Committee: World Health Organization

Topic: The Question of Reducing Maternal and Infant Mortality in Low-Income Regions

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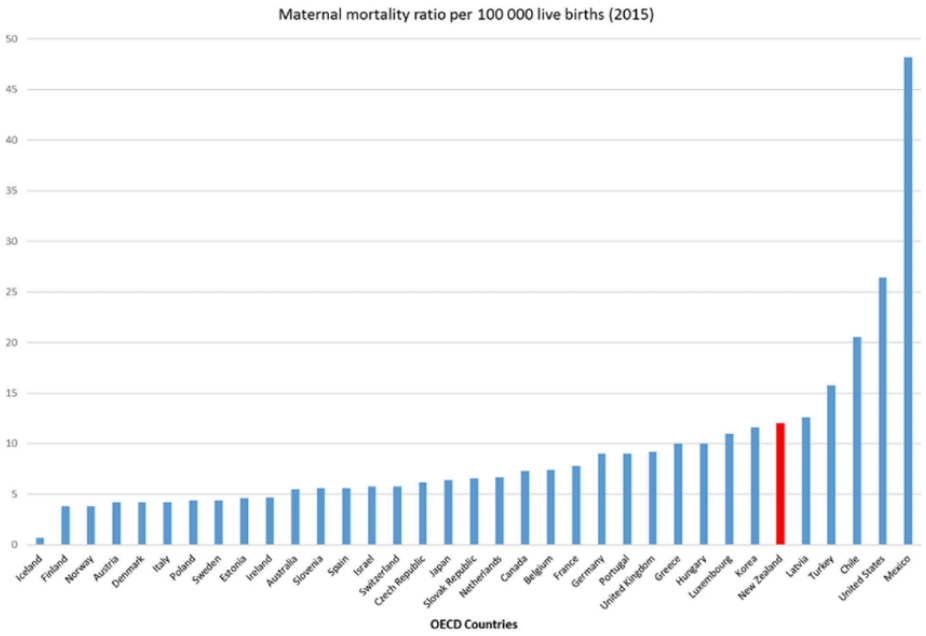
Introduction

The right to life and the right to health are two of the most fundamental human rights, enforced and improved throughout the years. The World Health Organization, which serves to improve global health, was founded 3 years after the United Nations, which displays the importance of global health. The importance of global health was once again brought up by the Sustainable Development Goals. Created to ensure all people's health, justice, and prosperity, the third goal of the SDGs was good health and well-being. SDG 3 explicitly calls for ending preventable maternal and neonatal deaths by 2030, setting quantitative targets to reduce the global maternal mortality ratio to below 70 per 100,000 live births and to end preventable deaths of newborns and children under 5 years of age by 2030 in the first two subgoals.

Indeed, the efforts to reduce both maternal and neonatal mortality were significant. Maternal mortality rates declined by 40 percent in 23 years, dropping from 328 per 100,000 to 197 per 100,000, and neonatal mortality rates also decreased by great numbers from 37 per 1,000 to 17 per 1,000 in only 12 years, according to the United Nations Children's Fund (UNICEF). However, 197 maternal deaths per 100,000 also means that every day, 720 women die because of pregnancy. The situation is worse when it comes to newborns. It is estimated that in 2022 alone, 2.3 million newborns died. Converted, this means each and every day, 6500 newborns die, unable to live a full month. And though the decrease in both maternal and neonatal deaths is impressive, it is also true that from the initial goal of reducing maternal mortality rates to 70 per 100,000, 197 per 100,000 is still way off.

Yet, fortunately, this hardship does not apply to all nations. Nations in the Organisation for Economic Co-operation and Development, or OECD nations, have an average maternal mortality rate of about 17 deaths per 100,000 live births in 2023, which is already less than half of the global

average. Even in Mexico in 2015, when abortion was still considered illegal, maternal mortality rates still did not exceed 50 per 100,000 live births. Japan, which is one of the most medically advanced nations globally, has a mortality rate of 3 per 100,000, which is impressive, considering that South Sudan's maternal mortality easily exceeds 1,000 deaths per 100,000 live births and is estimated to be around 1,150 to 1,223, according to figures from the World Bank. Kat Lay, a global health correspondent, writes in her column in 'The Guardian' that a 15-year-old girl in a low-income country has a 1 in 66 chance of dying from a pregnancy or childbirth-related cause. In a high-income country, however, the figure is 1 in 7,933.



(Maternal mortality ratio per 100,000 livebirths - Organisation for Economic Co-operation and Development, 2015)

Understanding why these disparities exist is essential for addressing them effectively. The polarity between low and high-income nations is in the systemic barriers. While nations with high incomes are capable of providing adequate care for both the mother and the newborn by medical professionals in sanitary environments, many nations with low incomes, especially in Sub-Saharan Africa, suffer from a lack of professional workforce and unsanitary birth environments. These are only the most definitive factors that low-income nations lack. Underfunded health systems, aid shortfalls, healthcare workforce shortages, geographic and gender inequities, and the destabilizing effects of armed conflict in low-income regions lead to consequences such as the erosion of essential health service delivery, the exacerbation of global health disparities, and the undermining of decades of progress toward internationally agreed targets such as the Sustainable Development Goals.

In this issue, it is important to find a solution where lower-income countries find a solution to the pre-existing gaps in medical technology and to clear obstacles like inequalities in healthcare access, political disagreement, and national beliefs. While high income nations are able to provide monetary support for resolving frequent causes of maternal and infant mortality, this is near impossible for low income countries. Even if they are provided funds from high income nations, they should use these resources to improve birthing environments and provide medical support to pregnant women and newborn infants, not conducting research on one's own.

Definition of Key Terms

Mortality Rates

Mortality rates, often mistaken for morbidity rates, refer to the number of deaths in a given area or period, or from a particular cause. Mortality rates essentially indicate the frequency of death within a certain group, but they can also indicate the burden of a certain disease or be used for public health monitoring. Thus, treating mortality rates as just a set of numbers would narrow one's perspective and would restrain them from providing essential solutions to the topic's matter.

Mortality rates can also be separated into specific groups: age, sex, disease, maternal, and infant. The latter two would be discussed further in other columns, so the former three would be explained in more detail. These scopes each provide information that, when utilized, can help strengthen a nation's welfare. Age-specific mortality provides information about the overall health of a given age group and the effectiveness of a nation's intervention. Sex-specific mortality, combined with cause-specific mortality, is used to analyze information on diseases that have a disproportionate ratio of incidence rate between the two sexes. Disease-specific mortality, or cause-specific mortality, can be used to indicate how a certain disease affects a population, identifying how fatal a disease is and the effectiveness of the nation's intervention for it. Using these statistics, one can effectively analyze both the social and epidemiological status of their member state and find solutions to its inferiority.

Morbidity Rates

Morbidity, unlike mortality, refers to having a disease or a symptom of a disease, or the medical problems caused by a treatment. Thus, morbidity rates stand for the amount of disease within a population. When understanding morbidity rates, one should be able to track their incidence and prevalence. The term incidence stands for the number of new cases of a disease that develop in a population over a specific time period, and the term prevalence refers to the total number of both new and existing cases of a disease in a population at a specific point in time.

Morbidity rates work as an indicator to quantify how widespread a health issue is within a specific population. They help in understanding the health status of a population, identifying trends in disease occurrences, and planning for healthcare needs. Morbidity rates are used in various contexts,

such as tracking the spread of infectious diseases and monitoring the prevalence of chronic conditions. It can also be used when calculating insurance rates, especially when calculating premiums for health, life, and long-term care insurance policies.

Infant Mortality

An infant refers to a born child under the age of 1. Thus, infant mortality refers to the death of a child before their first birthday. Infant mortality rate is the number of deaths of infants under one year of age, expressed as a rate per 1,000 live births. Infant mortality rate is a key indicator of a country's overall health and socioeconomic conditions, reflecting factors such as the nation's welfare system, access to nutrition and sanitation, and the state of medical technology.

Maternal Mortality

The term maternal mortality refers to the death of a woman while pregnant or within 42 days of the end of pregnancy, from any cause related to pregnancy or its management. The maternal mortality rate is evaluated by the number of women who die from pregnancy-related complications per 100,000 live births.

Abortion

Abortion can be divided into two types: spontaneous abortion and induced abortion. While spontaneous abortion is the unexpected loss of pregnancy before the twentieth week and is referred to as 'miscarriage', induced abortion is the deliberate termination of pregnancy before the fetus can survive on its own.

Gestational Viability

Being a relatively newly developed term, gestational viability stands for a legally defined point in pregnancy where a fetus is medically considered capable of surviving outside of the uterus. Gestational viability is measured in weeks from the last menstrual period and is typically set between weeks 20 to week 24. As it is nearly impossible to determine the exact point where a fetus can survive outside of its mother's womb, the threshold developed is imprecise, leading to challenges and controversy. Some, like the medical organization American College of Obstetricians and

Gynecologists (ACOG), oppose viability language in legislation, arguing it creates an arbitrary line and stigmatizes late-term abortions, while others argue that the fetal right to life must be guaranteed when the health of both the woman and the fetus is in a severe state.

Gestational Limits

Gestational limits refer to the legal point at which abortion is legally restricted or prohibited, as the gestational viability of a fetus is medically ensured. Gestational limits, like gestational viability, are also measured like gestational viability, and are typically set between week 20 to week 24. However, these limits vary significantly by jurisdiction, reflecting differing cultural and ethical perspectives, and are often based on an estimated point of fetal viability or other specific legal grounds. While some jurisdictions allow abortion without limits, others, such as many countries and US states, have gestational limits that restrict when an abortion can be performed. Ethical and medical controversy is present when setting gestational limits, as while some assert that gestational limits can act as barriers to abortion access and lead people to seek unsafe procedures, others claim that a baby born earlier than gestational limits would be provided life-saving medical care and would be living a life like others.

Contraception and Contraceptives

Contraception is the act of preventing pregnancy. This term can apply to a broad range, as the word ‘contraception’ can stand for a device, a medication, a procedure, or a behavior. Contraception plays a significant role in family planning, as it allows the control of one's reproductive health and affords the woman the ability to be an active participant in her family planning. By helping individuals avoid unintended pregnancies, family planning reduces pregnancy-related health risks, particularly for adolescents. Family planning also enables women to pursue education and employment opportunities, helping families and communities thrive. According to the WHO, about 874 million women are now using modern contraceptives, which helps access to family planning, supports public health, advances gender equality, strengthens health systems, and promotes economic development.

Contraceptives are the tools used to implement contraception, and include methods such as hormonal methods, barrier methods, intrauterine devices, and surgical procedures. Some, like implants, intrauterine devices (IUDs), and sterilization, are highly effective and last for years. Others, such as pills, injections, patches, and vaginal rings, are used regularly and work well when taken

correctly. Barrier methods like condoms are effective at preventing pregnancy if used correctly. However, education about contraceptives is still needed. There are still regions that are not fully aware of the use of contraceptives and engage in sexual intercourse without protection. Nations must educate their citizens about safe sexual intercourse and promote the widespread adoption of it.

Preterm Birth

Preterm birth refers to an infant born before 37 weeks of pregnancy. It is categorized into 3 groups based on gestational age: extremely preterm, being infants born before 28 weeks into pregnancy; very preterm, being infants born between 28 weeks and 32 weeks into pregnancy; and moderate to late preterm, being infants born between 32 weeks and 37 weeks into pregnancy, according to the WHO. 13.4 million infants were born preterm in 2020, which is over 1/10th of all newborns. Though it is not clear why preterm birth occurs, the consequences of preterm birth are significant. Preterm births have a higher mortality rate than regular births, and they may bring lifetime consequences such as visual and hearing loss. So, it is important to provide them with the proper treatment and monitoring they need, especially when half of the infants born at or below 32 weeks die due to a lack of feasible, cost-effective care such as warmth, breastfeeding support, and basic care for infections and breathing difficulties. The lack of technology and care causes an increased burden of disability among preterm babies who survive the neonatal period, so it is important for nations to implement neonatal care.

Sudden Unexpected Infant Death

Sudden Unexpected Infant Death, or SUID, is a term that encompasses all sudden and unexpected infant deaths. SUID can have various causes, such as accidental suffocation, entrapment, or metabolic disorders, but the main factor of SUID is SIDS. Sudden Infant Death Syndrome, SIDS for short, refers to the sudden and unexpected death of an infant under the age of one year, where no apparent cause of death can be found after a thorough investigation, including autopsy. However, ongoing research suggests that unsafe sleep practices such as bed sharing and soft bedding, maternal smoking, and premature birth are all risk factors for SIDS. Risk factors for SUID are more diverse, some depending on specific circumstances such as overheating or the lack of breastfeeding, while other factors include maternal lifestyle choices, such as smoking or alcohol use during pregnancy, prematurity, and low birth weight. Also, certain racial/ethnic groups are at higher risk. Black, Native

American, and Alaska Native infants have a disproportionately higher risk of SUID, likely due to systemic factors such as poverty and discrimination.

Obstetrics and Gynecology

Obstetrics and Gynecology (OB-GYN) is a medical specialty focused on women's health, specifically the care of the female reproductive system and pregnancy. Before explaining in further detail, it is important to understand that obstetrics and gynecology are two different fields of study. Obstetrics is the branch of medicine and surgery concerned with childbirth and the care of women giving birth, focusing on pregnancy, childbirth, and the postpartum period. Gynecology is the branch of medicine focused on the health of the female reproductive system. It specifically focuses on diagnosing and treating disorders of the female reproductive organs and other related women's health issues, such as menopause, hormonal problems, and infertility. These two fields of study were founded in the mid-20th century, when public concerns about women’s health were intensified. The reason the two are put together is that they both focus on the care of women, encompassing both pregnancy and childbirth, and the female reproductive system. They share a foundation in women's reproductive anatomy, endocrinology, and the need for longitudinal care. And as the two have an intertwined nature, medical experts tend to combine them into a single specialty, creating the job of Obstetrician-Gynecologist, who acts as a primary care physician for women. Thus, it is important for a nation to implement Obstetrician-Gynecologists, or to focus on these fields of study.

Antenatal Care and Postnatal Care

Antenatal care (ANC) and Postnatal care (PNC) fall into the category of Obstetrics and Gynecology, and unlike it, are two different specialties. Antenatal care, or prenatal care, monitors a woman during pregnancy to ensure the well-being of the mother and the baby, providing regular check-ups, screening, education, and guidance for the upcoming birth. Postnatal care focuses on recovery for the mother and the newborn, and usually provides maternal and newborn assessment. However, it is important to acknowledge that antenatal care and postnatal care must both be provided to the mother to ensure maternal and infant health, as antenatal care promotes a healthy pregnancy and postnatal care provides the safe transition to the postnatal period by making proper postpartum care essential for survival and long-term health. It is important for nations that struggle with developing an effective healthcare system or unsafe sexual intercourse, as antenatal care and postnatal care work as a link to broader health systems, providing an important connection to the healthcare system, potentially

leading to better access to other services, such as sexual health, contraception, and detection of other health issues.

Neonatology

Neonatology is the branch of medicine that specializes in the care of sick, premature, and critically ill newborn infants. It developed rapidly after President John F. Kennedy signed the bill providing the National Institute of Child Health and Human Development with a 250 million research fund for the development of neonatology. Neonatology takes a big part in reducing infant mortality, as neonatologists manage a wide range of conditions, including respiratory problems, infections, birth defects, and metabolic disorders, to provide specialized care for vulnerable newborns. The most crucial reasons for infant mortality, such as infections, respiratory distress, brain injuries, heart conditions, and intestinal problems, are all dealt with in neonatology, and premature or born with birth defects are mostly treated by neonatologists.

Perinatology

Perinatology is a medical specialty that focuses on the care of high-risk pregnancies and the health of the mother and the developing fetus. Unlike Obstetrics, which sets its scope on the overall care of pregnancy and its aftermath, Perinatology specializes solely in the care of high-risk pregnancies and the health of the mother and the developing fetus. Perinatologists, who are experts in perinatology, diagnose and manage conditions that can occur before conception, during pregnancy, and in the postpartum period, using advanced monitoring techniques like ultrasounds to screen for fetal abnormalities and maternal health issues, ensuring a healthy pregnancy and delivery. They focus on women with chronic conditions such as heart disease or diabetes, high-risk complications such as preeclampsia or multiple pregnancies, and women with fetal risks such as genetic disorders, chromosomal abnormalities, or other congenital issues identified during screening. It is important for regions with high maternal mortality to implement perinatal care in order to reduce deaths from high-risk pregnancies.

Gross Domestic Product

Gross Domestic Product, GDP for short, measures the monetary value of final goods and services bought by the final user produced in a country in a given period of time. It counts all of the output generated within the borders of a country. GDP is composed of goods and services produced

for sale in the market and also includes some nonmarket production, such as education or services provided by the government. The difference it has with Gross National Product (GNP) is that while GDP only holds the output in the country, GNP includes the income of residents who reside outside the country inside the GNP. Countries with high GDP would be able to focus more on the country's health and welfare, while countries with low GDP would prioritize economic growth. Because low-GDP nations would focus on economic growth, the lack of proper treatment for mothers and newborns leads to higher maternal and infant mortality. And the fact that regional governments tend to ignore the predicaments and deaths during and after pregnancy makes proper care even more difficult to access. Thus, it would be irrational for a nation with a low GDP to fully set its scope on improving socioeconomic factors such as healthcare, considering its current stance.

Gross National Income

Gross national income (GNI) is the aggregate value of the gross balances of primary income for all sectors. GNI is the GDP plus net income from abroad of compensation of employees, property income, and net taxes less subsidies on production. Compensation of employees receivable from abroad is that which is earned by residents who essentially live inside the economic territory but work abroad, or for seasonal workers, and whose center of economic interest remains in their home country. Property income receivable from/payable to abroad includes interest, dividends. GNI is used to classify nations, and by it, nations can solidify their stance and focus on what they can and cannot do with their income.

Human Development Index

The Human Development Index (HDI) is a measure of achievement in human development. The standards for the HDI are a long and healthy life, being knowledgeable, and having a decent standard of living. The HDI is the geometric mean of the normalized index for each of the three aspects.

The health area is measured by average life expectancy; the education area is measured by the average years of schooling for adults from 25 and older, and the expected years of schooling for children. The standard of living is measured by GNI per capita. The scores for the three HDI area indices are then aggregated into a composite index using the geometric mean. The HDI can be used to question national policy choices, asking how two countries with the same level of GNI per capita can end up with different human development outcomes. These contrasts can stimulate debate about government policy priorities. While nations such as the United States of America started developing

neonatology, a branch of medicine, back in the 1960s, many nations still do not have a proper Neonatal Intensive Care Unit (NICU) available, exposing the large gap in human development. It is also true that nations with low income struggle even to achieve economic growth, but they should show that they are also taking socioeconomic factors into account.

World Bank Classification of Countries by Income

The World Bank creates a yearly classification of countries by income for all countries with populations over 30,000. The World Bank Group assigns the world's economies to four income groups: low, lower-middle, upper-middle, and high. The classifications are updated each year on July 1st, based on the GNI per capita of the previous calendar year. GNI measures are expressed in United States dollars using conversion factors derived according to the Atlas method, which in its current form was introduced in 1989. The World Bank's income classification aims to reflect a country's level of development, drawing on Atlas GNI per capita as a broadly available indicator of economic capacity.

While countries with high income are more likely to have better welfare, more advanced technology, and a more accessible infrastructure, countries with lower income are not likely to do so. The quality of welfare is directly linked to mortality rates, as the lack of welfare would result in comparatively more deaths. This is also correlated with both maternal and infant mortality rates, as causes and rates of both maternal deaths and preterm births are correlated with the economic and socioeconomic status of a nation. Thus, understanding a nation's economic group/status is important when understanding what a nation can do to resolve a problem it currently faces.

Background Information

Causes that Increase Infant Mortality

There are many factors that influence infant mortality. Primarily, maternal health is a significant factor. Managing pre-existing conditions, taking regular medical checkups can help. For the fetus to maintain good health, it is important for the mother to take preconception and prenatal care, including prenatal checkups, attentive healthcare, and going on a healthy diet to provide proper nutrition to the fetus. Risk-appropriate care during pregnancy could also reduce both maternal and infant mortality, as well as the fetus could be treated if it has a complication. Postnatal care, such as vaccination and breastfeeding, also helps in reducing infant mortality. But the top 5 causes of infant mortality are: 1. Neonatal encephalopathy, or problems with brain function after birth. 2. Infections, especially blood infections, 3. Complications of preterm birth, 4. Lower respiratory infections, and 5. Diarrheal diseases.

The most prominent cause of infant death is neonatal encephalopathy (NE). Unlike congenital disabilities, neonatal encephalopathy happens after birth for a variety of reasons. Hypoxic-Ischemic Encephalopathy (HIE), which is when brain damage is done to newborns due to the lack of oxygen and blood flow during birth, is the most frequent cause, leading to birth trauma and nervous system issues. Happening because of prolonged or difficult labor, improper use of instruments, abnormal fetal positioning, or complications like oxygen deprivation, NE may result in long-term disabilities or even death. Though there is no clear diagnosis of neonatal encephalopathy, medical professionals often suspect newborns with NE with symptoms such as seizures or altered neurological function shortly after birth, so it is important to keep an eye on the baby to see if they have seizures, feeding difficulties, or respiratory problems. Early detection and treatment can improve outcomes and may prevent long-term disability.

The second cause, blood infection in an infant, is called neonatal sepsis. Neonatal sepsis is a leading cause of infant deaths, especially in low income regions, and can be divided into two groups: early-onset sepsis (EOS), and late-onset sepsis (LOS). EOS refers to sepsis before 72 hours after birth while LOS refers to sepsis between 72 hours and 28 days of life. Neonatal sepsis should be treated with rapid intravenous (IV) antibiotics immediately after it is suspected, as prolonging that period may lead to fatal conditions. While EOS is treated primarily with ampicillin and aminoglycosides, a class of antibiotics used to treat serious infections by gram-negative bacteria, such as gentamicin, LOS

typically uses vancomycin and an aminoglycoside or a third-generation cephalosporin, depending on the suspected pathogen.

The third cause, complications of preterm birth, include conditions such as RDS (Respiratory Distress Syndrome), the collapsation of the lungs after exhaling, or ventricular septal perforation, the life-threatening rupture of the muscular wall between the heart's ventricles, most often a complication of a severe acute myocardial infarction (heart attack) or following chest trauma. Though there are a range of complications that happen because of preterm births, the causation of preterm birth itself is still not fully understood. Outside of the reasons mentioned in the key terms, adolescent pregnancy is also associated with preterm birth. According to the WHO, Adolescent mothers (aged 10–19 years) face higher risks of eclampsia, puerperal endometritis and systemic infections than women aged 20–24 years, and babies of adolescent mothers face higher risks of low birth weight, preterm birth and severe neonatal condition.

The fourth cause, lower respiratory tract infection (LRTI), consists of Bronchitis, Bronchiolitis, and Pneumonia. The most prevalent LRTI types in infants are Bronchitis, an inflammation of the bronchioles in the lungs by respiratory syncytial virus, and pneumonia, an infection causing inflammation of the air sacs in the lungs, which can be bacterial, viral, or caused by other microorganisms. Caused by RSV, viruses, and bacteria, LRTI include cyanosis around the lips, flaring of the nostrils, or inward pulling of the chest. It is important to seek a doctor before LRTI further advances, so when an infant show signs of persistent cough, high fever, or difficulty breathing, it is important to see a doctor to get proper treatment, The treatments of LRTI focuses on supportive care, such as maintaining hydration and clearing nasal passages with saline and suction, while hospitalization may be needed for severe symptoms like dehydration or hypoxia.

Lastly, diarrheal diseases take the place of the fifth most prominent cause of infant mortality. The reason why diarrheal diseases, a relatively easier causation to cure, takes place in the top 5 causes of infant mortality is in diarrheal dehydration. Caused by water contaminated by bacterial, viral, and parasiting organisms, diarrhea expels the water and nutrients essential for infants. The dehydration and nutrient loss, along with septic bacteria infection are responsible for the deaths caused by diarrhea. However, the cure to diarrheal diseases are quite accessible, both to low income and high income regions. It should be treated with oral rehydration solution (ORS), a solution of clean water, sugar and salt. In addition, a 10–14 day supplemental treatment course of dispersible zinc tablets shortens diarrhea duration and improves outcomes. To prevent diarrheal diseases, it is important to enhance overall sanitation, especially paying attention to sanitary water supply.

It is also important to recognize that socioeconomic factors also influence infant mortality. Poverty, sanitation, and access to clean water and food all influences infant mortality rates greatly. Accessibility to health care is also a big part in reducing both infant and maternal mortality. If there are many hospitals or health centers that one can access at an affordable price, morbidity and mortality rates will reduce, along with the early treatment of infant health complications.

How Abortion is Performed and How Legalizing Abortion Helps in Reducing Maternal Mortality

To reduce maternal mortality, not only is it important to provide women with quality antenatal care, but it is also vital to provide women with the right to abortion. Though preventing unwanted pregnancies by utilising contraceptives is ideal, unwanted pregnancies happen. And regardless of the causation of unwanted pregnancies, all women, including adolescents, need access to safe abortion services to the full extent of the law, and quality post-abortion care.

There are a variety of reasons why abortion is performed, but it is generally categorized into two groups. The first group, therapeutic abortions, is when abortion is performed by virtue of medical necessity, especially to save the life of the person going through pregnancy, or to prevent the birth of a child with a significant risk of mortality or morbidity. Conditions like severe preeclampsia, placental abruption, or certain heart conditions that may threaten the life of the pregnant individual could be the cause of therapeutic abortion, while fetal abnormalities or genetic conditions that would possibly end up in postnatal deaths could also be a validated reason for therapeutic abortion. The second group, elective abortions, is performed primarily for social or financial reasons. Unwanted pregnancies from lack of contraceptive use are a major cause of elective abortion, and some individuals also choose abortion due to financial concerns, personal decisions, or even from sexual assault.

While most countries fully prohibit abortion before gestational limits, some nations, especially nations in Africa or nations with Islamic cultures, restrict abortion fully, even in situations like rape or incest, or to some extent. Some nations may prohibit only therapeutic abortions, while others may ban the process itself. This restriction on access leads to an increase in illegal and unsafe abortion, as it is nearly impossible to gain access to reliable medical procedures as explained above. The damage it causes, however, is extreme. While deaths from safe abortion are negligible, where less than 1 person dies in 100,000 abortions, the maternal mortality rates are high in regions where unsafe abortions are common, being over 200 per 100,000 abortions. Estimates from 2012 indicate that in developing countries alone, 7 million women per year were treated in hospital facilities for complications of unsafe abortion. Safe abortion methods according to the WHO calls for a medical

professional performing the procedures in a sanitary environment, and methods include: medication abortion, which involves taking pills that terminate a pregnancy; vacuum aspiration, which is an in-clinic or surgical abortion procedure involving gentle suction to remove tissues; dilation and evacuation (D&E), another in-clinic or surgical abortion procedure that involves dilating (or opening) the cervix and removing tissue from the uterus. Unsafe methods, on the other hand, include outdated methods like sharp curettage or the use of illegal drugs. Urgently admitted to the hospital, a woman may need a blood transfusion, major reparative surgery, or a hysterectomy, which is a complete and irreversible removal of the uterus if an illegal performance of abortion fails.

As more and more nations recognize women's bodily autonomy and the dangers of illegal abortion, the global trend is changing to prohibit abortion, at least to some extent. One example is the Republic of Colombia. Before the year 2022, Colombia's laws criminalized abortion, making only three exceptions for decriminalization, which are pregnancy resulting from rape or incest, fetal abnormality, or risk to the mother's health. Even these exceptions were legalized in 2006, laid out by a 2006 Constitutional Court decision. When a woman's health was at risk, when a fetus had serious health problems, or when a pregnancy resulted from rape. Anyone else who had an abortion or helped a woman obtain one could be sentenced to 16 to 54 months in prison. Prosecutors in Colombia open about 400 cases each year against women who have abortions or people who help them, according to the attorney general's office. At least 346 people have been convicted in such cases since 2006. However, the criminalization of abortion faced many protests and criticism throughout the years from its citizens, as it limits the 'self-determination' of Colombian women. From an interview with CNN, Alejandra Gutierrez, a 23-year-old cancer patient from Bogota, had to go through a panel discussion between a gynecologist, a hematologist, and a psychiatrist before her request was approved, receiving little clear information about the risks of pregnancy and going through numerous interviews in the process.

After abortion rights advocates had campaigned for two decades, abortion was finally decriminalized in the Republic of Colombia. On February 21st, 2022, Colombia's nine constitutional court magistrates voted five to four in favor of decriminalization. In an interview following the vote, Judge Alberto Rojas Ríos, who co-wrote the ruling in favor of decriminalization, called the decision "a symbol of the eternal fight for women's freedom" and a step toward "self-determination" for Colombian women. These changes showed immediate effects in reducing maternal mortality, as maternal mortality in 2021 was 147 per 100,000 livebirths, but declined to 59 per 100,000 in 2023. This rapid 59.86% decrease from the year before and after the legalization of abortion shows how much of an effect allowing abortion has on women's health.

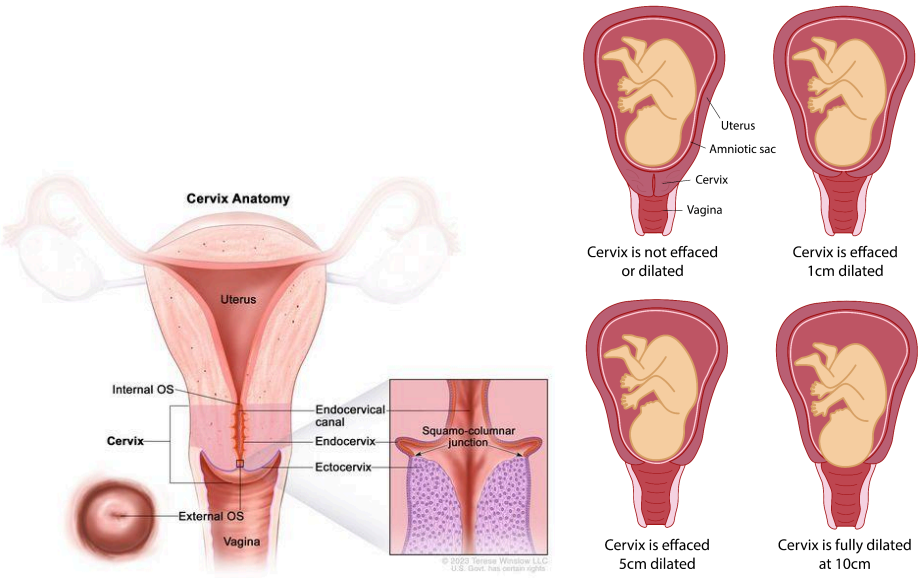
How the Absence of Education about Abortion and Contraceptives Affects Citizens

Contraception and safe abortion care go hand in hand in the strategy to reduce unwanted pregnancies, unsafe abortions, and maternal deaths. Increasing access to modern contraception is an essential component to reducing unintended or unwanted pregnancies and the abortions or unplanned births that often follow. However, contraception alone is not sufficient as a solution. In many regions, not even the basic uses of the most common contraception methods are not explained, which increases unwanted pregnancies. And for every 6 out 10 unwanted pregnancies, induced abortion is chosen, with 45% of them taking the risk of unsafe abortion. What is worse however, is when citizens are not educated about the process of abortion and try to perform it on themselves.

For better understanding of abortion, it is important to understand the female genital organs and the process of fertilization. The female genital organs consist of the ovary, fallopian tube, uterus, vagina, and the vulva. So when the spermatozoa is transported to the uterus through the uterus cervix, it travels through the female reproductive tract towards the fallopian tubes. The fallopian tubes guide the spermatozoa to the ovum, which was previously released from the ovaries during ovulation. A single spermatozoon finally penetrates the ovum's protective layers, or the zona pellucida, and fertilization happens.

This process happens within minutes minutes to 5 days, so if one had been been educated that it is possible to delay or prevent the release of an egg from the ovaries by taking an Levonorgestrel, an emergency contraception pill which is 95% effective during the first 24 hours and 80%~85% effective the second day, they would have been able to prevent pregnancy. However, the absence of education stops many women from protecting themselves from unwanted pregnancies. Since contraceptives are considered 'explicit' or a 'misdeed' in some regions, both men and women are blocked from learning how to utilize contraceptives, and how useful they can be to prevent Sexually Transmitted Infection, or STI in short.

The consequences from the deficit of education are indeed devastating. Many women go through unplanned or unwanted pregnancies since they were not able to properly understand the suitable contraceptive methods for their cases. A study from the NIH indicates that even going through a simple, theoretical based videotape can positively affect the knowledge and perception of contraceptives. This could be a great solution to nations with low income and a high illiteracy rate, since creating audiovisual data would be cost efficient and easy to understand.



(Anatomy of the cervix - National Cancer Institute, 2023) (Cervix dilation - Fertility and Sterility, 1998)

But to understand why educating citizens about safe abortion methods is important, one should understand the anatomy of the uterine cervix. The uterine cervix is the lower, narrow fibromuscular part of the uterus that connects to the vagina, measuring about 3-4 cm in length and 2.5 cm in diameter. The opening of the cervix is called the os, or the orifice, and as seen on the image reference above, both the internal and external os are very narrow, the internal cervical canal generally 8 mm wide, while the external os is generally about 5–8 mm, limited to nulliparous women. This means that it is impossible to self perform abortion by trying to penetrate through the cervix to delete the fetus without dilating the cervix, as the os is too narrow for any non-medical tool to pass through. Even in Manual Vacuum Aspiration (MVA), which is a safe medical abortion service approved by the WHO, it requires a dilating process before the suction tube can be inserted into the womb to remove the pregnancy tissues. Naturally, it is only when the woman is right before giving birth when the cervix begins to dilate, which means beforehand, it is impossible to penetrate through the cervix.

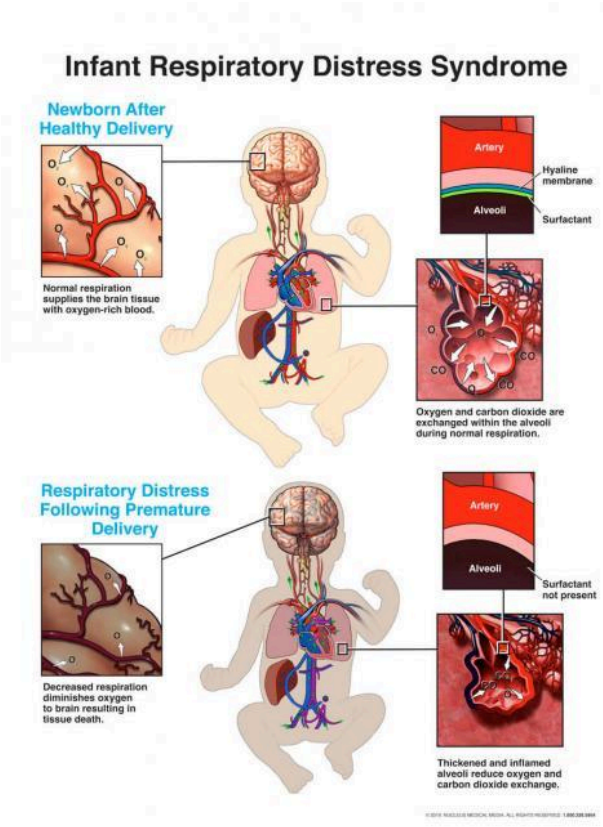
Contrary to common beliefs, abortion performed in sanitary conditions with methods suggested by the WHO is considered safe. In fact, abortion is safer than many common health services, such as taking a shot of penicillin or extracting teeth, if performed the WHO suggested way. However, some citizens, especially those who reside in low income regions, are not informed of this information. This leads to citizens fearing abortion as they are perceiving abortion in a distorted way, thinking of it as a highly fatal process and can threaten the life of the pregnant woman. They are not aware that if abortion is performed before the 11th week of pregnancy, it can be done by taking two pills: Mifepristone to end the pregnancy and misoprostol to empty the uterus. Even after the first 11 weeks, there are still other safe abortion methods. The procedures of abortion has developed rapidly in the last 20 years, from Dilation and Curettage (D&C), which dilates the cervix and scrapes out the

uterine tissue using a curette, to MVA, which is a much safer method that uses suction instead of a curette. Social stigma is also another problem. Currently, society has a tendency of equalling fetuses as newborns or human lives. This makes performing abortion a burden, as society treats abortion as a 'sin' as it 'kills' a 'human life.' The social pressure may make the women choose to perform abortion oneself, which can be methods such as sharp sticks inserted up through the vagina and the cervix into the uterus, ingesting toxic substances such as bleach, inserting herbal preparations into the vagina, and inflicting trauma such as hitting the abdomen, or falling. Not only are these methods ineffective, these may lead to consequences including severe haemorrhage, sepsis, poisoning, uterine perforation, or damage to other internal organs.

It is important to recognize that the 'education' mentioned above also needs to be applied to medical professionals. Taking Colombia as an example, the recent legalization of abortion raised another social issue: the quality of abortion. Being only the third year after abortion was fully legalized, quality control in abortion is a significant concern in Colombia. There still exist training gaps between the illegal providers of abortion, who have gone through the process before legalization, and medical professionals who, though are professionals, lack experience in performing abortion. Complications such as incomplete abortion and heavy bleeding are high, compared to other nations, and the unequal distribution of resources between urban and rural areas makes it hard for medical staff in rural areas to provide safe abortion services and quality care.

How the Main Cause of Infant Mortality Was Resolved

According to the National Institute of Health (NIH), Respiratory Distress Syndrome, RDS for short, was a main cause of infant mortality in the United States of America in the 1980s. RDS is a breathing disorder that occurs due to the lack of pulmonary surfactant, a substance that reduces surface tension in one's lungs. The pulmonary surfactant prevents the lungs from collapsing after exhalation, providing the necessary oxygen one needs. Without it, newborns aren't able to breathe properly, and the alveoli, or air sacs, become thickened and inflamed. RDS mainly occurs in infants before 28 weeks of age, making it hard for newborns to obtain the necessary levels of oxygen they need, sometimes leading to death.



(How RDS affects infants - National Heart, Lungs, and Blood Institute, 2022)

RDS, previously named as Hyaline Membrane Disease (HMD), was the reason that led former U.S. President John F. Kennedy's second-born son, Patrick, to his death. On August 7, 1963, Patrick was born as a preterm infant and had conditions of HMD. He was immediately transported to Boston Children's Hospital, but unfortunately, the hospital did not have a neonatal intensive care center, and Patrick died 39 hours after he was born.

The death of Patrick Bouvier Kennedy focused new attention on HMS, both to researchers and the public eye, and this was when President John F. Kennedy signed the bill providing the National Institute of Child Health and Human Development (NICHD) with a 250 million research fund for the study of HMS and the development of neonatology. The results of the research were significant. For instance, the name Hyaline Membrane Disease was replaced with Respiratory Distress Syndrome, and researchers found that the cause of RDS was due to the lack of surfactant in an infant's body. Innovations were made to NICU devices, and new jobs such as neonatal nurses were created.

But even after these attempts, the cure to RDS wasn't found. As the lungs of newborns right after they are born, newborns with RDS need ventilators to expand their lungs. And as newborns were

comparably small in terms of size and were immature, the process was burdensome and had to be more delicate. It was only after 1980 that Professor Tetsuro Fujiwara of Iwate University used pulmonary surfactant from cow lungs to create a medicine that is still currently used to cure RDS, reducing infant deaths. Now, infant deaths due to RDS are less than 2%, or 12.6 per 100,000 live births, whereas in the 1950s and 1960s, when oxygen was the only cure for RDS, the mortality rates were over 50%.

The success story of RDS indicates various facets. It shows that solutions could be found to problems unsolved if both academic and public interests are considered. Neonatology developed precipitously, new jobs were created, and an essential cure for the disease was found. It shows a potential for finding solutions to unsolved factors of infant deaths, such as SIDS. However, research, especially done intensively in an untouched field, does need a great deal of funds. Thus, countries with strong economic strength usually conduct large-scale research or produce products. To reduce maternal and infant mortality in low-income regions, it is important to cooperate with high-income countries such as the United States of America or Japan in order to get assistance in terms of education and technology.

Possible solutions

Reducing Burdens in Healthcare and Expanding National Welfare Systems

Many countries, including the USA and China are countries that do not provide universal health coverage. According to the World Bank, the benefit of universal health coverage allows countries to build a strong human capital asset. Every country needs their people to sustain their nation, so providing them with fair welfare and healthcare services benefits both the nation and its people. Supporting health represents a foundational investment in human capital and in economic growth. It also reduces the mortality rates of a nation, as healthcare gets more accessible to people with relatively low income. Women are able to receive antenatal care, which helps in maternal and newborn assessment. Antenatal care may also reduce maternal mortality by performing induced abortion earlier in their pregnancy in safer methods. As they are able to check the medical conditions of themselves and the fetus, they would make necessary decisions if the woman or the baby has severe health risks or if the fetus has congenital disabilities. Postnatal care, supporting safe transition to the postnatal period, would help reduce infant mortality, as newborns would be assisted after birth. With lower infant mortality rates, children can grow to support and sustain their nation as they reach their full potential, while adults are able to live healthy lives. MEDC countries or countries categorized as middle-high or high income that don't provide universal health coverage can utilize this method to lessen the burden of healthcare and health insurance, reducing both maternal and infant mortality rates to SDGs goals or lower.

Requesting Foreign Aid

LEDCs or countries with low income or welfare should be the member states that would specifically focus on this solution. By adopting this solution, nations that are willing to receive financial aid do so with a reasonable excuse to obtain monetary support. Reasons may vary from achieving the SDGs goals to This is essential to the countries obtaining the money because the money can then be used to enhance national welfare, conducting research on this matter, or using the money to increase hygienic birthing environments or medical infrastructure. However, nations such as LEDCs would not be in favor of providing monetary support. As they are primarily aiming their scope to increase national income, LEDCs tend to care less in providing its citizens with quality healthcare, not to mention the lack of infrastructure it holds. LEDCs must search for a reasonable cause for the support or provide other resources in return for obtaining monetary support.

Carrying Out Sex Education

Like infant mortality, maternal mortality can be reduced by proper treatment, better welfare, and hygienic birthing environments. But there are other ways than just improving health care systems that could significantly reduce maternal mortality, education. In some areas, proper education about reproductive rights and the use of contraceptives is not provided. This causes a steep rise in illegal and unsafe abortions, as women have to deal with unwanted pregnancies. External organizations like Médecins Sans Frontières (MSF), also called Doctors Without Borders, work on educating citizens with this information, but there is still a need for regional governments to work on education to raise awareness.

When carrying out sex education, regional governments should primarily focus on educating new generations to protect adolescents from unwanted pregnancies and STI. Nations should concentrate on educating its citizens the various methods of contraception and provide barrier method contraceptives such as condoms.

Decriminalizing Abortion

Though there are still more than 50 countries that strictly restrict the range of abortion or prohibit it completely, the global trend is changing to decriminalize abortion and allow it until gestational limits. Until recently, the vast majority of women of reproductive age in Latin America and the Caribbean, 97%, lived where abortion was highly or moderately restricted by law. That proportion is falling now, as countries such as Colombia now accept induced abortion up to the 24th week in pregnancy, and 3 nations in South America, Cuba, Uruguay and Argentina, also permit induced abortion, decriminalizing it in 1965, 2012 and 2021, respectively. During the last five years, women in South America have been raising their voices about their reproductive rights, starting movements such as the ‘Green Wave’ to fight for the rights of women. Being so influential, the ‘Green Wave’ spread from Argentina to all over Latin America, which played a big role in legalizing abortion both to Argentina and Colombia. Now, Mexico also has similar laws, decriminalizing abortion on demand up to 12 weeks of pregnancy in most of Mexico following a 2023 Supreme Court ruling that found criminalizing abortion unconstitutional.

However, the expedited decriminalization of abortion may lead to unexpected consequences, or even failure. Argentina, though already decriminalized abortion in 2021, is still criticized for inaccessible abortion services. The Guttmacher institute reports that as Argentina is cutting its fund for contraceptives and ending the distribution of abortion pills, it is ‘stripping back’ abortion rights

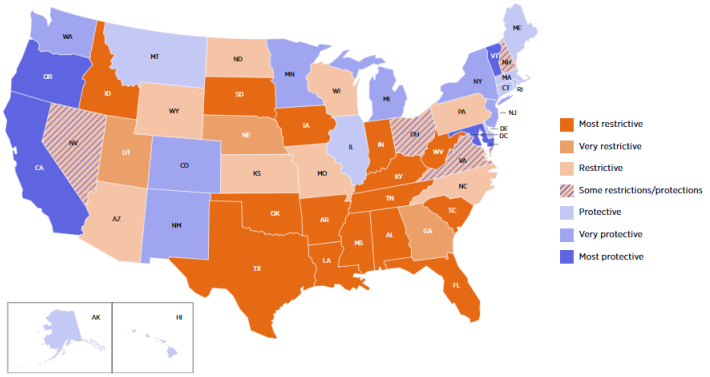
internationally. The Argentinian president Javier Gerardo Milei, after taking power in 2023, is dismantling dozens of public policies relating to women's rights and even claiming abortion as "aggravated murder", not to mention his declaration to the World Economic Forum that feminists were "promoters of the bloody, murderous abortion agenda".

Thus, although decriminalization of abortion is possible and effective, it is important to keep in mind that the change of the regime or the nation's previous beliefs may make it difficult to decriminalize abortion or to uphold the decision. To implement the decriminalization of abortion with precision, it is important to reflect the public's opinion after thorough surveys and research, and make sure it does not contradict major beliefs, especially with state religions, or the majority of the society.

Major parties involved

United States of America

The maternal mortality of the United States of America was 18.6 per 100,000 live births in 2023. Though this number is reasonably lower than the SDG 3.1 objectives, it is still higher than the average maternal mortality rates of the OECD countries, which is 17 per 100,000 live births. The reason why the United States of America has high maternal mortality is in its lack of health support provided to its citizens. The United States of America is one of the few countries that does not provide Universal Health Coverage. Not only that, the prices of health insurance are so high that citizens with lower income are unable to get health insurances or to settle with health insurances with poor coverage. Also, the restricted availability of abortion increases the maternal mortality rates in the USA. As the USA consists of states, each state applies different abortion policies. Some allow it even after the third trimester while 9 of them bans and illegalizes them completely. These factors all contribute to increasing maternal mortality in the USA.



(Interactive Map: US Abortion Policies and Access After Roe - Guttmacher Institute, 2025)

Infant mortality rates in the USA also show similar tendencies on account of the same reasons. From the 2023 annual report of the America's Health Rankings, the United States of America is ranked 33rd out of the 38 OECD countries, with an infant mortality rate of 5.4 deaths per 1,000 live births. Considering that the OECD average is about 3.8 deaths per 1.000 live births, it is clear that the USA's infant mortality rate is significantly higher. Other than the factors that contribute to increasing both the USA's maternal and infant mortality, a wider income disparity and higher rates of poverty also correlate with higher infant mortality.

However, it is true that the USA puts a lot of effort in its research to reduce these mortality rates. As mentioned above, the USA is one of the leading countries in neonatology, finding the cause for RDS in the 1980s. Along with Japan, which also helped resolve RDS by finding an adequate cure, the USA has a potential to be a big contributor in both monetary funds and further research.

Arab Republic of Egypt

Egypt is one of the few countries that criminalizes abortion in almost all circumstances, but a crucial exception allows for procedures to save the mother's life or health, as certified by two physicians. The country's Penal Code restricts and criminalizes unauthorized abortion, with punishments varying depending on involvement and the methods used. However, Egypt has a maternal mortality rate of 17 per 100,000 live births, which, although may not seem impressive when taking OECD nations like Japan into account, but considering that the average maternal mortality rate in the African region is 442 per 100,000 live births, this is an impressive number. The infant mortality rate in Egypt is also relatively low compared to the average of the African region, being 15.00 in 2023 while the average of the African region is 47.00.

The reason why Egypt’s maternal and infant mortality rate is lower than neighboring nations is due to improved health services, including extensive training for healthcare providers, the establishment of a national maternal mortality surveillance system to guide interventions, and the impact of Safe Motherhood programs in reducing deaths from major causes like hemorrhage. The distinctive feature of Egypt’s system is in its Safe Motherhood programs, the National Maternal Mortality Surveillance System (NMMS). The NMMS collects data including the 1992-93 and 2000 studies, allowing the tailoring and evaluation of interventions, leading to informed program adjustments. Because Egypt uses a Data-Driven Approach, data collection and monitoring have been crucial in understanding trends and informing strategies to improve maternal and child health outcomes, creating the NMMS has contributed to decreasing mortality rates.

Also, Egypt provides universal health coverage through its Universal Health Insurance System (UHIS), launched in 2018 with the goal of covering all citizens by 2030/2032. While the system is in a phased implementation, it aims to ensure access to quality healthcare services without causing undue financial hardship. Though it still has challenges like population growth and physician shortages affecting its progress, these efforts all contribute to reducing both infant and maternal mortality.

Republic of South Sudan

In contrast to Egypt, where maternal mortality rates are almost the lowest in the region, South Sudan shows an exceptionally high maternal mortality rate of 1,223 per 100,000 live births. This rate is not only the highest in the African region but also the highest in the world, exceeding the average maternal mortality rate in Africa by almost 3 times and also exceeding the SDG 3.1 goal by more than 17 times. The situation is only getting worse, as the maternal mortality rate in South Sudan is increasing, from 1,150 in 2017 to 1,223 in 2023. For newborns, the burden is equally severe, with 40 deaths per 1,000 live births and a stillbirth rate of 26 per 1,000. This high rate, linked to long-term socio-political instability, a weak healthcare system, and limited access to skilled health personnel and emergency care, highlights the significant challenges in maternal and newborn healthcare within the country.

Outside of regular socioeconomic factors, South Sudan has recently gone through a civil war. Started in 2013, the South Sudanese Civil war began when President Salva Kiir fired Vice President Riek Machar, accusing him of orchestrating a coup. The tension escalated, creating corruption and political conflict and eventually, war. Officially, the war was resolved in 2018, when the 2018 Revitalized Agreement on the Resolution of the Conflict in South Sudan (R-ARCSS) was made, establishing a power-sharing government and a commitment to unify armed forces, leading to the formation of a unity government in 2020. However, the increased tension in South Sudan, from rising military conflicts, is a warning of another war. The latest wave of violence erupted on 4 March when a youth militia called the ‘White Army’ overran the South Sudanese army. In response, Government forces launched retaliatory aerial bombardments on civilian areas, causing significant casualties. If this situation is prolonged, another war might break out, resulting in more civilian deaths.

Thus, it is important for South Sudan to de-escalate the tension within the nation and focus on recovery rather than immediately turning its focus on healthcare and reducing both maternal and infant mortality. Though it holds natural resources, it is virtually impossible for South Sudan to carry out policies or implement infrastructure targeted for maternal care as it is not its priority to reduce maternal mortality rates when a war is about to break out. Rather, it should ask the United Nations or other external agencies for support to increase the number of skilled healthcare professionals, such as midwives, and also for financial assistance if they are hoping to reduce such mortality rates.

Timeline Of Events

Date	Description of event
Adoption of the World Summit for Children September 6, 1990	UNICEF and world leaders pledged to reduce child and maternal mortality as part of the first global commitment toward child survival.
Launch of the Millennium Development Goals (MDGs) September 8, 2000	UN members committed to MDG 4, lowering the global under-five mortality rate by two-thirds between 1990 and 2015, and MDG 5, reducing the maternal mortality ratio by three-quarters and achieving universal access to reproductive health services.
Partnership for Maternal, Newborn & Child Health (PMNCH) Founded April 19, 2005	WHO, UNICEF, and partners formed a coalition to align global efforts in reducing maternal and infant mortality and to contribute to further worldwide progress for women's, children's and adolescents' health and well-being.
Launch of the UN Global Strategy for Women's and Children's Health September 20, 2010	Announced by UN Secretary-General Ban Ki-moon, mobilizing over $40 billion in commitments to improve maternal and child health worldwide.
Adoption of the Sustainable Development Goals (SDGs) September 25, 2015	SDG 3 set a global target to reduce maternal mortality to less than 70 per 100,000 live births and to end preventable deaths of newborns and children under 5 years of age by 2030.
Every Woman Every Child (EWEC) Global Strategy 2016–2030 January 23, 2017	Implementation began to accelerate efforts toward the SDGs, with focus on equity and access to health services in low-income regions.
WHO launches recommendations on antenatal care June 11, 2019	WHO released updated guidelines to improve quality of care during pregnancy, aiming to prevent avoidable maternal and infant deaths.
Global "Ending Preventable Maternal Mortality" (EPMM) Targets Updated May 5, 2021	WHO and partners revised global strategies with 2025 and 2030 milestones, emphasizing emergency obstetric care, skilled birth attendance, and health equity.
UNICEF and WHO Joint Report on Child Mortality September 21, 2022	The report highlighted slow progress in low-income regions and called for urgent acceleration of maternal and infant health programs.

UN Involvement, Resolutions, Treaties and Events

- The World Health Assembly (1948~)

The World Health Assembly saw a resolution to accelerate progress towards reducing maternal, newborn, and child mortality, with support from health professionals. The Partnership for Maternal, Newborn & Child Health (PMNCH) flagship events at 77th World Health Assembly focused on galvanizing political leadership and promoting collaborative action on MNCH. It additionally adopted resolutions like WHA55.19 (2002) and WHA57.12 (2004), specifically addressing reproductive health, which is closely linked to maternal health.

- The Human Development Report (2004)

The Human Development Report (HDR) is an annual report intended to provide a ranked list of all member countries according to the level of human development. It is a summary measure of average achievement in key dimensions of human development: a long and healthy life, being knowledgeable and having a decent standard of living. The HDI is the geometric mean of normalized indices for each of the three dimensions. The Human Development Report has had an extensive influence on development debate worldwide.

- The Convention on the Elimination of All Forms of Discrimination against Women is a treaty overseen by the CEDAW Committee, prohibits discrimination against women in health care, including maternal health which was established in 1979. The Committee has addressed maternal mortality as a human rights issue, emphasizing the need for timely and non-discriminatory access to maternal health services.

- The Safe Motherhood Initiative (1987), launched at the International Conference on Safe Motherhood in Nairobi, urged UN member states to improve women's health and reduce maternal mortality. This initiative also highlighted the disparity in maternal health between developed and developing countries.

- The International Conference on Population and Development (ICPD) (1994) Programme of Action promotes universal access to reproductive health services and addresses social determinants of health, which are crucial for reducing maternal mortality.

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- Human rights Council Resolution 18/2 (2011) called for technical guidance on applying a human rights-based approach to maternal mortality reduction.
- A WHO program, EPMM (2015), as mentioned above, stands for Ending Preventable Maternal Mortality. It aims to eliminate health inequities and improve the quality and outcomes of care for maternal and newborn health by focusing on women's empowerment, a human rights approach, and country-level leadership.
- SDG 3.1 (2015) specifically targets a reduction in the global maternal mortality ratio to less than 70 deaths per 100,000 live births by 2030.
- SDG 3.2 (2015) focuses on ending preventable neonatal deaths, or deaths of newborns and children under 5 years of age, by 2030.
- SDG 3.7 (2015) aims for universal access to sexual and reproductive health-care services to achieve reproductive health and rights.

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