SSALMUN'25

WHO

Agenda Item: Promoting Safe and Informed Birth Choices: Balancing the Benefits of Natural Birth and Respecting Maternal Autonomy

What is MUN ?

MUN stands for Model United Nations, which is a simulation of the United Nations (UN) where students act as diplomats representing different countries or organizations. Participants debate and discuss global issues, negotiate resolutions, and work to solve international problems in a manner similar to how the real UN operates.

In MUN, each participant is assigned a country, and they must research and represent their assigned nation's views and policies on various topics. The debates take place in committees that reflect those in the UN, such as the General Assembly (GA), Security Council (SC), Economic and Social Council (ECOSOC), and others. Participants collaborate to draft resolutions that aim to address global challenges such as climate change, conflict resolution, human rights, and more.

MUN conferences can take place at schools, universities, or as international events, and they offer students a chance to improve skills like public speaking, diplomacy, research, and teamwork while engaging with complex international issues.

Letter From Under Secretary General

Welcome, delegates. Today, we address the important issue of maternal healthcare, specifically the choice between normal and cesarean births. While cesarean sections are lifesaving in certain situations, they come with higher risks and longer recovery times. Normal births generally pose fewer complications for both mother and child.

As future leaders, it’s our responsibility to ensure women have access to safe, informed choices regarding their births. Whether advocating for the use of cesarean sections when necessary or supporting natural births, our goal should be to improve maternal and child health globally.

The decisions we make now will shape the health of future generations. Let’s work together to find solutions that safeguard the well-being of mothers and children everywhere.

Yağmur Ezgi Bak

Committee Introduction

The **World Health Organization (WHO)** is a specialized agency of the United Nations focused on improving global public health. Headquartered in Geneva, Switzerland, and established on April 7, 1948, it is supported by 194 member states. WHO aims to achieve the highest level of health for all, defining health as "complete physical, mental, and social well-being." Its work includes controlling diseases, improving public health education, setting international health standards, and coordinating responses to global health crises. WHO has been instrumental in eradicating smallpox, advancing vaccine development, and promoting universal health coverage worldwide.

introduction

Today as much as other options appeard on childbirth, vaginal birth had also become much safer. Despite this worldwide caesarean section rates have risen from around 7% in 1990 to 21% today, and are projected to continue increasing over this current decade.

(According to WHO)

“Caesarean sections are absolutely critical to save lives in situations where vaginal deliveries would pose risks, so all health systems must ensure timely access for all women when needed,” said Dr Ian Askew, Director of WHO’s Department of Sexual and Reproductive Health and Research and the UN joint programme, HRP . “But not all the caesarean sections carried out at the moment are needed for medical reasons. Unnecessary surgical procedures can be harmful, both for a woman and her baby.”

Caesarean sections can be essential in situations such as prolonged or obstructed labour, fetal distress, or because the baby is presenting in an abnormal position. However, as with all surgeries, they can have risks. These include the potential for heavy bleeding or infection, slower recovery times after childbirth, delays in establishing breastfeeding and skin-to-skin contact, and increased likelihood of complications in future pregnancies.

Current Situation

(According to NIH)

A total of 27 pregnant women underwent in-depth interviews. Age ranged from 24 to 45 years (median 34), with 14 women being nulliparous. Six categories and 14 themes emerged from the analysis (Table 1). From the in-depth interviews, most women had more than one reason that convinced them of their decision.

I. Fear of childbirth

- Fear of labor pain
- Fear of facing two painful events (failure of vaginal delivery and cesarean section)
- Fear of harming the baby

II. Safety concerns related to health risk perceptions

- Underlying medical diseases (diabetes mellitus, heart diseases and HIV)
- Biological risks (advanced maternal age and obesity)
- Reproductive health problem (infertility)

III. Previous negative birth experiences

- Inadequate pain control
- Dystocia
- Baby injury

IV. Positive attitudes toward cesarean delivery

- Advantages of cesarean delivery
- Disadvantages of vaginal delivery

V. Access to biased information

- Personal advice
- Mass media

VI. Superstitious belief in auspicious birth dates

- Good fortune

Advantages of Natural Birth

- Squeeze out amniotic fluid sequestered in the baby's lungs.
- The baby acquires immune-boosting bacteria while passing through the vagina.
- It is non-surgical, eliminating the risk of surgical complications, such as infections, internal bleeding, and scar formation.
- The hospital stay is shorter. Without complications, mothers can usually return home within two days.

Disadvantages of Natural Birth:

- The prescheduled time for delivery is not feasible because the onset of natural childbirth depends on the baby's readiness.
- Mothers may feel anxious about the unpredictable start of labor.
- The baby risks birth trauma due to shoulder dystocia or assisted labor.

C-section (Caesarean) birth:

Advantages of Caeserean Birth:

- The childbirth can be pre-planned, so you have less stress and anxiety and are more mentally prepared.
- Mothers with a previous C-section or vaginal delivery complications. Preexisting medical conditions, e.g., hypertension, diabetes, herpes, or HIV. Cesarean birth may be a safer method.
- High-risk pregnancies, from multiple pregnancies, placenta previa, to a large head circumference or breech presentation. Mother needing an emergency delivery due to prolonged labor, birth asphyxia, or low-volume amniotic fluid.

Disadvantages of Caeserean Birth:

- The hospital stay and recovery are longer.
- The baby may not be ready for childbirth, i.e., difficulty breathing due to retained fetal lung fluid.
- There is a risk of complications such as excessive blood loss, blood clots, and infections.
- It is essential to know that child delivery may not go as planned. Some who want to have natural childbirth may end up with a C-section due to a medical necessity.

- Article by Dr Sornpin Armarttasn

Socioeconomic Effects:

(According to WHO)
There are significant discrepancies in a woman's access to caesarean sections, depending on where in the world she lives. In the least developed countries, about 8% of women gave birth by caesarean section with only 5% in sub-Saharan Africa, indicating a concerning lack of access to this lifesaving surgery.

Conversely, in Latin America and the Caribbean, rates are as high as 4 in 10 (43%) of all births. In five countries (Dominican Republic, Brazil, Cyprus, Egypt and Turkey), caesarean sections now outnumber vaginal deliveries.

Worldwide caesarean section rates have risen from around 7% in 1990 to 21% today, and are projected to continue increasing over this current decade. If this trend continues, by 2030 the highest rates are likely to be in Eastern Asia (63%), Latin America and the Caribbean (54%), Western Asia (50%), Northern Africa (48%) Southern Europe (47%) and Australia and New Zealand (45%), the research suggests.

The increasing trends of cesarean delivery (CD) are globally acknowledged [1–3]. However, socioeconomic inequities in many low- and middle-income countries (LMIC) appear to have created a pattern of underuse and overuse based on income and levels of education [2,4]. The impact of cesarean delivery trends on neonatal survival has also not been adequately examined [5–7]. A recent multi-country study estimated a tripling of CD rates since 1990 to 19% in 2014 with wide variations among and within regions and countries [1]. Estimated rates in Latin America and the Caribbean varied from 5% to 58% while rates in high-income countries (HIC) in the Nordics ranged between 15% and 27% [1,2,8]. Whereas the World Health Organization (WHO) emphasizes access to CD for all mothers in medical need, the organization's 2015 review found that an optimal population-level CD rate should not exceed 10–15% based on medical indication [9]. Studies by Betrán et al. and Boatin et al. recommended increased access to CD in sub-Saharan Africa due to low CD rates, high maternal death rates, and slowly declining rates of newborn deaths within the first month, i.e. neonatal mortality rates (NMR) [1,2]. However, recent UNICEF country reports from certain sub-Saharan (SSA) countries including Kenya and Tanzania reveal unusual trends. The reports indicate comparatively higher rates of CD and disappointingly low declines in neonatal mortality rates among higher socioeconomic (SE) groups, despite higher coverages of both pre- and postnatal care and skilled birth assistance among these subpopulations [10–12]. New WHO recommendations such as 8+ antenatal visits [13] will expedite reduction of NMR to achieve target 2 of the Sustainable Development Goal 3 [14]. However, monitoring the impact of country-specific trends of CD rates and subsequent policy adjustments might sustain neonatal survival gains.
Cesarean delivery (or C-section) is an obstetric surgical procedure meant to save the life of a mother and her baby.

Breech presentation, antepartum hemorrhage, fetal distress, prolonged and obstructed labor, placenta previa and other life-threatening medical indications require CD for safe delivery [5–7]. However, most of the rising elective CD rates among low-risk births in many LMIC are due to maternal request or physicians' preference without plausible clinical indications [15–17]. In HIC such as Sweden, childbirth fear has also been associated with CD [18]. Elective CD has been associated with sepsis and respiratory problems, which are major causes of neonatal deaths globally [19]. While cesarean delivery has prevented many adverse pregnancy outcomes, the quality and conditions

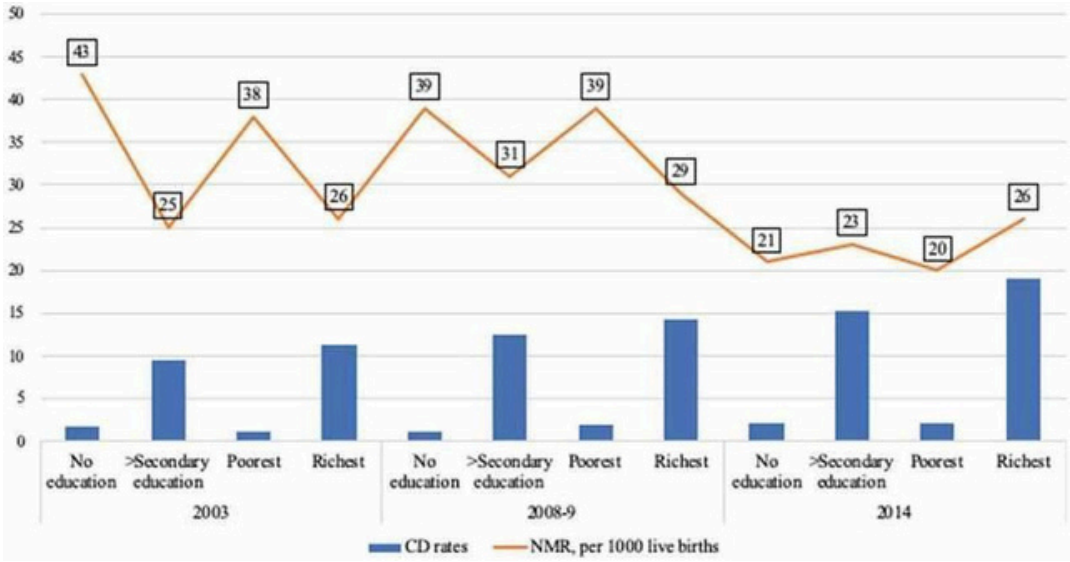
under which some procedures (both elective and emergency) are executed in many low-resourced settings have also resulted in many morbidities [20,21] and preventable mortalities [5,22–28].

The trade-offs between morbidities and benefits are generally unclear but also costly for weak health-care systems [29,30]. A cohort study in South America reported a significant increased risk of neonatal death among elective cesarean deliveries [28]. Another study in the USA also indicated a two-fold rise in neonatal deaths among CD-newborns without medical indication even after adjusting for key confounders [31]. Similarly, recent enquiry into maternal deaths in South African health facilities revealed 3 times higher risk of maternal deaths among CD births [24].

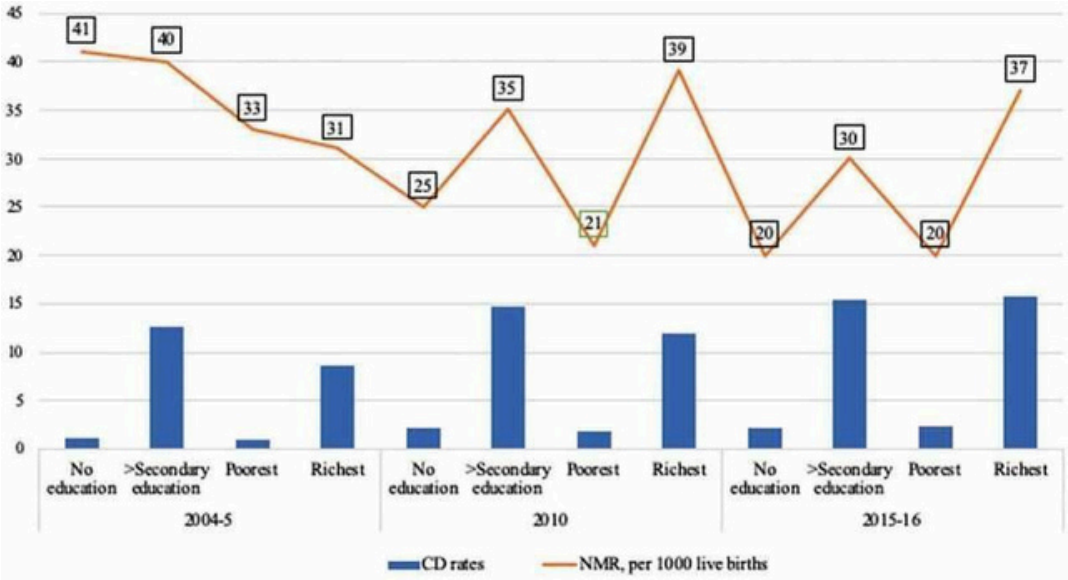
A systematic review in LMIC also found similar adverse neonatal outcomes after CD [24].
In many low-resourced settings, inadequate record-keeping makes it difficult to determine whether the adverse pregnancy outcomes occurred before birth or intrapartum or because of the CD procedure itself [29,32]. A study in five low-income countries (LIC) in SSA and Southeast Asia (SEA) found that 40% of health facility records had no CD fetal outcome information [6].
Nonetheless, although inadequate access to CD and delays by the expectant mothers to seek or reach care clearly have adverse impacts [33,34], incomplete records have also concealed emergency challenges of health facilities and impeded improvements in care as well as accountability [6,35–37]. Higher neonatal deaths associated with CD are reported in SSA than any other region [21].

It should be noted, however, that audits of a few upgraded and well-funded health facilities in SSA including Tanzania have reported reduction of both unnecessary CD and CD-related neonatal deaths [32,38].

In Kenya and Tanzania where about 100 neonates die daily in each country [10], CD rates among the richest and the secondary+ educated mothers, for Kenya 2014 and Tanzania 2016 indicate an overall difference of more than seven folds higher rates compared to the poorest and the uneducated, respectively, in both countries [11,12]. However, neonatal death rates among the highest SE groups in the two countries were markedly higher compared to those of lowest SE groups.
Further since 2003, NMR among the lowest SE categories in Kenya declined by almost half to 20 deaths per 1000 live births in 2014; in contrast, there was almost no overall change in NMRs among the highest SE groups [11,39]. Similar trends can be seen in Tanzania [12,40].
A summary of these reports can be seen in Figures 1 and 2. We identified no population-based studies concerning socioeconomic patterns of CD in relation to NMR in the two countries.
A recent global study by Ye et al. investigated the associations between CD rates and NMR accounting for human development index but the study did not adjust for within-country socioeconomic disparities [41]. This study examined the socioeconomic factors associated with cesarean delivery in Kenya and Tanzania. A secondary aim was to assess the impact of cesarean delivery on neonatal survival in both countries.



Neonatal mortality rates (NMR) and cesarean delivery (CD) rates among highest and lowest socioeconomic groups in Kenya between 2003 and 2014



Neonatal mortality rates (NMR) and cesarean delivery (CD) rates among highest and lowest socioeconomic groups in Tanzania between 2004 and 2016

This section collects any data citations, data availability statements, or supplementary materials.

1. Maternal and Newborn Health Disparities Country profiles . UNICEF DATA [Internet]. UNICEF DATA. 2019. cited 2019 November23. Available from: https://data.unicef.org/resources/maternal-newborn-health-disparities-country-profiles/

2. IAEG-SDG . 2018. SDG Indicators. UNSD, Sustainable development goals

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3. Kenya Population By Age Groups . Kenya Data Portal [Internet]. Kenya Data

https://kenya.opendataforafrica.org/lpdtibb/kenya-population-by-age-groups

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Possible Considerations For the Future

Possible Solutions to Increase Normal Childbirth:

- Education and Awareness: Educate expectant mothers on the benefits and safety of vaginal birth.
- Skilled Birth Support: Ensure access to trained midwives and obstetricians to support vaginal deliveries.
- Evidence-Based Practices: Promote labor support, freedom of movement, and other practices that aid vaginal birth.
- Minimize Inductions: Reduce unnecessary inductions, which can lead to C-sections.
- Pain Management Options: Offer diverse pain relief options to make vaginal birth more comfortable.
- Supportive Environment: Create a comfortable, less clinical setting for women to feel empowered during labor.
- Address Fear: Provide counseling to reduce fear of childbirth, which may lead to requests for C-sections.
- Support VBAC: Encourage vaginal births after cesarean (VBAC) when medically appropriate.
- Patient-Centered Care: Involve women in the decision-making process to ensure informed choices about their birth.

These solutions focus on empowering women and ensuring medical interventions are used only when necessary.

Guiding Questions:

- Political proportions that encourages vaginal birth.
- Education including vaginal birth should be preferred by medical reasons.
- How women should be able to birth however they want.
- Vaginal birth being overly stressful to some women.
- Unconscious c section preferences.
- Complications during and after C sections.
- Fear of labour.