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PROGRAMME

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Hello Delegate,

My name is Cecilia An and I will be your co-chair for AMUN 2010 UNDP. I am currently a senior in the Academy for Business and Finance. Our committee will focus on sustainable development to improve living conditions and use aid and resources more effectively. We will be debating the topics of Universal Education, world hunger, and maternal health and focusing on delivering adequate resolutions in our committee. Just like some of you, my first experience in Model United Nations was in the Academy Model United Nations Conference my freshman year. Since then, model UN has always been a club I have stayed with because I appreciated the eye-opening experience it gave its participants about the rest of the world and I have gone on to participate in NAIMUN and WAMUNC. I met countless new friends at these conferences and learned so much about international issues.

My name is Sunjoo Paik and I will be your co-chair for AMUN 2010 UNDP. I am currently a senior in the Academy for Medical Science Technology. I first started Model UN as a freshman. Clueless to what MUN was, I attended my first conference in Washington, DC, NAIMUN, with almost no knowledge of how these debates worked. By the end of the conference, I was knowledgeable on parliamentary procedure, working papers, and resolutions. By the time WAMUNC came around, I was more prepared and was able to effectively debate and sponsor several resolutions. I went on to participate in AMUN 2008 and also staff for AMUN 2009. The main reason why I continued to participate in Model UN was the sense of accomplishment I felt passing a working paper into a resolution after hours of debating and compromising. Also, the skills I acquired from participating in the debates were crucial in other aspects of my academic career. I am excited to be a part of this committee and see the debate from the other side as a chair and hopefully pass some great resolutions as a committee. I hope that those participating in this committee will have a great experience and learn a lot about issues facing the United Nations today.

If you have any questions, feel free to email us at peian@bergen.org or sunpai@bergen.org

Sincerely,
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TOPIC 3: MATERNAL HEALTH

History

In many developing countries, poor maternal health has been and continues to be a huge problem. The Millennium Development Goal for maternal health aims to reduce by three quarters the maternal mortality ratio and to achieve universal access to reproductive health. Amongst all the Millennium Development Goals (2015), maternal health has been the sector with the least progress. Globally, between 1990 and 2005, the rate of maternal mortality has diminished by about 1 percent per year. This slowly creeping rate does not even come close to the 5.5 percent annual decrease proposed by the Millennium Development Goals. Maternal mortality (also known as obstetrical death) is defined as the death of a mother during or shortly after child birth. Sub-Saharan African countries made negligible progress during that time period. In 1990, less than 50% of births in developing countries were handled by skilled health personnel; improvements were shown when in 2006, almost 61% of births were handled by skilled health personnel. In comparison to those percentages, only 40% of Southern Asia's pregnancies were cared for by skilled health personnel and only 47% in sub-Saharan Africa since both areas are among the most affected by maternal deaths.

Although adolescent rate of pregnancy has lessened since 1990 in developing countries, the decrease in numbers has been extremely sluggish. In fact, there have been marginal increases in the areas where adolescent fertility is most frequent. Girls that are between 15 and 20 years old are twice as likely to die in childbirth compared to those older than 20. Those under the age of 15 are

up to five times as likely to die while giving birth.

Current Situation

Maternal deaths are highly rare in developed nations; however, in developing countries these preventable deaths are frequent. Most of these deaths are caused by the same common issues, including unsafe abortion, hemorrhage, sepsis, hypertensive disease of pregnancy, and obstructed labor. All of these complications are due to lack of skilled personnel and lack of monetary and other resources to support safe births. Maternal bleeding can cause death in two hours, yet responses in blood replacement must be immediate. It causes 21% of the 500,000 annual maternal deaths. Due to lack of contraceptives, 19 million unsafe abortions a year occur in developing countries, leading to 68,000 deaths. Prolonged labor, usually obstructed, causes a fistula—a rupture in the birth canal, a severe injury due to childbirth. The success rate of repairing fistulas is ninety percent, and twenty countries have already begun implementing plans, providing fistula surgeries free of charge sponsored by UNFRPA donations.

Compared to the 1 in 7,300 chance of death from treatable complications in developed nations, there is a 1 in 22 chance a woman will die from the same complications in sub-Saharan Africa, exemplifying the disparity in living conditions. Over 500,000 deaths, 99 percent of which are women from developing countries, occur a year simply due to basic and treatable pregnancy complications, adding up to 10 million deaths in a generation. The two areas most highly affected by maternal deaths are sub-Saharan and South Asia. Although generally maternal death rates are on the decline, some

areas are suffering resurgence, especially areas where adolescent fertility is highest. Improvements are occurring slowly and much below the rate required to reach the MDG target – a mere one percent reduction occurred between the years of 1999 and 2005. While prevention for young girls is easily accomplished with the use of contraceptives, few have access to such resources due to the economic state of underdeveloped nations. Additionally, due to this issue, 1 million children a year are left without mothers, leading to a high chance of premature death. The child would likely be left to the mercy of an orphanage with insufficient resources and funding, hoping for adoption.

However, several areas have shown notable improvements in maternal care. Significant drops in the rates of maternal mortality have been noted in Jamaica, Malaysia, Sri Lanka, Thailand, and Tunisia. As more women were able to access family planning and skilled health personnel during childbirth along with backup emergency obstetric care, these declines took place. In only a few short years, the aforementioned countries were able to halve their maternal deaths. If more countries had access to trained professional health personnel and reproductive health services, those countries would also be able to significantly decrease their maternal mortality rates.

In many rural areas of developing countries, it is extremely difficult to find trained health personnel that deliver emergency obstetric care. The United Nations Population Fund (UNFPA) along with the Tigray regional health bureau of Ethiopia and Médecins du Monde, an international NGO, has proposed an extensive project that trains mid-level health officers. This program strives to train so that those officers are able to provide life-saving emergency surgery in rural hospitals

that have shortage of doctors. This project has received positive feedback.

Following an earthquake in Pakistan in 2005, a UNFPA-supported service unit went to those areas and gave the Pakistani women comprehensive care. Almost 900,000 patients were seen by skilled health workers and had antenatal care consultations, deliveries, post-miscarriage complications and referrals for Caesarean section. As a result, more than 40% of pregnant women of that area benefited from skilled birth attendance after the earthquake as opposed to the 30% national average in Pakistan.

Another UNFPA program strives to end Fistula since 2006. Their goal is to prevent and treat this childbirth injury which occurs when the birth canal is ruptured during prolonged and obstructed labor. Nine out of 10 fistulas are able to be successfully repaired when treated correctly. Eleven governments, as well as many private-sector supporters such as Johnson & Johnson and Virgin Unite, have donated to these types of programs.

What Needs to Be Done

Involving the governments of countries stricken by maternal death problems is essential to implementing sustainable improvement. The government of India is working closely with the UNFPA on the 100,000 deaths in its country every year. Providing adequate financing is just the beginning to creating a difference in maternal death statistics. Insuring the money reaches hospitals, and provides essential drugs, sanitation supplies, and equipment will have to be incorporated in the role of the government, for many nations suffer from poverty and overloaded health care systems already. Human resources are another essential need to handle the maternal

death situation across the world. Trained workers are essential to successful deliveries in a timed manner, as well as those trained in emergency responses. Furthermore, transportation services and communicative relations must be implemented in rural areas.

Beyond the birth of the child, protection from domestic violence as well as options for adoption is vital to the safety of the child and the mother. Along with these provisions, health insurance and free services would further the success of preventing maternal deaths. These resources are often expensive and families cannot afford to provide them to pregnant daughters and family members. From this point on, providing universal basic services to struggling women in developing countries is vital.

Besides resources allowing safe births, adolescent pregnancy prevention is key to reducing the number of dying adolescent girls every day. Education is necessary to motivate young girls to postpone their first pregnancy and avoid child marriage. Provision of contraceptives may reduce maternal deaths by up to a third each a year. This would not only prevent pregnancies, but create more space between pregnancies to remedy the risk of repeated pregnancy, for the risk of death increases every time.

Key Players

United States

Although both private and public sources on global health have tripled their spending from \$15 billion to \$45 billion between 2000 and 2006, the most undeveloped nations need substantial assistance from wealthier countries such as the United States. Since 2003, aid to the poorest and most disadvantaged countries has essentially stalled. The United States specifically ranks

in the middle range of donor nations for the EU target of giving .7 percent of its gross national income for official development assistance. In addition, even though global funding for maternal health has increased steadily, current investments are nowhere near what is needed to fulfill the MDG targets to reduce maternal mortality. The United States has fallen behind other industrialized nations in investing money towards global maternal health. In 2006 and 2007, United States government funding remained constant. However, because of inflation rates, the actual percentage of funds declined by 18 percent over the past decade. Also, a lack of accountability for tracking of United States maternal health funding has made it very difficult to measure specific investments in maternal health programs. In the past, United States investments in other global health priorities (ex. HIV and AIDS) via the President's Emergency for AIDS Relief have played imperative roles in increasing access to HIV prevention and treatment. It is crucial that the United States take on the role as a global leader of maternal health.

India

India has one of the highest rates of maternal mortality in the world. In addition, fertility rates have drastically declined. Over 100,000 women die each year from complications due to pregnancy. The majority of the deaths related to pregnancies could have been prevented with minimal medical attention. Many women feel that health care is unnecessary and thus are unwilling to seek medical help when needed. In addition, there are not many available health centers. Another reason why India has such a high rate of maternal mortality is that most women give birth at home where conditions are not sterile and where there are no medical professionals around.

Pakistan

Pakistan declared a public health forum entitled 'Achieving the Millennium Development Goals for Maternal Health and Child Survival in Pakistan' back in 2005. Prime Minister Aziz has agreed to increase expenditures on child care, as well as disease control, communicable diseases being a major reason for maternal death in Pakistan. Pakistan has taken a strong stance on the maternal health, declaring improvements in the health care delivery system, number of qualified nurses and health professionals, and health education. It is determined to fix the 1 in 31 lifetime risk of maternal fatality. However, experts contribute slow growth to lack of resources. Funds are at times allocated inefficiently, and it is assumed that with the help of the United Nations, it can further its goals.

Questions to Consider

1. What can be done to motivate the governments of suffering countries to work with the UNFPA?
2. How will training be provided to underdeveloped nations when their health care systems are already overstrained?
3. How can limited funding be properly allotted to programs striving to eliminate maternal deaths?
4. What kinds of incentives can be given to developing countries where maternal health is not a priority?

Sources

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