Maternity, though the instigator of life, should not be underestimated in its likelihood to take and ruin lives as well. Maternal mortality and maternal health are the measures of the safety and well-being of women throughout the process of carrying the child, giving birth, and raising it through its most dependant times. Sadly enough, this issue is more-so a characteristic of the lives of younger adults and teenagers. More than 16 million girls aged between 15 to 19 years old give birth each year, and that process is the leading cause of death for the age group across the world.

Often, the mental, physical, and emotional health of those with early first pregnancies is known to degrade greatly, as they find themselves in a situation that is greatly beyond their mental maturity, and their bodies ability. Since both the pubescent body and mind have not fully developed, they are biologically not prepared to undergo processes that are meant for their more developed counterparts.

As it stands a combination of a lack of education for young women, lack of maternal aid, and poor public medical systems, as well as a great amount of social pressures lead to a set few fates for these women. Either they undergo an unsafe abortion, putting their lives at great risk but keeping the information private, they can choose to abort in a safer manner through public services, but likely face great social backlash, or they can bear the child and put both of their lives at risk.

This reality is not often taught early enough to prevent the mistake before it occurs, and many take the responsibility of pregnancy without meaning to, or without being aware of its implications. Since there are not many methods of effectively counteracting the damage done by knowingly or unknowingly bearing a child, the most commonly discussed method of improving maternal healthcare is to prevent child and teen pregnancies. By moving the age of first pregnancy forward, the risk associated with that first pregnancy decreases, and as such moving this age forward has become a focus for many attempting to improve maternal health.

For many of these young women, the pregnancy signifies them losing the chance of having a happy ending to their stories, either ending their lives, or setting them back. For that reason the
Sustainable Development Commission wants to put an end to this cycle of ignorance that is creating a series of preventable, yet deeply scarring problems.

**Definition of Key Terms**

**Maternal Health**

Maternal health covers the condition of women during their pregnancy, the act of childbirth, as well as the postpartum period, or the six weeks after the childbirth. It includes not only the physical, but mental and emotional health of the individual in question.

**Maternal Mortality**

Maternal mortality is the likelihood of death of women from the beginning of their pregnancy to the end of the postpartum period. This is most notably used as maternal mortality ratio which is one of the indicators for the third UN sustainable development goal. It is important to not this only applies to deaths caused or aggravated by a factor of the pregnancy.

**Contraceptives**

Any form of birth control or fertility management. A lack of safe and accessible contraception is a very commonly cited cause of young and unplanned pregnancy. Unsafe abortions are also one of the leading cause of maternal mortality of adolescent mothers.

**Immunisation**

Immunisation is one of the most commonly discussed potential solutions to maternal mortality as a whole. Immunisation is protection against any disease as to limit the risk of it in the future, which comes in the form of 3 crucial vaccines that cover the most common and damaging diseases. It becomes an even greater issue when concerning uneducated youths who don’t understand the importance of it.

**Background Information**

The main causes of this issue

Maternal mortality has been a difficult issue to solve since, like most issues tackled by the United Nations, it stems from multiple different causes that are widespread across social to governmental issues.

*A history of miseducation*

A pattern that must realistically be recognised is the prevalence of the issue in nations of the sub-saharan Africa region which seems to suggest that it is propagated by factors unique to LEDCs, one of which being a lack of education. Of course this is not to claim that these issue only exist within this region, as this is statistically untrue, however an analysis of the clearer examples
of an issue can help identify its more obscure counterparts. The public systems in both the urban and rural areas of these nations often fail to provide a decent sexual education program that teaches the importance of waiting for the body to mature before bearing children, as well as the use and effects of contraceptive, both of which discourage early first pregnancies. Many of these educational systems suffer from social stigmas that can limit their ability to discuss certain topics. A prime example of this is the limitations on teaching the youth information that is often considered too mature for them, without realising that this simply increases the chances of their partaking in those overly-mature actions. A change in educational systems would not only challenge some of the social stigmas around women discussing their sexual health and opinions in more conservative societies, but also inform generations to come not only how to care for their maternal health, but also that of their children and relatives.

Lack of gender equality

To expand on why there might be such a disproportional amount of maternal mortality in these African nations, we must look at another factor that is common to many of them: gender inequality. A lack of gender inequality not only means that they might not experience the education mentioned above, but they are also at the mercy of men in society. With men making up the majority of political positions it becomes clearer why there hasn’t been that huge of a push for further reproductive healthcare, given that female politicians have often led that push in the western world. It is also not very common to see large-scale movements on such topics in LEDCs due to the implied disrespect of bringing up such often-stigmatised topics. Furthermore, common daily communication is limited just as much as political expression, and many women might find that educating themselves on the topic through sharing information will be further restricted, and accentuate the negative effects of the previously mentioned poor education. There is also the issue of child marriages leading to young first pregnancies, however that is due to young women being almost a resource for their family to be sold away, without having the rights to have control of her body, which requires a social and cultural shift to be addressed. Moreover, for women to express their needs of maternal mortality and request a pushing back of their first pregnancy to a spouse or a father-figure could likely cause issues, as often time this would mean that they are either disrespecting the wishes of the man in the household, or would be perceived as a selfish act, and depriving the family of income and joy, regardless of how twisted that view might be to the western world.

Finances as a barrier of entry to health

Another problems stems from the fact that even if young women find themselves educated about contraceptives and immunisation and how to protect their bodies, they will still be unable to afford them. It is unjust for expenses to be this high for basic products and resources that are needed if an easy and safe birth is to occur. Given how basic the idea of reproduction is, the fact that there are some who are excluded from it’s safe practice solely due to high prices is absurd, especially when it pushes them to other forms of contraceptives that are even more dangerous. There is a history if unsafe abortions that stem from people who either cannot afford or cannot gain
access to common contraceptives leading to extreme physical damage to the body of the women undergoing the procedure, potential long term physical issues, and even emotional scarring from the pain and memory. Many of these procedures involve the killing of the baby and its post-mortem removal from the mother’s body, and outside of the pain that must be experienced in such a procedure, the haphazard and most certainly unprofessional nature of these procedures often leads to infections and other unwanted or unexpected damage. This is only a problem within areas that have legislation that allows abortions, which is not the case in many parts of the world, though that discussion warrants a report to itself, though it should at least be stated that in cases where abortion is not legalised, then these procedures are even more so directly incentivised by that legislation.

Major Countries and Organisations Involved

WHO (World Health Organisation)

The World Health Organisation is an agency and sub-department of the United Nations that works to improve public health across the world. They have taken many steps to try and rectify and improve the current maternal mortality situation through improvements to immunisation on the topic and implementing projects to help all women.

Sub-Saharan African States

Though the Sub-Saharan African states should not have their ideologies or stances on the issue generalised, it is very important to note they overlap in many aspects. Of the 300,000 women who died to maternal issues in 2015, more than two thirds were residents of Sub-Saharan African states, a clear pattern that identifies a region that needs further work.

Timeline of Events

<table>
<thead>
<tr>
<th>Date</th>
<th>Description of event</th>
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<tr>
<td>28-30th April, 1985</td>
<td>The first World Health Organisation (WHO) Interregional Meeting on the Prevention Of Maternal Mortality</td>
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<tr>
<td>1987</td>
<td>The founding of the Safe Motherhood Initiative - An initiative joining nations across the globe to set long term goals on maternal healthcare</td>
</tr>
<tr>
<td>May, 2000</td>
<td>Maternal health is recouped within the WHO's Millennium Development Goals</td>
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Relevant UN Treaties and Events

- Resolution on Maternal Health, 27 September 2010 *(A/HRC/15/L.27)*
- Community health workers delivering primary health care: opportunities and challenges, 24 May 2019 *(WHA/27.3)*
- Preventable maternal mortality and morbidity and human rights, 16 June 2009 *(A/HRC/11/L.16)*

Previous Attempts to solve the Issue

The most notable attempts to solve the issue have been those that have come from the WHO. The WHO has been sending out and training Health Workers which have done great work in terms of being useful as medical officials in rural areas in less economically developed nations. Though this has helped improve the situation, it has failed to meet the WHO’s Millennium Development goal 5 to reduce maternal mortality by 75% by 2015. This is because it doesn’t tackle every aspect of the issue. It doesn’t help improve the pricing of contraception or vaccinations for the general public and as such there are many who go unattended to, as well as many who don’t even understand the issue due to poor education on the topic. As such, though it is a good step forward, it ultimately fails to achieve its goal.

Other attempts that have happened on the international levels include the much more historical Safe Motherhood Initiative. This initiative started in 1987 had the goal of reducing the maternal mortality by 50% by the year 2000. Though it did not accomplish its goal in its entirety its value to be found from the techniques that it employed. The initiative prioritised three main avenues of securing it’s goals: the first was to ensure that all communities within the region it was working in had some form of healthcare, then it wanted to build up the previously standing medicinal institutions in the area and have them work with the newly set up community institutes, and finally to link them through an alarm and emergency system that would communicate between both types of institution to ensure that patients were always treated when they required it. This worked to some extent, however it was no applicable on a worldwide level, and as such a lot of its focus was towards more western and developed nations that had the previously in place infrastructure that this program could build off of. As such it became a futile effort to implement it into region’s whose infrastructure could not support the project, and sadly enough those regions were the areas that have historically had the greatest deficiencies of quality maternal healthcare.

Possible Solutions

This issue is one that requires great amounts of causation-based thinking, and an understanding of social and cultural pressures. The idea behind this topic is that instead of improving healthcare through funding medicinal research or building hospitals, it is instead better to
ensure that teenagers never have their bodies and their lives in that position of risk to begin with: the medicinal research is a corrective measure, whereas the goal here is for there to be no problem to correct. The second part of that statement pertains to the mindset that must be used to analyse this topic. At the end of the day, the choice to reproduce at a young age or later in life is an individual one and there is not much that can be done to outlaw it, as such to keep people from doing so one must understand the pros, cons, and social pressures that are influencing those individuals to make that decision.

As mentioned above, there have not been many notable efforts to improve the dissemination of information about maternal health to the youth and their parents. There are two cases to consider here, those in which the choice to have a child is the choice is that of the young women, or those in which it is the choice of parental figures or a partner. For the former, educating the young women about the negative impact that such a choice could have not only on their health, but on the health of their potential children could serve as a means of discouraging the action, or at least ensuring that it was taken with all the negative effects taken into consideration. More often than not the situation will be the latter, so it is important to find a way to change the minds of members of the older generation, which will be significantly harder. We suggest making use of the pre-existing network of Health Workers that the WHO has already developed to spread educators and informants that can teach the problems with early first pregnancy and lobby in small communities for the rights of women to their own choices respectively.

Another potential solution would concern the improvement of the general quality of life of lower income families. Since for many of these families children are seen as an investment, and the building of a small workforce to help improve their financial standing, their is a direct correlation between their quality of life and their desire to have many children. Of course with that desire for many children also comes a desire for children to be brought into the family earlier rather than later so that they can begin to fulfil their role to their parents. Though the issue of poverty is one that stems from a variety of factors, and could not be holistically addressed as a sub-section of this topic it is better that this change in quality of life is addressed differently. If governments choose to inventive having a smaller family size, potentially with the implementation of extra subsidies or welfare benefits to those who choose not to exceed a certain limit on the number of children in their families, their could be a decrease not only in the rate at which people reproduce but also the time at which they first begin the process.

Due to the personal nature of this topic, there are a variety of avenues that could be taken to attempt and solve it. However, it is important to never lose sight of the human element of those who are being affected by these changes, and to consider what would truly begin through their head to influence their decisions.

Bibliography


