994 International Conference on Population and Development (ICPD) in Cairo, the organization increasingly linked HIV prevention to reproductive health services, sexual education, women's empowerment, and youth health.

UNFPA focused particularly on the social and demographic conditions that increased vulnerability to HIV infection. This included promoting access to condoms, strengthening maternal healthcare services, supporting public education campaigns, and addressing gender inequalities that limited women's ability to protect themselves from infection. Unlike agencies primarily concerned with clinical treatment or disease surveillance, UNFPA emphasized the connections between HIV/AIDS, reproductive rights, and human development, making it a particularly important stakeholder within the broader UN response.

iii. National Governments and Ministries of Health

Despite the growing involvement of international organizations, national governments remained the most important actors in the practical implementation of AIDS policies. Ministries of health controlled healthcare systems, allocated public resources, regulated prevention campaigns, and determined the availability of testing, treatment, and educational services. Consequently, the effectiveness of many HIV interventions ultimately depended upon domestic political decisions.

Government responses varied significantly across countries. Some states invested heavily in surveillance systems, public awareness campaigns, and prevention programs, while others responded more slowly due to limited resources, political denial, or resistance to discussing sensitive issues such as sexuality, homosexuality, and drug use. Governments also played a crucial role in shaping legal environments related to discrimination, migration, sex work, and drug policy. As a result, national responses were influenced not only by scientific evidence but also by political, economic, cultural, and religious considerations.

iv. NGOs and Activist Organizations

One of the most distinctive features of the AIDS epidemic was the unprecedented role played by civil society organizations and grassroots activism. In many countries, NGOs and community groups responded to the crisis way before governments even recognized it. These organizations often emerged directly from affected communities and therefore possessed levels of trust and local knowledge that public institutions frequently lacked. They provided education, counselling, legal advocacy, healthcare assistance, and support services to populations that were often neglected by official policies.

LGBTQ+ organizations were particularly influential during the early years of the epidemic, organizing awareness campaigns and support networks in the face of widespread discrimination. Activist movements such as ACT UP pressured governments, pharmaceutical companies, and research institutions to accelerate drug development and expand access to treatment. Other NGOs focused on women, youth, migrants, sex workers, prisoners, and people who inject drugs, helping to bridge the gap between public health institutions and vulnerable populations. By 1995, civil society had become an indispensable component of the global AIDS response, despite often facing funding shortages and political resistance.

3. Funding and Resource Allocation

By 1995, the unequal distribution of resources required to fight the epidemic was one of the biggest obstacles facing the global response to HIV/AIDS, not a lack of scientific knowledge. Despite the fact that researchers had discovered HIV and greatly advanced our understanding of how it spreads, many nations lacked the institutional and financial resources necessary to convert this knowledge into successful prevention and treatment initiatives. Funding and resource allocation issues consequently became crucial in worldwide discussions over the direction of the AIDS response.

HIV/AIDS needs sustained long-term investment rather than short-term intervention, in contrast to many public health catastrophes. Public education campaigns, testing services, blood screening systems, reproductive healthcare programs, healthcare worker training, and community engagement initiatives all required funding from governments and international organizations. This raised challenging issues about the distribution of scarce resources and which initiatives should be given priority.

i. Global Disparities in Healthcare Funding

The discrepancy between the areas where HIV/AIDS was spreading most quickly and the areas where healthcare resources were concentrated was one of the epidemic's most notable characteristics. Sub-Saharan Africa accounted for a growing portion of the world's illnesses by 1995, despite the fact that many of the region's nations had poor public health budgets and inadequate healthcare infrastructure. Richer nations in Western Europe and North America, on the other hand, typically had larger public health expenditures, better healthcare systems, and more capacity for research. Because of this, the areas with the highest disease burden frequently have the fewest resources at their disposal to adequately respond.

These differences were indicative of larger trends in global inequality. Economic development, state capability, and national income were all strongly correlated with access to public health investment, medical technology, and healthcare infrastructure. As a result, the geography of poverty and underdevelopment around the world began to merge with the geography of the AIDS epidemic.

ii. Foreign Aid and Dependency

International aid became a crucial part of many national AIDS programs as a result of these disparities. The financing, technical assistance, and support for healthcare services, surveillance systems, and prevention programs came from donor nations, international organizations, and development agencies. Such aid was required for many low-income nations to launch even rudimentary responses to the pandemic.

But depending too much on foreign assistance also paved the way for questions about sustainability and dependency. Donors frequently had a say in how money was distributed, which led to conflicts between local needs and global interests. Many initiatives were highly dependent on outside funding, which raised concerns about governments' ability to continue them in the event that help decreased. Concerns regarding development, sovereignty, and governments' long-term ability to create self-sustaining public health systems were all expressed in these discussions.

iii. Access to Prevention Infrastructure

In 1995, the majority of AIDS programs continued to prioritize prevention. Access to what is generally referred to as prevention infrastructure (condoms, testing facilities, counseling services, blood screening systems, public education campaigns, and reproductive healthcare programs) was essential for effective prevention. However, there were significant differences in access to these resources between and within nations.

The distribution of condoms provides a vivid example of these disparities. Condoms were seen by many health organizations as one of the best ways to prevent HIV transmission, but their accessibility was frequently hampered by a lack of funding, shoddy institutions, societal stigma, or political opposition. Access to HIV testing and counseling services varied similarly, especially across urban and rural areas. Even in cases when assistance were officially available, marginalized groups, such as women, young people, migrants, and sex workers, frequently encountered additional social and legal obstacles. As a result, access to tools for prevention as well as personal conduct often influenced HIV vulnerability.

4. Data Collection and Surveillance

Determining the actual scope of the AIDS epidemic was one of the biggest problems facing governments and international organizations. Reliable data on infection rates, transmission patterns, susceptible populations, and the success of prevention initiatives are essential for the development of successful public health policy. However, social stigma, political sensitivities, and inadequate testing capacity frequently made it difficult to determine the full scope of the epidemic over a large portion of the 1980s and early 1990s. Consequently, epidemiological surveillance and data collecting became more crucial elements of the worldwide response.

Surveillance in the context of HIV/AIDS included monitoring transmission channels, assessing prevention initiatives, tracking infection rates, and identifying demographic trends. Governments could not depend only on visible disease or fatality figures because HIV can be asymptomatic for years before developing into AIDS. As a result, many nations worked to create testing and reporting systems that could identify illnesses before symptoms appeared. Policymakers were able to better distribute scarce resources, spot trends, and target vulnerable populations because of reliable data.

Accurate data collection, however, proved challenging. Stigma was a significant barrier. Many people were deterred from getting tested or revealing their status out of fear of prejudice, social rejection, or legal repercussions. Because of this, it was frequently most challenging to keep an eye on the groups most susceptible to illness. Surveillance operations were made more difficult by political factors. Concerns about the country's reputation, tourism, or internal political stability made some governments reluctant to admit the extent of the epidemic, while others just lacked the institutional capability required to obtain trustworthy data.

For UNFPA and other international organizations, demographic data became particularly important. Understanding how HIV affected women, young people, migrants, and other vulnerable populations enabled policymakers to design more targeted interventions. Organizations such as the World Health Organization also played an important role in establishing common reporting standards and improving international cooperation, helping transform HIV/AIDS from a collection of national health problems into a recognized global issue.

Surveillance also brought up significant ethical issues. Individual rights and public health goals clashed as a result of the gathering of private health data. Confidentiality, access to personal medical records, and obligatory testing were among the topics of debate. For marginalized groups, these worries were particularly important since they frequently felt that surveillance data may be used to support exclusion, criminalization, or prejudice. As a result, a number of public health specialists contended that successful surveillance relied not just on obtaining precise data but also on safeguarding privacy and fostering confidence between public institutions and vulnerable groups.

By 1995, it had become increasingly clear that reliable data was essential for combating HIV/AIDS. Yet the epidemic also demonstrated that surveillance is never purely technical. The quality of information depends on social trust, political commitment, and the willingness of individuals to engage with healthcare systems. As a result, successful surveillance requires balancing epidemiological needs with respect for human rights, confidentiality, and public confidence.

E. Regional Overview of the Epidemic

To craft effective, localized solutions, H-UNFPA delegates must understand that the global AIDS epidemic is not a single, uniform crisis. Instead, it manifests as a collection of distinct regional epidemics, each driven by unique transmission pathways, socioeconomic conditions, and geopolitical realities. This is mainly because of the inequalities for example the mortality rates persisted in Sub-Saharan Africa while it was decreasing in Western Regions after the development of HAART.

1.Sub-Saharan Africa

This region is the center of the global crisis. It has the highest number of infections and deaths in the world. Unlike in the West, the virus here spreads mostly through sex between men and women. More than half of the infected people here are women and young girls. This happens because women often have less power, less money, and face more violence. Because so many young mothers have the virus, many babies are born with HIV. By the late 1990s, in countries like South Africa and Botswana, 1 out of every 5 adults had the virus. This left millions of children without parents and completely broke local hospitals causing very big moral and economical harm.

2.North America and Western Europe

In wealthy Western countries, the virus did not spread to the general public as much. Instead, it stayed inside specific, smaller groups. In the beginning, the virus mostly hurt gay men. Soon after, it began spreading fast among people who shared needles to inject drugs. In 1996 HAART was created. In the West, these drugs stopped people from dying and turned AIDS into a manageable disease. Even though the medicine existed, it was very expensive. Rich people got the treatment, but poor communities ,especially Black and Hispanic groups in big cities, continued to get sick and die.

3.Latin America

In Latin America, the epidemic is mostly found among specific groups like male sex workers, gay men, and drug users, but it is slowly spreading to others. In the region strict cultural ideas about being a strong, dominant man (machismo) mean that many men who have sex with other men hide it. They marry women and pass the virus to them without knowing it. In 1996, the government of Brazil did something brave. They ignored international drug patents and made cheap, copycat versions of the expensive AIDS drugs. They gave these medicines to all of their citizens for free, saving thousands of lives.

4.Eastern Europe and the Soviet Sphere

For a long time, the Soviet Union reported almost no cases of HIV. But when the Soviet Union collapsed in 1991, everything changed very fast. The collapse caused poverty and brought a lot of cheap drugs into these countries. Millions of young people started using heroin(a drug causing a severe addiction).The virus exploded because people shared dirty needles. In places like Russia and Ukraine, 70% to 80% of all early HIV cases came from shared needles. The new governments were broke.They were even too broke for basic health needs. They did not have money for basic HIV tests and they banned programs that gave out clean needles, which made the virus spread even faster.

5.Middle East and North Africa (MENA)

This region reports very low numbers of HIV cases, but these numbers do not show the real story. Strong religious and cultural rules make sex, homosexuality, and drug addiction massive taboos. Many governments simply pretended that HIV did not exist in their countries. Because being gay or doing sex work is illegal, people are terrified to get tested. If they test positive, they could go to jail or be kicked out by their families. In this area, UNFPA cannot just hand out condoms easily. Instead, they have to hide HIV education inside safe topics, like general health for pregnant mothers or teenagers.

Questions to Be Answered

What kind of an effect did HIV/AIDS population had on development, demographic structures, and socioeconomic stability in heavily impacted regions?

To what extent have stigma, discrimination, and moralization hindered national and international efforts in combatting HIV/AIDS?

How have legal, cultural, and religious factors shaped national responses to HIV/AIDS and influenced the effectiveness of prevention efforts?

What can UNFPA do to strengthen the implementation of and access to prevention programs, especially in but not limited to countries which have less resources?

What measures can be implemented to ensure correct and complete information around HIV?

How can HIV transmission among marginalized and vulnerable groups be addressed especially in social and political ways, without infringing national sovereignty?

What strategies can be adopted to improve healthcare capacity and infrastructure, especially in but not limited to regions that are heavily affected by HIV/AIDS?

What mechanisms can be established to improve cooperation and coordination between UN agencies, national governments, NGOs, and community organizations?

How can data collection and epistemological surveillance be strengthened while protecting privacy and preventing discrimination?

What can be done to address the feminization of the epidemic? What kind of strategies can be adapted?

How can youth-centered HIV prevention strategies be developed, especially in the context of sexual-education vs. abstinence-prioritization debate?

Royal Model United Nations

2026

BOSPHORUS
COLLECTIVE