World Health Organization (WHO)

TOPIC A:

The question of enabling access to maternal healthcare to meet the 2030 Sustainable Development Goal (SDG).

I. Introduction of Topic:

Enabling access to maternal healthcare is part of the third goal of the 2030 Agenda “Ensure healthy lives and promote well-being for all at all ages”.The goal is to reduce the maternal death rate worldwide to less than 70 per 100,000 live births. Health as a universal human right, regardless of background and status, is a key feature of global health policy, as expressed in the UN Sustainable Development Goals and related actions. It includes women’s and children’s health and the aim is to guarantee maternal health. WHO is in charge of tracking the World Health Organization's progress towards the reduction of maternal deaths. To support the achievement of global targets and evidence-based strategies for ending preventable maternal mortality (EPMM) and improving maternal health and well-being, WHO produces data, research, clinical guidelines, and programmatic tools. The health of women during their pregnancies, deliveries, and postpartum periods is referred to as maternal health. To ensure that women and their infants achieve their maximum potential for health and well-being, every stage should be enjoyable.

Despite significant advancements over the previous 20 years, 287,000 women lost their lives during or after pregnancy and childbirth in 2020. In addition to indirect causes like anemia, malaria, and heart disease, the most frequent direct causes of maternal injury and death are high blood pressure, infection, unsafe abortion, obstructed labor, and excessive blood loss.

The majority of maternal fatalities can be avoided with prompt intervention by a qualified healthcare provider in a caring environment. However, merely making it through pregnancy and delivery cannot ever serve as an indicator of

effective maternal health care. To improve health and well-being, it is crucial to increase efforts aimed at reducing maternal injury and disability. To guarantee that every woman has access to respectful and high-quality maternity care, it is essential to address inequalities that impact health outcomes, particularly those related to gender and sexual and reproductive health and rights.

This issue affects majorly vulnerable women. 94% of all maternal deaths occur in low and lower-middle-income countries. The highest rates of maternal mortality are found in poorer and rural communities. Pregnant teenagers (ages 10–14) are more likely than other women to experience complications and even pass away. Women's and newborns' lives can be saved by providing skilled care before, during, and after childbirth.

II. Definition of key terms:

Pregnancy: the period in which a fetus develops inside a woman's womb or uterus. Pregnancy usually lasts about 40 weeks or just over 9 months.

Childbirth: the completion of pregnancy where the baby or the babies are finally born; the act of giving birth to a baby.

Maternity/maternal health care (MHC): all formal health care related to pregnancy, prenatal care, childbirth, and postnatal care.

Maternal mortality: the death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the place of death, from any cause related to or aggravated by the pregnancy, or its management, but not from accidental or incidental causes.

Family planning (FP): the practice of controlling the number of children one has and the intervals between their births, particularly by means of contraception or voluntary sterilization.

Primary health care (PHC): essential healthcare made universally accessible to individuals and acceptable to them at a cost the country and community can afford.

Obstructed labor: labor that does not advance despite adequate uterine contractions because fetal size is out of proportion to the mother's birth canal.

Abortion: the deliberate termination of a human pregnancy, most often performed during the first 28 weeks of pregnancy.

Maternal injury: mechanical or anoxic trauma incurred by the infant during labor or delivery to the mother.

Maternal morbidity: the state of health of a mother and the presence of certain physical or mental illnesses related to pregnancy and/or childbirth.

Vulnerable women: all categories of migrants but also categories of native women such as ethnic minorities, poor and homeless women, sex workers, disabled women, female victims of violence, addicts to drugs, HIV-positive women, and female prisoners.

Postnatal care: a form of social care shaped by welfare state policies but also by cultural norms. These formulate the assumptions about whether the need for care exists, how it is provided, whether it is formal or informal, its duration and geographical location, as well as how it is financed.

Antenatal care (ANC) coverage: an indicator of access and use of health care during pregnancy. The antenatal period presents opportunities for reaching pregnant women with interventions that may be vital to their health and wellbeing and that of their infants.

Skilled birth attendant (SBA): an accredited health professional such as midwives, doctors, or nurses who has been educated and trained to proficiency in the skills needed to manage women during normal (uncomplicated) childbirth and the immediate postnatal period as well as in the identification

III. Background information:

The development of technologies and drugs to prevent and manage obstetric complications was crucial, but change occurred at different rates in different countries, despite the general availability of the new technologies. What made a difference was the political will to implement these technologies required societal recognition of female social, economic, and political emancipation as a prerequisite for social development and social peace, and the involvement of medical professionals in promoting this emancipation.

In 1928, the UK's Ministry of Health initiated investigations into the persistently high rates of maternal death, prompted by concerns from the medical community. Government committees of inquiry were established to investigate women's health conditions, including non-political representation from women's organizations. Senior medical professionals and the women's movement worked together to ensure that no government could disregard women's health, particularly during pregnancy and childbirth.

An explicit provision of the WHO Constitution addresses maternal and child health. One of the Organization's responsibilities is "to promote mother and child health and welfare. However, the WHO was not founded before there was a global interest in safe motherhood. In 1930, the League of Nations Health Section raised concerns about maternal mortality, reflecting the increasing interest of many colonial powers to transfer to their colonies the benefits of medical progress, which was evident it would not suffice.

This established the foundation for the WHO and UNICEF-sponsored 1978 International Conference on Primary Health Care in Alma Ata. Nations made a clear commitment to create comprehensive health plans that addressed the underlying social, economic, and political causes of illness in addition to just offering services. Primary health care (PHC) would be free for all, meet the needs of the underprivileged, promote community involvement, and concentrate on addressing the major issues facing the community, such as maternity and child health.

NGOs and UN agencies frequently established vertical family planning organizations apart from the health sectors to support population policies in developing nations. Donors neglected various aspects of women's health, such as the safety of pregnancy and childbirth, in their quest to demonstrate the efficacy and efficiency of their aid.

In the 1970s and 1980s, infant mortality data became more reliable due to statistical improvements and household surveys. In 1985, WHO supported community studies on maternal mortality rates in developing nations, estimating that 99% of maternal deaths worldwide occur in developing countries, based on these studies and hospital data. In 1987, Dr. Hafdan Mahler, the Director-General of the World Health Organisation, highlighted the neglect of women's health compared to child survival and health. In 1989, the World Summit for Children in

New York brought together senior representatives from nations, NGOs, and the international development community. The summit aimed to track maternal mortality reduction and increase prenatal care attendance, highlighting the need for a more comprehensive approach to child health. However, the primary focus of maternal mortality research was on guaranteeing the survival and well-being of children. The 1976–1985 UN Decade for Women contributed to introducing women's health and rights to the center of the global conversation. The 'Forward Looking Strategies,' (British Medical Bullettin) which demanded a decrease in maternal mortality by the year 2000, were the culmination of the Decade.

The International Day of Action for Women's Health was established on May 28, 1990, following a call to action by the Latin American & Caribbean Women's Health Network International and the Women's Global Network for Reproductive Rights. The campaign aimed to raise awareness of maternal mortality, particularly in Latin America, and addressed unsafe abortion practices as well as the subpar treatment that women—especially poor or indigenous women—received from the official health care system.

The United Nations held a series of international conferences in the mid-1990s. The social, cultural, and gender-based determinants of health and development were once again the focus of discussions at the International Conference on Population and Development (ICPD) in Cairo in 1994, the Fourth World Conference for Women (FWCW) in Beijing in 1995, and the Social Summit in Copenhagen in 1995. These conferences led to a reevaluation of development initiatives, with a focus on safe motherhood and a broader perspective on women's health and reproductive issues.

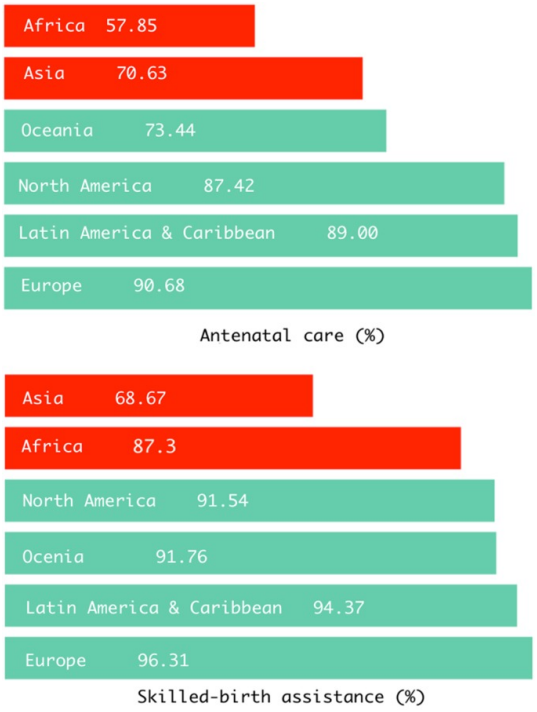
The changes in perspective that took place in Beijing and Cairo, along with the reaffirmation of the connections between human rights and health, added an important new dimension to the movement in favor of safe motherhood. There was a claim that maternal deaths weren't like other deaths. For the benefit of humanity, women must go through pregnancy as a normal physiological process rather than as a disease. As long as humans can reproduce, women will still require care during pregnancy and childbirth. Failure to take action to prevent maternal death amounts to discrimination because only women face the risk. This perception of the different nature of maternal mortality within the general context of illness and disease has stimulated renewed interest in a rights-based approach to safe

motherhood.

The Millennium Declaration, adopted by 189 nations in December 2000, aims to improve maternal health and reduce maternal mortality. The Millennium Development Goals (MDGs) are a framework for assessing development progress, focusing on significant improvements in people's lives, especially for the poor.

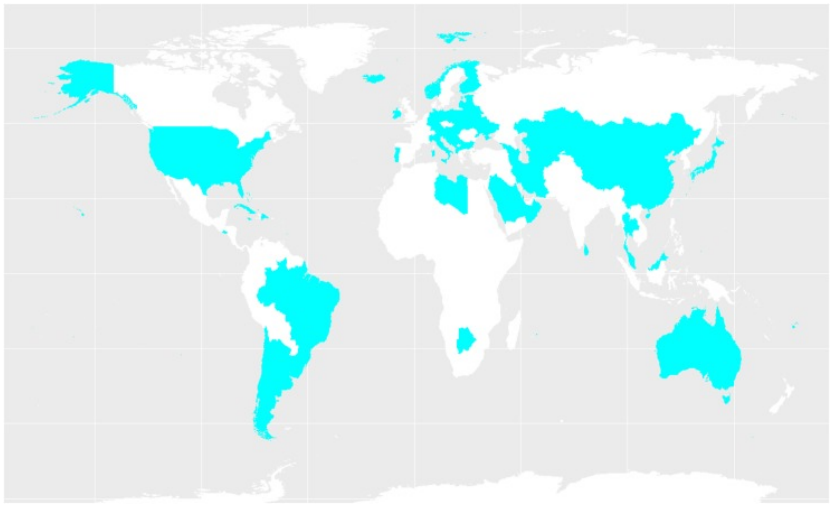
IV. Major countries and agencies involved in the issue:

Globally, the poorest performing countries included Afghanistan, Somalia, and South Sudan where more than three-quarters of the women remained deprived of antenatal care (ANC) and skilled birth assistance (SBA) services during 2012 and 2015, which comprised a critical component of the entire health system owing to its pivotal role in ensuring safe motherhood and survival and health of newborns as well the overall well-being of families and communities.



(National Library of Medicine from WHO)

We can see that the percentage of both ANC and SBA is below 50% in Asia and Africa, which are the least developed continents in this aspect.



Regions with a prevalence of Anc and Sba use above global average. (National Library of Medicine from WHO)

Regions with a prevalence of Anc and Sba use below global average. (National Library of Medicine from WHO)

Maternal mortality ratios (MMR) have been reported to have decreased nationwide in Bolivia, Bangladesh, China, Nepal, and Honduras. The initiatives in these nations focused on particular regions with high rates of maternal mortality, giving particular attention to the most isolated rural areas. The interventions included the creation of financing systems such as

community-based funds, the removal of financial barriers to maternal health care services such as the establishment of Maternal and Child National Insurance (Bolivia, China, and Nepal), and the development of health facility accountability such as health facility performance-based funding (in certain Chinese provinces). It was reported that these policies would make skilled attendance more accessible to women.

Furthermore, the Pan American Health Organization's (PAHO) Latin American Centre for Perinatology / Women's Health and Reproductive Health (CLAP/WR) was founded in South America. This organization offers excellent technical cooperation to support, enhance, and improve women's, mothers', and newborns' health care throughout the nations in the Americas region. It was established in Montevideo in 1970, and the Health Systems and Services (HSS) Department currently houses it. Its operational areas fall under a number of the third Sustainable Development Goals (SDGs), including lowering the rate of maternal death, lowering the death rate of newborns, and lowering the premature death rate from non-communicable diseases through treatment and prevention.

V. Previous resolutions and decisions:

Seventy-second World Health Assembly, Agenda item 11.5, 24 May 2019, “Community health workers delivering primary health care: opportunities and challenges”, https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_R3-en.pdf

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