PUCP MUN 2025

| STUDY GUIDE

CSW

Commission on the Status of Women

Strengthening maternal health and reducing mortality in developing countries, conflict zones, and under-resourced settings

INDEX

1. Letter from the Secretary General

Dear delegates and faculty advisors of PUCP MUN 2025,

It is an honor to address you as the Secretary-General of the 14th edition of PUCP MUN 2025. Over the past seven years of participating in Model United Nations, taking on various roles and engaging at both national and international levels, I have had the privilege of experiencing the transformation these events bring to young people. This experience has given me a unique perspective on MUN: they are one of the most powerful tools for youth education and empowerment, more than we often realize. MUN has changed my life, offering me the chance to enhance my leadership, public speaking, and teamwork skills, as well as gain a deep understanding of international issues. This long but rewarding journey has now led me to the honor of leading the biggest conference in the country, with the primary goal of providing you with a unique and formative experience at all levels.

For this edition, we have managed to bring together more than **1,000 participants** and, through great effort, we have established valuable connections with the United Nations and other international organizations. With the support of **Pontificia Universidad Católica del Perú**, this conference is grounded on three fundamental pillars: academic and organizational excellence, decentralization, and the formative experience we offer.

From my perspective, we have identified three key issues that will guide this conference. First, closing educational gaps to provide an accessible space for all students. Second, bringing Model United Nations closer to the real work of the United Nations. And third, placing the human factor at the center of discussions, recognizing that behind every committee and every debate are human lives directly impacted by the issues we address.

I deeply thank the team that has made this edition possible, as well as **PUCP** for its unwavering support. To you, delegates and participants, I assure you that you will experience a journey filled with learning and personal growth during **PUCP MUN 2025**. We eagerly await your participation and hope that you make the most of this opportunity.

Sincerely,

Micaela Loza Rivera
Secretary-General of PUCP MUN 2025

PUCP MUN 2025

COMMITTEE GUIDE

2. Introduction to the committee

The Commission on the Status of Women (CSW) was first established in June 1946 under the Economic and Social Council (ECOSOC). Its devotion to ensure equality by promoting women's rights developed in the arduous responsibility of advancing towards the incorporation of women in national and international affairs. Hence, during the first session of the Commission at New York, 1947, the first achievement was obtained: a revision of the Universal Declaration of Human Rights to include gender-sensitive language against the generalized use of "men" as a synonym for humanity.

Up until 1962, the efforts of the CSW remained focused in setting standards and formulating international conventions motivated to change discriminatory legislation and foster global awareness of women's issues: lack of universal access to political rights, illiteracy, economic dependence, amongst others. Such efforts drove the UN General Assembly to request a draft resolution for a Declaration of the Elimination of Discrimination against Women, ultimately adopted in 1967. Furthermore, the Commission recommended that 1975 be designated International Women's Year, followed by the UN declaring 1976 to 1985 the United Nations Decade for Women: Equality, Development and Peace. From then on, a series of global conferences and summits facilitated the integration of a common agenda to support the empowerment of women, especially the Fourth World Conference on Women (Beijing, 1995). According to UN Women (2019).

> The Beijing Declaration and Platform for Action, adopted unanimously by 189 countries, built on political agreements reached at the three previous global conferences on women, and consolidated five decades of legal and policy advances aimed at securing the equality of women with men in law and in practice. (p. 12)

Currently, the CSW remains attentive to the achievements of measurable results with the 2030 Agenda for Sustainable Development, identifying six strategies to accelerate implementation: strengthened laws and policies; strengthened and increased support for institutional mechanisms for gender equality and the empowerment of women and girls; the transformation of discriminatory norms and gender stereotypes; significantly increased investment to close resource gaps in the implementation of the Platform for Action; strengthened accountability for the implementation of existing commitments; and enhanced capacity-building, data collection, monitoring and evaluation (UN Women, 2019, p. 17). With over 70 years of existence, the Commission on the Status of Women has transformed the path to achieve gender equality and support the development of women's capacities globally. The commitment remains intact, expanding the normative framework, consolidating fair practices and building an equal community for women and girls everywhere.

3. Introduction to the topic

Especially for those living in conflict-affected areas and developing countries, women's issues are barely taken into account when political action is designed. According to *Women's Health Care* (2013), a woman's chance of dying during childbirth is 300 times higher in contexts with limited resources, most often due to obstetric hemorrhage, obstructed labor, infection, or other direct and indirect causes (p. 2). Similarly, UNICEF (2023) reports that "712 women are dying each day from complications in pregnancy and childbirth, which is equivalent to one every two minutes." Even though the global maternal mortality ratio (MMR) has decreased by 40 percent from 2000 to 2023, significant progress is still needed to improve maternal health coverage and equity.

The Sustainable Development Goals (SDGs) aim to reduce the global maternal mortality ratio to fewer than 70 deaths per 100,000 live births by 2030. However, statistics alone do not reveal the deeper issue: maternal mortality reflects a structural problem rooted in the status of women. Societal inequalities, intertwined sexism, and unequal access to power and resources continue to define the experiences of women in much of the developing world. These inequalities translate directly into limited access to health care, economic instability, and vulnerability to violence, all of which increase the risks of pregnancy and childbirth.

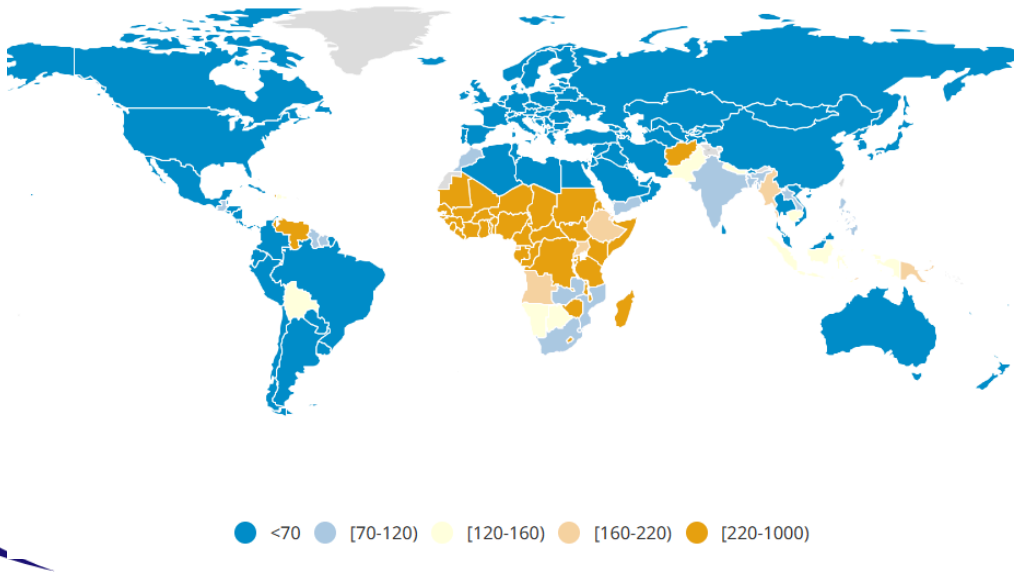
In many of the poorest or most fragile countries, maternity is not a joyful or safe experience. It is often shadowed by fear and uncertainty. Insufficient clinics, understaffed hospitals, dangerous travel routes, and cultural barriers limit women's ability to reach medical care when they need it most. Behind every number is a mother, a sister, or a daughter who wanted nothing more than to bring a child safely into the world. In 2023 alone, more than 260,000 women lost their lives to pregnancy or childbirth-related causes (World Health Organization, 2025). These women's deaths were not inevitable, they were preventable if they had adequate systems and support in place. In under-resourced settings, essential medicines are often out of stock, skilled birth attendants are scarce, ambulances may never reach remote villages, and health facilities may have been damaged or destroyed by conflict. At the same time, women face social norms that discourage them from seeking care, and in many households, decisions about their health are not theirs to make. The United Nations Population Fund (UNFPA, 2025) warns that "harmful gender norms, stereotypes and inequalities continue to limit access to essential services" (p. 17). When a woman lacks autonomy over her body and her health, her life is at greater risk, and so is the future of her family and community.

The connection between maternal health and broader societal well-being cannot be overstated. A woman who gives birth in a safe hospital, attended by skilled professionals and supported before and after delivery, is more likely to survive, to recover fully, and to

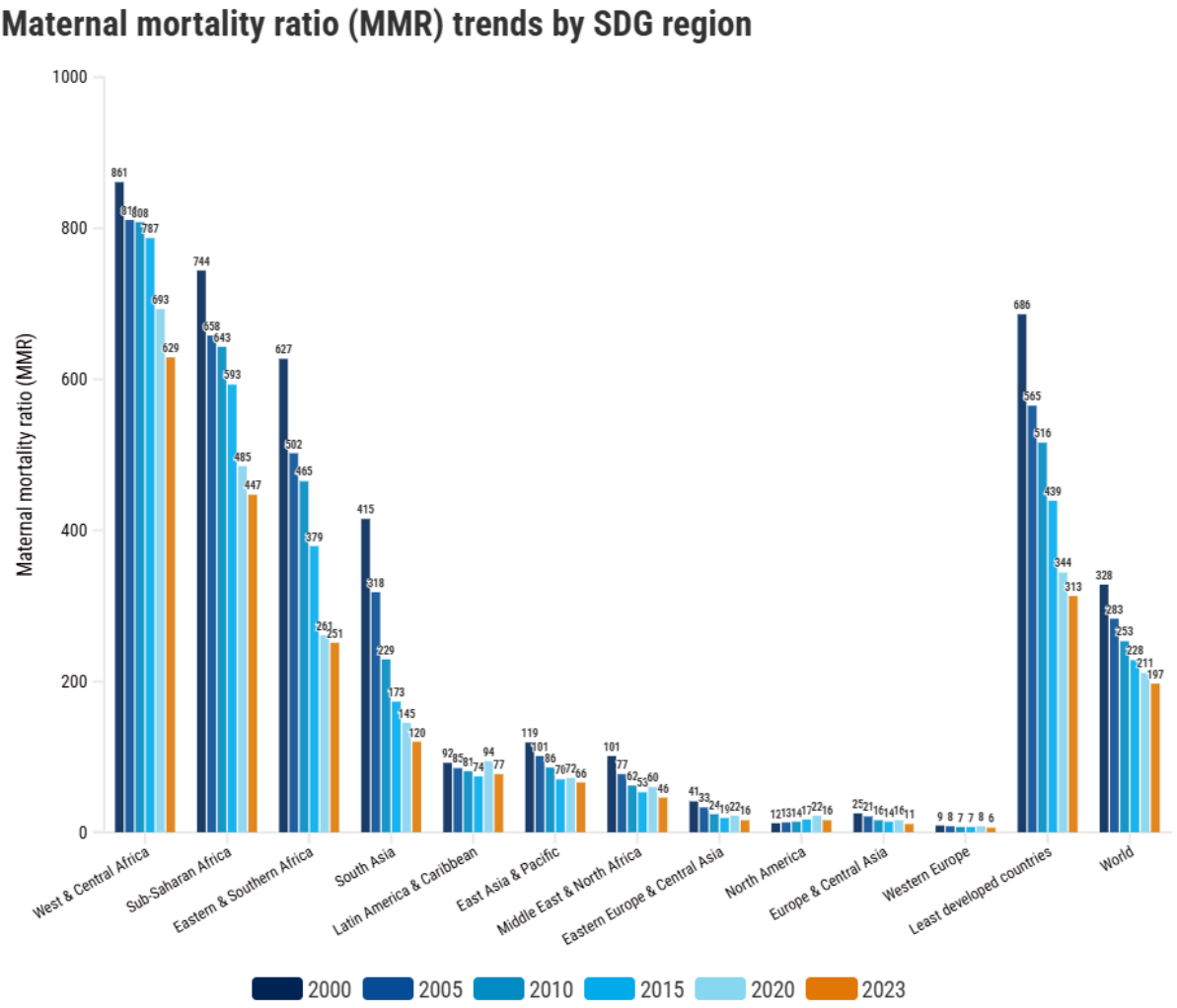
nurture her child. She is also more likely to participate actively in her community and contribute to the local economy. But when a mother dies, the impact ripples far beyond her immediate family: newborns are left vulnerable, households lose stability, and entire communities suffer long-term social and economic losses. In conflict-affected regions, these challenges multiply. Health systems in such settings are not merely underfunded, they are often collapsing. Hospitals and clinics may be targets of violence, health workers may flee for safety, and humanitarian access may be blocked. Women may be forced to give birth in refugee camps, in unsafe conditions, or even while fleeing violence. For them, childbirth becomes an act of extraordinary courage and resilience rather than a moment of hope.

The political dimension of maternal health is therefore central. Policies and investments that strengthen maternal health systems must go hand in hand with efforts to transform the gendered power relations that determine access to care. Women's health is not only a medical issue but also one of justice, agency, and equality. For many women in developing and conflict-affected countries, the essential question is not simply "Can I survive childbirth?". It transforms into "Do I have the power to demand care, to decide when and where to give birth, and to be treated with dignity?"

Reducing maternal mortality requires political will, adequate funding, strong health systems, and above all, the dismantling of discriminatory structures that have placed women at risk for generations. In crisis settings, it also requires rapid humanitarian action: protecting health workers, restoring medical facilities, and ensuring that emergency care transitions into long-term, sustainable systems. Ultimately, strengthening maternal health and reducing mortality in developing countries, conflict zones, and under-resourced settings is about affirming a universal truth: every woman deserves the chance to survive pregnancy and childbirth, not by luck but by design.



Source: UNICEF, 2023. https://data.unicef.org/topic/maternal-health/maternal-mortality/



Source: UNICEF, 2023. https://data.unicef.org/topic/maternal-health/maternal-mortality/

4. Historical background

The history of maternal health reveals a persistent struggle against inequality, neglect, and systematic barriers that have shaped the survival and dignity of women across generations. For much of the twentieth century, maternal death was seen as an inevitable part of childbirth, especially in poorer countries. Medical advances benefited women in developed nations, but those living in under-resourced regions continued to face unacceptable risks. By the early 2000s, the World Health Organization (2003) reported that a woman in sub-Saharan Africa was 175 times more likely to die while giving birth than a woman in a high-income country. The same report estimated that 95 percent of maternal deaths occurred in Africa and Asia, highlighting not only a medical crisis but also a social and economic injustice rooted in inequality. Maternal mortality was increasingly

recognized as a mirror of a country's development, reflecting disparities in wealth, education, infrastructure, and above all, the status of women in society.

The beginning of the new millennium marked a turning point. With the adoption of the Millennium Development Goals (MDGs) in 2000, the international community placed maternal health at the center of global development under Goal 5: "Improve maternal health." The target was to reduce maternal mortality by 75 percent between 1990 and 2015 (World Health Organization, 2015). This period saw a wave of international collaboration, with organizations such as WHO, UNFPA, and UNICEF joining efforts to train midwives, increase skilled birth attendance, and expand access to emergency obstetric care. Progress followed, but unevenly. By 2015, global maternal deaths had declined by around 44 percent, falling from approximately 532,000 in 1990 to 303,000 (WHO, 2015). Despite this improvement, only a handful of countries reached the MDG target, and the burden remained overwhelmingly concentrated in the poorest regions.

The transition from the Millennium Development Goals to the Sustainable Development Goals in 2015 reflected a growing understanding that maternal health could not be separated from broader social realities. The shift in language and approach was significant. Maternal mortality was no longer seen solely as a health indicator but as a test of equity, governance, and human rights. As global attention expanded, the specific vulnerability of women in fragile and conflict-affected settings became impossible to ignore. Wars, internal displacement, and economic collapse have all had devastating effects on reproductive health systems. In these environments, maternal health systems are often nonfunctional: hospitals are destroyed, supply chains are cut off, and medical personnel are forced to flee. Women frequently give birth in unsafe conditions, sometimes in refugee camps or while escaping violence. The experience of the MDG era showed that international cooperation and funding could bring measurable improvement, but it also exposed the fragility of those gains when political will fades or conflict erupts. The SDG framework thus reaffirms the lesson that health cannot be built in isolation from human rights and social justice.

Understanding this history is crucial for shaping future policy and debate. It reminds us that behind every number is a woman whose life could have been saved, a family forever changed, and a community impacted. The persistence of maternal deaths in developing and conflict-affected countries underscores not only the limits of past strategies but also the moral responsibility of the international community to act with renewed commitment. Strengthening maternal health is about confronting the historical injustices that have placed certain women, by virtue of where they are born, at a greater risk of dying while giving life. Only by recognizing and learning from this history can nations and institutions

craft solutions that truly ensure that every woman, everywhere, can survive pregnancy and childbirth with safety, dignity, and hope.

5. Statement of the problem

Maternal mortality is not only a health crisis, it is also a profound moral and social failure that reflects the persistence of inequality and the fragility of systems meant to protect life. Despite global progress in reducing maternal deaths over the past two decades, hundreds of thousands of women still die every year from preventable causes related to pregnancy and childbirth.

The problem is multidimensional. It cannot be understood purely as a lack of medical infrastructure or trained personnel, though these are significant barriers. Maternal mortality persists because of an interconnected web of structural inequalities: poverty, gender-based discrimination, weak governance, fragile health systems, and ongoing conflicts that destroy basic social services. Each of these factors not only increases medical risk but also determines who receives care and who is left behind. In many developing countries, giving birth safely depends less on a woman's health and more on her socioeconomic status, geographic location, and political context.

In under-resourced settings, health facilities are often inaccessible, unequipped, or unaffordable. Rural women, in particular, are disproportionately affected because infrastructure, transportation, and social services fail to reach them. A woman in a remote village may face hours of travel on unsafe roads, only to find that the clinic lacks electricity, blood for transfusion, or even a trained midwife. The consequences of these systemic failures are devastating: complications such as hemorrhage, sepsis, eclampsia, and obstructed labor often become fatal simply because no timely intervention is available.

However, the problem extends far beyond medical access. Maternal mortality is deeply tied to gender inequality and the broader social position of women. In many societies, women have limited decision-making power over their own bodies and health. Cultural norms and patriarchal systems often prevent them from seeking care without male permission or from prioritizing their health above domestic responsibilities. When women lack education, income, or autonomy, their ability to demand or obtain quality healthcare is severely compromised.

In conflict-affected and fragile settings, the situation becomes even more urgent. War and instability devastate health systems, displace populations, and expose women to additional risks such as sexual violence, forced pregnancy, and unsafe abortions. In such environments, maternal health becomes not just a public health issue, but a humanitarian

one. A woman in a refugee camp or conflict zone faces unimaginable choices: whether to risk traveling for medical help amid violence, or to give birth in unsafe conditions that could end her life.

Another dimension of the problem is the unequal distribution of global health funding and attention. While maternal health is recognized as a priority in global development agendas, resources are often insufficient, inconsistent, or diverted to more visible emergencies. The World Bank (2025) has noted that international aid for maternal and reproductive health has slowed since 2016, leaving the most fragile health systems dependent on short-term humanitarian aid rather than sustainable investment. This creates cycles of dependency and fragility: progress made in times of stability can vanish when crises strike or when funding wanes.

The persistence of maternal mortality also reveals gaps in political accountability. Many governments have adopted national strategies for maternal health, but implementation is weak due to corruption, lack of coordination, or insufficient local engagement. Too often, health reforms remain concentrated in urban centers, while rural populations (where most maternal deaths occur) remain excluded. Even where policies exist, they rarely address the deeper causes of maternal vulnerability: lack of education for girls, early marriage, gender-based violence, and the undervaluing of women's labor.

At its core, the maternal mortality crisis embodies a larger question about justice and global priorities. Why, in the twenty-first century, does giving birth remain one of the leading causes of death for women in parts of the world? Why are women's lives so unequally protected depending on where they live? Addressing these questions requires moving beyond charity and technical solutions toward structural change: ensuring that women have rights, voice, and access to care at every level of society.

Ultimately, the persistence of high maternal mortality rates demonstrates that the global community has not yet treated women's health as a true priority. It is a reflection of whose lives are valued and whose suffering remains invisible. The issue is not only medical but profoundly political and ethical. Strengthening maternal health requires a collective commitment to dismantling the inequalities that sustain this crisis. To invest in health systems that are resilient, equitable, and inclusive; to empower women to make decisions about their own bodies; and to ensure that no woman dies giving life simply because the world failed to act.

6. Key Terms & Definitions

a. **Maternal Mortality**
   Maternal mortality refers to the death of a woman during pregnancy,

childbirth, or within 42 days of the termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management. The Maternal Mortality Ratio (MMR) is the number of maternal deaths per 100,000 live births.

b. **Maternal Health**

Maternal health encompasses the health of women during pregnancy, childbirth, and the postpartum period. It goes beyond survival to include the promotion of physical, mental, and social well-being. Good maternal health depends on access to skilled care, nutrition, mental health support, and the ability to make autonomous reproductive choices. In developing and conflict-affected settings, maternal health often deteriorates because of poverty, weak health infrastructure, and gender inequality, factors that turn a biological process into a social risk.

c. **Skilled Birth Attendant (SBA)**

A Skilled Birth Attendant is a trained health professional, such as a midwife, nurse, or doctor, who can manage normal (uncomplicated) pregnancies and childbirth, and identify, manage, or refer complications. The presence of SBAs is one of the strongest determinants of maternal survival. Yet, in many low-income or conflict-affected countries, the shortage of trained personnel and the lack of safe facilities make this standard of care inaccessible for millions of women.

d. **Antenatal and Postnatal Care**

Antenatal care refers to the routine medical care a woman receives during pregnancy to monitor the health of both mother and baby, while postnatal care addresses the period after birth, focusing on recovery and newborn well-being. Both are essential to preventing complications such as anemia, infection, or postpartum hemorrhage. However, in fragile states or remote areas, these services are often disrupted or non-existent, leaving women without professional support during the most critical phases of pregnancy and recovery.

e. **Reproductive Rights**

Reproductive rights are the rights of individuals to make informed, voluntary decisions about their reproductive health, including the right to access contraception, safe maternity services, and comprehensive sexual education. They are grounded in human rights principles of autonomy,

dignity, and equality. Violations of reproductive rights directly endanger maternal health and perpetuate gender inequality.

f. **Gender Inequality**

Gender inequality refers to the unequal distribution of resources, opportunities, and power between men and women. It manifests in economic disparities, limited access to education, restricted political participation, and gender norms that devalue women's health and autonomy. In the context of maternal health, gender inequality often

determines whether women can seek care, afford services, or even decide when to have children. It is both a cause and a consequence of poor maternal outcomes.

g. **Conflict-Affected Areas**

Conflict-affected areas are regions experiencing armed conflict, political instability, or humanitarian crises that disrupt essential services. In these contexts, health systems may collapse entirely: hospitals are destroyed, health workers flee, and supply chains for medicines and equipment break down. Women in such settings are at dramatically higher risk of maternal death and often face compounded threats such as displacement, sexual violence, and loss of community support networks.

h. **Humanitarian Response**

A humanitarian response refers to coordinated efforts by governments, NGOs, and international agencies to provide emergency aid during crises caused by conflict, natural disasters, or displacement. In maternal health, humanitarian responses aim to restore basic reproductive services, ensure safe delivery conditions, and protect health workers. However, these responses are frequently underfunded and temporary, highlighting the need for stronger transitions from emergency aid to sustainable health systems.

i. **Sustainable Development Goal 3 (SDG 3)**

SDG 3, part of the United Nations' 2030 Agenda for Sustainable Development, seeks to "ensure healthy lives and promote well-being for all at all ages." Within it, Target 3.1 aims to reduce the global maternal mortality ratio to less than 70 deaths per 100,000 live births by 2030. Achieving this goal requires not only improving access to health services but also

addressing deeper social determinants, poverty, gender inequality, and the effects of conflict that influence maternal outcomes.

j. **Structural Inequality**
Structural inequality refers to the systemic and institutionalized patterns of discrimination that disadvantage certain groups within society. In the case of maternal health, structural inequality manifests through unequal access to healthcare, education, employment, and political representation. It perpetuates a cycle in which poor and marginalized women remain at greater risk of dying during childbirth simply because of where they were born and the social systems that surround them.

k. **Health System Strengthening**
Health system strengthening involves building the capacity of a country's health infrastructure, workforce, financing, and governance to deliver equitable, quality care. It is fundamental for sustainable maternal health improvements. Yet in many developing countries and conflict zones, health systems remain fragile, dependent on external aid, and unable to reach rural or marginalized populations. Without resilient systems, short-term interventions fail to create lasting change.

7. Past actions

Over the years, the CSW has played a pivotal role in advancing global commitments to maternal health and gender equality. As the principal intergovernmental body dedicated to promoting women's rights within the United Nations system, the CSW has served as both a forum for dialogue and a catalyst for international policy. Its work has consistently emphasized that maternal health cannot be separated from the broader struggle for gender equality, social justice, and the empowerment of women.

Since its establishment in 1946, the CSW has advocated for the recognition of women's health as a fundamental human right. Early sessions focused on the elimination of discrimination and the inclusion of women's needs in development planning, setting the stage for later integration of health issues. However, it was during the 1990s that the Commission began explicitly linking maternal health to women's autonomy and reproductive rights. The 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Fourth World Conference on Women in Beijing, both closely supported by the CSW, marked historic milestones. The Beijing Platform for Action, adopted under CSW's guidance, established "Women and Health" as one of its twelve critical areas of concern. It called for universal access to healthcare services, including

those related to sexual and reproductive health, and demanded that governments ensure safe pregnancy and childbirth for all women (UN Women, 2019).

Following the adoption of the Beijing Platform, the CSW took on a monitoring and implementation role, using its annual sessions to assess progress and push for accountability. Throughout the 2000s, it continuously reaffirmed that reducing maternal mortality was essential to achieving gender equality and sustainable development. In 2009, during its 53rd session, the CSW addressed "The equal sharing of responsibilities between women and men, including caregiving in the context of HIV/AIDS" (Division for the Advancement of Women, 2008), linking women's unpaid care burden to health outcomes and access to maternal services. This demonstrated a growing understanding that maternal health is not only a health issue but also a socioeconomic one, shaped by unequal gender roles and limited political representation.

The CSW's contribution was further strengthened after the adoption of the Millennium Development Goals. In its sessions during the early 2010s, the Commission consistently reviewed global progress toward MDG 5, "Improve maternal health", and called attention to the persistent disparities between developed and developing countries. The 58th session of the CSW in 2014 was especially significant. Dedicated to reviewing progress toward the MDGs for women and girls, it reaffirmed that "no woman should die giving life" (UN, 2014) and called for stronger commitments to universal health coverage and equitable access to maternal care. This session also began to prepare the groundwork for the 2030 Agenda for Sustainable Development and its inclusion of gender-sensitive health goals. The outcomes of the 2014 CSW were instrumental in shaping the language of Sustainable Development Goal 3.1, which commits to reducing global maternal mortality, and SDG 5, which promotes gender equality and women's empowerment (UN, 2025).

Since the adoption of the SDGs, the Commission has continued to monitor implementation and maintain maternal health at the center of gender and development discussions. During its 62nd session in 2018, the CSW examined "Challenges and opportunities in achieving gender equality and the empowerment of rural women and girls," (UN Women, 2018) emphasizing how limited access to healthcare in rural and conflict-affected areas directly increases maternal mortality. More recently, in its 67th session in 2023, the CSW reaffirmed that technology and innovation can play a transformative role in improving maternal healthcare delivery, especially in under-resourced settings. It urged Member States and stakeholders to leverage digital tools to expand telemedicine, data collection, and training for midwives in remote areas (UN, 2023).

Through its resolutions, agreed conclusions, and policy recommendations, the CSW has consistently sought to ensure that maternal health remains both a priority and a right. Its advocacy has shaped the mandates of UN entities like UNFPA, WHO, and UNICEF, aligning their efforts with a gender-responsive and human rights-based approach. The Commission's legacy is not limited to policy, it also lies in fostering a global understanding that improving maternal health is inseparable from empowering women to make decisions about their own bodies, to access education, and to participate fully in political and economic life.

Nevertheless, the CSW's work also reveals enduring challenges. While its recommendations have inspired progress, their implementation depends on Member States political will and resources. In many conflict and developing contexts, women's reproductive health continues to be neglected or undermined by restrictive laws, social stigma, and insufficient funding. The Commission thus remains not only a forum for dialogue but also a space of moral leadership, reminding the international community that maternal mortality is both preventable and unacceptable in the twenty-first century. Its ongoing mission is clear: to translate the principles of equality and human dignity into tangible realities for every woman, everywhere, especially those whose voices are often unheard.

8. Bloc Positions

The international debate on maternal health and women's rights within the Commission on the Status of Women (CSW) reflects the geopolitical and economic divisions that characterize the broader international system. The CSW and other UN bodies faced a challenge: the deterioration of health and protection systems in conflict zones, including for women and mothers.

From a bloc perspective, the *European Union* has positioned itself as one of the strongest advocates for integrating maternal health into the broader framework of human rights and sustainable development. The EU consistently supports resolutions at the CSW calling for universal access to sexual and reproductive health services, including in emergencies. It emphasizes that gender equality, climate resilience, and peacebuilding are inseparable. Following the invasion of Ukraine, European countries have sought to strengthen international cooperation to protect women and girls in crises, linking humanitarian aid to gender-responsive health programs.

By contrast, developing countries and the Global South, particularly in Africa, Latin America, and parts of Asia, often highlight the economic and structural barriers that limit the implementation of CSW recommendations. Many argue that international frameworks must go beyond declarations to ensure equitable funding, technology transfer, and local

capacity building. The African Group, for example, has repeatedly stressed during CSW sessions that maternal health initiatives should focus on strengthening national health systems rather than relying on temporary aid (African Union, 2021). Regional initiatives such as the African Union's CARMMA campaign have demonstrated progress but continue to demand greater international support. Latin American states, coordinated through the GRULAC bloc, have similarly emphasized the intersection between maternal health, poverty reduction, and reproductive rights, often advocating for policies grounded in the principles of the Beijing Platform for Action and the Montevideo Consensus on Population and Development.

On the other hand, conservative or religiously aligned states, often led by blocs such as the Group of the Islamic Conference (OIC) or individual nations with restrictive reproductive laws, tend to express reservations toward CSW resolutions that explicitly reference sexual and reproductive rights. These states usually support maternal health initiatives in principle but resist language that includes access to safe abortion or comprehensive sexuality education. This ideological divide has frequently delayed the adoption of agreed conclusions within the CSW, reflecting deeper tensions between cultural sovereignty and universal human rights.

Meanwhile, countries in conflict and fragile states such as Yemen, Sudan, South Sudan, and the Democratic Republic of the Congo continue to present the most alarming maternal mortality rates. These governments often depend heavily on humanitarian actors like UNFPA, WHO, and Médecins Sans Frontières to deliver basic reproductive health services. In CSW debates, representatives from these nations frequently call for stronger protection of healthcare workers and the depoliticization of humanitarian aid. The Commission, recognizing the intersection between conflict, displacement, and maternal mortality, has repeatedly urged the Security Council and donor states to ensure that women's health remains a priority in peacekeeping and reconstruction missions.

The United States, under different administrations, has demonstrated fluctuating positions regarding maternal and reproductive health at the CSW. Historically, it has supported gender equality and maternal health initiatives through USAID and multilateral cooperation. However, debates around reproductive rights, particularly concerning abortion, have influenced its stance within UN negotiations. During progressive administrations, the U.S. has pushed for the inclusion of "sexual and reproductive health and rights" (SRHR) language, while conservative periods have seen partial withdrawals from such commitments, sometimes aligning more closely with conservative states.

China and Russia have approached the issue through a sovereignty-based lens. While both countries acknowledge the importance of maternal health, they tend to resist

external monitoring or framing it within human rights mechanisms, preferring to emphasize national development strategies and traditional family roles. Russia's invasion of Ukraine has also complicated its participation in gender equality forums, with several Western nations using CSW sessions to denounce the humanitarian impact of its actions on women's health and security.

Taken together, these bloc positions illustrate that debates within the CSW on maternal health reflect not only medical or humanitarian concerns but also global power dynamics and ideological divisions. While the European Union and Latin America often push for a rights-based, inclusive approach, conservative blocs and major powers prefer frameworks that preserve state sovereignty or traditional values. In the middle, developing and conflict-affected countries demand tangible resources and equitable partnerships rather than rhetorical commitments.

Ultimately, the CSW remains a crucial forum for negotiating these tensions and fostering shared commitments. The Commission's challenge lies in balancing autonomy, equity, and interdependence. Strengthening maternal health requires international cooperation not built on dependency, but on shared responsibility and solidarity. The outcome of these negotiations will determine whether maternal survival becomes a universal guarantee or remains a privilege shaped by geography, politics, and power.

9. QARMAs

a. How can the international community strengthen maternal health systems in conflict-affected and under-resourced settings, ensuring that women and girls have equitable access to essential and life-saving care?

b. What measures can be implemented to guarantee the protection of maternal health services and personnel during armed conflicts and humanitarian crises?

c. In what ways can governments and UN bodies address structural gender inequalities that exacerbate maternal mortality, particularly in developing countries?

d. How can investment in healthcare infrastructure and training of skilled birth attendants be expanded and made sustainable in regions with limited resources?

e. What strategies can be adopted to ensure that data collection and reporting on maternal health are inclusive, accurate, and representative of marginalized groups, including rural and displaced populations?

f. How can partnerships between the Commission on the Status of Women, WHO, UNFPA, and UNICEF be enhanced to coordinate international assistance programs aimed at reducing maternal mortality?

g. What role can community-based initiatives and local women's organizations play in promoting safe motherhood, and how can they be supported through funding and policy frameworks?

h. How can international development funds and humanitarian aid be allocated more effectively to prioritize maternal health within broader health and gender equality agendas?

i. What educational and cultural interventions can be designed to combat harmful gender norms and practices that endanger maternal and reproductive health?

j. How can technological innovation, such as telemedicine, mobile health platforms, and digital record systems, be leveraged to overcome barriers to maternal healthcare in isolated or conflict-affected regions?

10. Position paper guidelines

The purpose of this document is to provide an overview of each delegation's position, its potential solutions, and its role within the committee. Delegates are encouraged to follow a structured format when drafting their documents, which will facilitate the writing process and improve readability for the Director. Furthermore, to be eligible for an award, each delegate must submit a Position Paper by the deadline.

In the first paragraph, you should state your country's position on the issue, clearly demonstrating an understanding of your country's policy. In the second paragraph, you may mention the main previous UN actions related to the issue. You should analyze the impact these actions have had on your country, explaining why they were successful or unsuccessful. You may also include actions taken by other international organizations and by your own country on the issue.

In the final and most important paragraph, you should present your proposals for addressing the problem. Each proposal must be supported by detailed information,

covering the who, what, when, where, and how of implementation. Regarding the format, the document should be a maximum of one page, with 1.15 line spacing, Times New Roman font, size 11, and 2.5 cm margins on all sides. Remember that all references must be properly cited. It should be sent to: positionpaperspucpmun@gmail.com.

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