

RESEARCH PAPER

MESSAGE FROM THE COMMITTEE PRESIDENT

Dear Delegate,

Welcome to the research paper we have prepared for you.
This is a great starting point for your research.

If you have any questions about this research, please write
to us at *obsmun@obs.edu.pt*

Happy debating and see you soon.

PURPOSE OF THIS GUIDE

This research guide was compiled by the Secretariat of the OBSMUN 2025. OBSMUN aims to provide delegates with the opportunity to further develop their research skills that will help them in their academics. Thus, these research guides do not cover the whole breadth of the issues at hand. Instead, they are designed to provide a basis from which delegates can undertake their own research into the topics, with the aim of developing clauses from their independent research.

This guide is not sufficient as background information to prepare yourself for the country, since it does not look at the information from your countries point of view, but instead a generalised one.

WHEN RESEARCHING FOR INFORMATION REGARDING YOUR COUNTRY YOU MAY WANT TO ASK YOURSELF THE FOLLOWING QUESTIONS;

- **Where does your country stand on the issue being addressed?**
- **Does it affect the country you are representing?**
- **Would your country be in favour / against taking action on the issue?**
- **What policies are currently in place in your country to address this issue?**
- **Given your country's stance & policies, what type of solution would you support?**
- **What measures would benefit your country?**
- **What measures would be detrimental to your country? Which ones would your country be especially be opposed to?**

MOCK CONFERENCE: ADDRESSING THE ISSUE OF THE RISING AMOUNTS OF ADOLESCENT PREGNANCIES

Key timeline:

- **1948:** World Health Organization is formed, beginning the collection of data on worldwide health, including children's and mothers' (WHO, 2023).
- **1960s–1970s:** Adolescent pregnancy becomes widespread throughout much of the world. To some, it is offered as custom, to others, it is a way of avoiding school and childhood (UNICEF, 2023).
- **1990:** The UN and the WHO come to understand that pregnancy among teenagers is not only a health issue but also a social issue and is tied to poverty, child marriage, and gender inequality (UNFPA, 2024).
- **2000:** The Millennium Development Goals vow to reduce child and maternal mortality and thus indirectly encourage less teenage pregnancy (World Bank, 2024).
- **2010:** It is estimated that about 16 million adolescent girls give birth annually, with the majority being in developing countries (WHO, 2023) and leads them to prioritise motherhood over school.
- **2016:** The United Nations chose the Sustainable Development Goals that directly outlined ending child marriage and giving access to reproductive health to every girl (UNFPA, 2024).

- **2020:** Schools close and health care gets disrupted during the COVID-19 pandemic. Safe spaces are lost by many girls and they are denied contraception, pregnancy rises in some of Africa, Asia, and Latin America (UNICEF, 2023).
- **2023:** UNICEF indicates that nearly 1 in 5 adolescent girls in developing countries first give birth at age 18 and below.
- **2024:** UNFPA warns that teen pregnancy traps girls in poverty and states that a priority action is needed to offer girls choice, freedom, and futures (UNFPA, 2024).

Background information:

Teen pregnancy happens when a girl between 10 and 19 years old gets pregnant. For the majority of such girls, it is not a choice but due to unfinished education, early marriage, lack of contraceptive methods, or hazardous conditions (WHO, 2023). Globally, 21 million girls aged 15–19 get pregnant each year in developing countries, and almost 12 million give birth (UNICEF, 2023). Almost 777,000 girls under the age of 15 give birth every year (UNICEF, 2023).

Not only do these girls lose their education, but their health is also threatened by dangers. These dangers include giving birth which is the largest killer of adolescent girls all over the world (WHO, 2023). Their babies are also more vulnerable as

they have a higher risk of being born premature, resulting in more baby deaths (UNFPA, 2024). As soon as a girl becomes pregnant at an early stage, she drops out of school. Her dream of education is prevented, and she must focus on motherhood, made harder by impoverished conditions. Poverty is spread, and the cycle repeats itself generation after generation (World Bank, 2024).

In richer countries, such as the U.S., adolescent pregnancy rates have fallen dramatically with better provision of sex education and contraception but are still many times higher in the poor or disadvantaged groups (CDC, 2024). It is even more tragic in Sub-Saharan Africa, where poverty, child marriage, and social conventions continue to drive teen pregnancy (Our World in Data, 2023).

The need for preventing teen pregnancies:

- Education and awareness are vital as young bride may get pregnant before they understand what is happening (UNICEF, 2023).
- A girl in a refugee camp may have no education or contraception whatsoever, leaving her at risk for precocious pregnancy (UNFPA, 2024).
- A girl with a poor urban upbringing can hide the pregnancy out of fear, denying herself much-needed medical care (CDC, 2024).

If these pregnancies are not supported:

- Mothers die, undergo unsafe abortion, or get long-term damage (WHO, 2023).

- Babies lose their lives (UNFPA, 2024).
- Girls are permanently removed from school, losing the opportunity to escape poverty (World Bank, 2024).
- Their psychological well-being is impacted, with most experiencing depression, anxiety, and loneliness (UNICEF, 2023).

Prior WHO and UN action:

The WHO has discussed avoiding adolescent pregnancy by equipping health professionals to deliver neutral advice to adolescents, enhancing access to contraception, and encouraging sexuality education (WHO, 2023). UNICEF conducts projects that keep girls in school and every year of schooling decreases the chances of adolescent pregnancy (UNICEF, 2023). They also address child marriage, which is among the strongest forces behind teen childbearing. UNFPA provides millions of women and girls with contraception, often in camps and areas of conflict where access is most limited (UNFPA, 2024). Additionally, The World Bank has highlighted the financial cost of teen pregnancies, showing that countries with high teen birth rates lose potential workers and have a larger social expense (World Bank, 2024).

Questions for additional research:

- What ways do religious and cultural beliefs dictate countries response to teen pregnancy?
- How widespread is the ability of private clinics, community organizations, and NGOs to reach girls off official radars?
- What resources (safe school, health clinic, contraception) are most required?
- Has the WHO succeeded in educating most nations to this purpose?
- Do cultural practices allowing child marriage to have a moral obligation to respect global health policies and women's rights?
- How does the affordability of contraceptives and medication affect poor countries' ability to protect adolescent girls?
- Can new technology offer girls confidential and safe access to information and support?

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TOPIC 1: ADDRESSING THE ISSUE ON THE RISE OF FLAVOURED TOBACCO AND NICOTINE PRODUCTS FOR THE YOUTH POPULATION

Background information:

Almost all nicotine and tobacco products, including traditional tobacco such as cigarettes and cigars to smokeless products like snuff and snus, heated tobacco products (HTPs) and electronic nicotine delivery systems (ENDS) are available with a variety of flavours (El-Hellani, Davis and Suchitra Krishnan-Sarin, 2021). The market is heavily aimed towards teenagers, from its colourful packaging, widely distributed ads and friendly designs. This can trigger reward centres in adolescent brains, which often weakens their ability to perceive health warnings and associated risks (UN News, 2025). With pods flavoured from strawberry to “frosted sugar cookie”, this acts as an attraction to many young people. This rises as a concerning issue since research has shown that flavour is considered as one of the most significant factors in trying flavoured nicotine products (Jones and Salzman, 2020).

By flavouring tobacco and nicotine, it can essentially “mask” and mute the harshness of its original taste due to its confectionary flavouring and additives. Not only this contributes toxicity to the products, but it can also cause many health problems in the respiratory track and developing

brain. In addition, its appeal can also turn initial use to progress into regular use, resulting in dependency of the product (El-Hellani, Davis and Suchitra Krishnan-Sarin, 2021). Research in the United States of America shows that over 70% of adolescent e-cigarette users would quit if the products were not available to any flavoured options (WHO, 2024), highlighting that flavouring plays a key role in consistent use of nicotine products. Nicotine addiction also often originates in youths with research showing that nearly 90% of daily adult smokers started before the age of 18. Thus, flavoured tobacco and nicotine products are essentially assisting in creating a new generation of people vulnerable to addiction (Jones and Salzman, 2020).

Restrictions regarding flavoured tobacco and nicotine differs from country to country. Many countries prohibit the use of disposable flavoured e-cigarettes, although the ruling of menthol flavoured products further varies. Some countries ban any tobacco or nicotine products with “characterizing flavours”, which is defined as “flavours with a taste or aroma, apart from tobacco, distinguishable before, during or after tobacco consumption” (El-Hellani, Davis and Suchitra Krishnan-Sarin, 2021). Rulings regarding the product also has differences, as many bans on flavoured nicotine only extend to cigarettes and e-cigarettes. Regardless of nationwide bans and strict restrictions, flavoured nicotine and tobacco is still widely available due to various reasons. Poor diplomatic relations with countries such as China, which has some of the largest flavoured nicotine manufacturers and is a large contributor to tobacco production, can lead to a difficulty in managing the influx of such products (Grandview Research,

n.d.). The rapid market growth of flavoured nicotine also contributes to the availability of the product. Its complexity of the industry makes it difficult to police and easy for brands to evade regulations (Noguchi, 2023). Loopholes within regulations and restrictions were also constantly used as a way for brands to stay on the market and create new products such as “flavour accessories”, thus constantly attracting adolescent appeal in the tobacco-nicotine industry (WHO, 2025).

Past WHO and UN action:

Just ahead of 31st of May 2025, the UN health agency released a series of information sheets to call on governments to ban all flavours in nicotine and tobacco products to protect adolescents from lifelong addiction and disease. As of December 2024, over 50 countries have adopted policies regulating tobacco additives, with most targeting flavourings. WHO also is continuing to urge all 184 Framework Convention on Tobacco Control (FCTC) parties, which makes up 90% of the world’s population to implement and enforce strong bans and restrictions on flavoured products and its related additives (UN News, 2025). As early as 2010, in adopting the Partial Guidelines for Implementation of Articles 9 and 10 of the FCTC, it was recommended in prohibiting or restricting ingredients that can increase the attractiveness of product and “palatability” (WHO FCTC, 2017). Additional articles such as Articles 13 and 16 were also implemented to restrict the limits of adolescent use (World Health Organisation, 2003). In 2008, WHO introduced the MPOWER package to assist in

national-level implementation of reducing tobacco use (World Health Organization, 2023).

Key timeline:

- **1870** – Smokeless tobacco products with fruit flavours first appeared.
- **1934** – First wintergreen-flavoured chewing tobacco product was introduced by the U.S. Smokeless Tobacco Company.
- **1970** – Characterising flavoured cigarettes entered the U.S market.
- **1999** - Camel Exotic Blends released at least 18 different flavours, marking the rise of characterising flavoured nicotine and tobacco products.
- **2003** - The first commercially successful electronic cigarette was created in Beijing, China.
- **2006** – E-cigarettes are introduced to Europe and U.S
- **2008** – Turkey’s Health Ministry suspends the sale of e-cigarettes, claiming that they are just as harmful as regular cigarettes.
- **2009** – The Federal Food, Drug and Cosmetic Act (FDCA) was amended by the Family Smoking Prevention and Tobacco Control Act (FSPTCA) that established the rule of which it is now prohibited for any cigarette (e-cigarettes and other forms of tobacco were not considered) to contain additives, artificial or natural flavour (excluding menthol) or an herb or spice that is a

characterising flavour of the tobacco product or tobacco smoke. Australia bans the possession and sale of electronic cigarettes that contain nicotine, however excluding use for replacement therapies. Jordan's Ministry of Health bans the import of the electronic cigarettes. Canada bans the sale, advertising and import of electronic cigarettes. Hongkong's Department of Health bans electronic cigarettes.

- **2010** – Singapore and Thailand ban e-cigarette importation, distribution and sales.
- **2011**- Sales of flavoured products remaining on the market like little cigars, smokeless products rose 482% since 2000.
- **2015** – JUUL entered the nicotine industry, revolutionising “pod-mod” e-cigarettes where characterising flavours could be easily obtained through buying its specific pods and replacing its flavours. Nicotine salts were also popularised after JUUL's launch into the market, causing a more appealing sensation and growing popularity amongst youths.
- **2016** - The state of Pennsylvania enables a 40% wholesale tax on tobacco products such as snuff and snus, roll-your-own tobacco, pipe tobacco and e-cigarettes.
- **2019** – The first disposable e –cigarette pod kits entered the market
- **2020** – More popular brands started to emerge, creating disposable vapes with flavouring and continuing adding additives to other tobacco products. The FDA

announced that e-cigarette manufactures are no longer allowed to sell flavoured cartridges or pods. This led to a sharp increase in disposable e-cigarette usage as it manoeuvres the law implemented. The White House announces a ban on the sale of flavored vaping cartridges and pods that contain flavoured nicotine, exempting tobacco and menthol flavours. An EU wide ban on menthol cigarette sales was implemented.

- **2021** – Popularity amongst disposable e-cigarettes continues to rise across the US and EU.
- **2023** – Amongst 18- to 24-year-olds, about 29% have been using e-cigarettes in the UK compared to 9% in May 2021.
- **2024** - Nicotine pouches were the second most used nicotine product amongst adolescents, behind e-cigarettes with 91% of sales being as a flavoured product.
- **2025** – The UK government banned the sale and supply of disposable e-cigarettes.

Focus questions for additional research:

- There have been many laws, bans and strict regulations amongst flavouring nicotine and tobacco, yet WHO continues to raise the issue on the rise of these products. What factors have limited the effectiveness of such bans and regulations?
- Looking at your country's stance, was there any actions taken to reduce the harm of flavoured nicotine and

tobacco products? To what extent have they been effective?

- What role does online marketing play in the appeal of adolescents consuming flavoured nicotine and tobacco?
- Looking at your country's perspective, does any cultural, political or economic views and interests influence the impact of flavoured nicotine and tobacco?
- Were there any actions taken regarding to support adolescents going through nicotine withdrawal? Were they effective?
- How effective were WHO and the UN in acting and addressing the rise of flavoured tobacco and nicotine?

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TOPIC 2: ADDRESSING THE ISSUE OF NEEDS IN INCREASING AMOUNTS OF CHILDHOOD TRAUMA TREATMENTS NEEDED IN LEBANON

Key timeline:

- **1946:** The last French troops left Lebanon after WW2, leaving it an independent country.
- **1948:** Lebanon supported neighbouring Arab countries in a war against Israel and 100,000 Palestinian refugees fled to Lebanon due to the war.
- **1977:** The Palestine Liberation Organization attacks from Lebanon into Israel and tension between the two countries rises.
- **1981:** The defence minister Ariel Sharon begins to draw up attack plans targeted to the Palestine Liberation Organization's military base.
- **1982:** Israel invades Lebanon, aiming to support Lebanese forces driving out the Palestine Liberation Organization. A civil war began, and American, French and Italian forces were deployed in the capital to supervise the evacuation.
- **Late 1980:** The Lebanese pound collapsed, leading to more than 200,000 children living on bread subsidised by the government as the economy worsened.

- **1988:** The parliament failed to elect a successor to President Gemayel as a result of differences in the Syrians, Muslims and Christians.
- **1989:** A peace plan was accepted and a ceasefire established, leading to the ports and airports reopening and refugees to return.
- **1990:** The civil war in Lebanon ended after with the signing of the Taif agreement.
- **2000:** Israeli forces withdrew from Lebanon, despite conflict and tension continuing.
- **2011:** The National Unity Government collapsed due to growing tension within the government. The parliament elected Najib Hezbollah, making him responsible for the new government.
- **2012:** The Syrian war continues to grow and threatens to enter Lebanon, leading to incidences of armed clashes.
- **2014:** The number of Syrian refugees in Lebanon rose to one million
- **2019:** Public demonstrations in protest of planned taxes on tobacco, online phone calls and gasoline and expanded to a country wide criticism. Former minister of education was elected by the government as the next prime minister and responsible to form a new central government.
- **2021:** Lebanon was threatened by a nationwide power outage as money issues lead to the inability to buy fuel from power stations and ultimately the country lost power for 24 hours.

- **2022:** They held an election, the first since the economic crisis: Hezbollah and its allies lost their parliamentary majority as its partners, including President Michel Aoun's Free Patriotic Movement, lost seats to Samir Geagea's Lebanese Forces, while the Sunni Future Movement's withdrawal created a political vacuum for other Sunni politicians.
- **2023:** Lebanon is considered a failed state as it suffers from chronic poverty and economic mismanagement and threatening collapse.
- **2024:** The Gaza war has reparked tensions with conflicts rising leading to the invasion of Lebanon by Israel. A ceasefire deal was signed between Israeli and Lebanese armed groups.
- **2025:** Elections lead to Joseph Aoun to be elected the president after a two-year vacancy in this position.

Background information:

Lebanon is a country in the middle east with 10,452 km² of land and, as of 2023, a GDP of 20.08 billion USD. Its population is more than five million (Wikipedia Contributors, 2019) and the country is a part of the UN, being one of the founding members. It is bordered with Syria to the north and east and Israel to the south, with the mediterranean sea to the west. On the Human Development Index, it is ranked 112th, being classified as a lower middle-income country (Wikipedia Contributors, 2019). After World War II, Lebanon was freed from French influence, however this freedom has led to altering periods of political instability. Events including the

Lebanese liquidity crisis, along with corruption and the 2020 Beirut explosion has led to the collapse of Lebanon's currency, resulting in political instability, poverty and unemployment.

After continued tension between Lebanon and Israel, a cease fire happened on the 27th of November 2024, but the GDP has shrunk by 38% since 2019 (World Bank Group, 2024) as the current war in Gaza has had a big impact. As of 2024 there are more than 1 million people displaced by hostility, mostly Syrian, which have taken residence in the south of Lebanon, even though it has no health infrastructure. Many hospitals here are running below capacity, have staff shortages and suffer from a lack of funding. Moreover, more than 530 health workers have been injured and killed from attacks on the health care system and additionally water and sanitation systems have been disrupted, leading to the high risk of a disease outbreak (World, 2024). The continued conflict in the middle east has led thousands of families to remain on the move, with some risking becoming exposed to the remnants of war when they return home, which poses a multitude of health risks.

The need for specialised trauma care is growing as since October 2023, more than 4000 people were killed and 17 000 injured solely in Lebanon. Despite the recent ceasefire allowing areas to become more accessible, the death toll has continued to rise as more bodies are being found within eight million tonnes of debris of buildings. One in four people suffering from life changing injuries will require long term rehabilitation, including prosthetics and specialised support (World, 2024), which Lebanon's current state cannot eThe

need for addressing the rising levels of childhood trauma is crucial as many children have experienced bombings, armed clashes and domestic violence linked to the civil war or the refugee crisis. Being a refugee child and a child of war can lead to experiencing family separation, poverty, disrupted education and unsafe living conditions, all which can have an immense negative impact on a child's upbringing. Limited access to education healthcare increases the children's vulnerability to psychological distress which can manifest as PTSD, anxiety, depression or behavioural issues as an outlet for the trauma (Itani et al., 2014). Due to the economic collapses and 80% of the population living in poverty, children suffer with food insecurity and child labour, compounding to traumatic stress and those under financial strain are less available to support a child's emotional needs, leading to feelings of isolation (Itani et al., 2014). In Lebanon, mental health services are scarce and sustainable systematic trauma treatment programs are lacking resources and productibility.

Untreated trauma from the childhood leads to lower educational success, higher risk of substance abuse, chronic health problems and aggression, making it crucial we face this issue and make improvements.

Past WHO and UN action:

The WHO sees the priority of ensuring there are enough health workers who have been trained in war-related trauma and can-do plastic reconstructive surgery. Three weeks into the 8-week ceasefire in 2023 allowed the WHO and public health works to replenish medical supplies and restore health services across the country. This has allowed mass casualty management training across Lebanon which allows more successful responses to injury and trauma. Ongoing operations include training surgeons on specialised trauma care in areas of high conflict, providing mental health training to health workers and scaling up the trauma crew's capacity to fit the demand. Additionally, the WHO is working to build up the rehabilitation capacity in post-conflict areas and replace damaged equipment. There is also pressure to prepare for similar scenarios in the future and become more prepared for the devastation. Furthermore, the WHO has provided 5000 contingency blood bags and developed awareness material in areas of health risks for first responders and civilians. Additionally, the WHO and ministry of public health run a country wide surveillance for disease outbreaks which are a high risk in post conflict settings (World, 2024).

Focus questions for additional research:

- What role do alliances (regional blocs, trade partners) play in shaping your country's stance?
- What role could private companies, non-profit organisations or regional organizations play?

- What resources (money, medicine, training, infrastructure) does Lebanon need most?
- How effective has the WHO been historically in coordinating international responses to issues like this and what structural limitations exist?
- To what extent should global health policy prioritize sovereignty vs. international cooperation?
- How does intellectual property (agreements on medicine and vaccines) affect equitable access in countries like Lebanon?
- What lessons can be learned from past international health crises (HIV/AIDS, COVID-19, Ebola) and how can they apply here?
- What ethical responsibilities do developed nations have toward developing nations in global health?
- What role could emerging technologies (AI, telemedicine, biotech) play in solving this issue?

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