Surf City XIX

Huntington Beach High School

3rd SOCHUM

Topic A: *Maternal and Neonatal Healthcare in Developing Nations*

Topic B: *Humanitarian Crisis in Colombia*

Welcome Letter

Dear Delegates,

On behalf of the Huntington Beach High School Model United Nations Program, we would like to welcome you to our Surf City XIX advanced conference!

Our annual Surf City conference upholds the principles and intended purpose of the United Nations. Delegates can expect to partake in a professional, well-run debate that simulates the very issues that those at the United Nations discuss every day. Both novel and traditional ideas will be shared, challenged, and improved.

It is our hope that all delegates will receive the opportunity to enhance their research, public speaking, and communication skills as they explore the intricacies of global concerns through various perspectives, some of which may be very different from their own. We hope their experiences here give them new insight and values that they can apply outside of the realm of Model UN for the betterment of the world community.

Please do not hesitate to approach our Secretariat or Staff Members with any questions or concerns that you may have throughout the day. We wish the best to all our participants and hope that they may share a fulfilling experience with us!

Enjoy the conference!

Sincerely,

Zach Bernstein
Secretary General

Vivian Bui
Secretary General

Lauren Le
Secretary General

Alison Miu-Martinez
Secretary General

Meet The Dais

Jaiden Co

Hey Delegates!! My name is Jaiden Co, and I am so excited to be one of your Surf City XIX chairs! I am currently a senior at HBHS, and this is my fourth year in MUN. On campus, I am a Varsity Track and Field Captain, president of the Community Caretakers and Activism Club, vice-president of BRIDGES, and a volunteer for National Honors Society and Link Crew!! In my free time, I work alongside various surgeons at Kaiser Permanente to develop new forms of medical diagnosis (#WomenInStem!), read my favorite romantic comedy series, *After,* by Anna Todd, listen to Harry Styles (Ellee has not been a fan for 11 years like me, btw), RELIGIOUSLY listen to (my role model) Tana Mongeau's podcast, *Cancelled*, and watch 2010 One Direction interviews and video diaries!!!! Despite how nerve-racking MUN can be, don't forget to have fun, make some friends, and remember that awards are just a piece of paper ;) Good luck, delegates!

Ellee Nakamura

Hi! I'm Ellee Nakamura, and I'm one of your chairs for Surf City! This is my fourth year in MUN and my second year chairing. At HBHS, I am a Dramatic Production major (playwriting), president of the Community Caretakers Club, and secretary of the Creative Writing Club. In my free time, I write/produce children's books to distribute to underprivileged children without access to education, read romantic comedy novels (my favorite is *After* by Anna Todd!), and listen to One Direction/Harry Styles. I remember how insanely nervous I was for Surf City, so I totally understand how nerve wracking this can be, especially if this is your first in-person conference! As long as you research diligently and know your content, you have nothing to worry about. I highly recommend engaging with other delegates during speeches or moderated caucuses, to spark productive debate. I hope you enjoy researching this topic as much as we have! Good luck!

Joshua Dang

Hi, my name is Joshua Dang and I am a junior here at Huntington Beach. This is currently my third year in MUN and my first year being able to chair Surf City. MUN has been an amazing experience for me so far and has given me the opportunity to make friends across schools and come up with creative and unique ideas I otherwise would have never been able to without taking MUN. Outside of MUN, I am a part of my school's cross country and track team, with my personal favorite track event being the 800 meters where I got a third-place last year. I also am part of my school's Bridges program as a treasurer which works with Orange County Human Relations Center to help make our campus a more inclusionary place and has given me the opportunity to explore unique community projects and possibilities. In my free time, I also work with Oak View Community Outreach center in order to provide food to the working poor through the utilization of leftover food from grocery stores. I am excited to be chairing the 3rd SOCHUM committee and look forward to a fruitful debate and hearing all your unique solutions!

All Papers are due on **JANUARY 30, 2022** by 11:59pm to

surfcity.3rdsochum@gmail.com

Topic A: Maternal and Neonatal Healthcare in Developing Nations

Background

Maternal care focuses on the health of women during pregnancy, birth, and postnatal care[1]. The quality of care for mothers varies drastically from developed nations such as the United States (which has seen a drastic increase in maternal care since 1935) compared to developing nations. Currently, developing nations facilitate ninety-nine percent of all maternal deaths. In fact over fifty percent of maternal deaths occur in sub-Saharan Africa and a third occur in South Asia. In developing nations, 239 out of 100,000 infants die, whereas in developed countries, only 12 out of 100,000 infants die. Within these developing countries, there is an even further divide between women with high incomes and women with low incomes as well as women living in either rural or urban areas. Seventy five of maternal deaths are caused by unsafe abortion, obstructed labor, high blood pressure, infection, and hermorrhage, all causes that are either preventable or treatable. In addition, giving birth at a young age increases health risks for both mothers and infants. Developing countries have a going rate of 1 in 180 adolescent women dying from pregnancy. The remaining twenty-five percent are caused by diseases such as Malaria and HIV-AIDS.

These causes are easily preventable through antenatal care (routine care of pregnant women to identify high-risk pregnancies and to educate women on how to ease the process), oversight during the birth, and monitorization in weeks following birth. The simple presence of a skilled health professional can save both the mother and the child from a terrible fate. Methods of handling childbirth complications are well researched, so there are little to no gaps in the knowledge needed in caring for pregnant women. Most of these complications have solutions that can be easily practiced. For example, severe bleeding can easily be prevented by injecting oxytocin, infection can be prevented through proper hygiene, and pre-eclampsia can be prevented through drugs like magnesium sulfate. Unfortunately, these simple preventative measures are not often accessible in remote areas and low-income countries, due to not enough available information, cultural stigmas, distance, poverty, and lack of proper services.

The African Region is currently the most problematic region when it comes to maternal and neonatal health, seeing as it lacks basic maternal health interventions such as antenatal care (identifying high-risk pregnancies and educating women for the purpose of a successful, seamless delivery) while simultaneously having the highest teenage birth rate. The countries with the most maternal death annually are South Sudan, Chad, Sierra Leone, Nigeria, and the Central African Republic. In Africa, 120 out of 1,000 teenagers give birth, and 830 women die from pregnancy and childbirth every day, which marks the highest number of maternal deaths in a region. In West Africa specifically, thirty-three percent of pregnant women do not receive antenatal care visits. In Sub-Saharan Africa, maternal death has decreased by forty-one percent; however, the death rate is still 303,000 annually. The Plan International's report titled “State of the World’s Mothers” states that the ten worst countries to be a mother are located in sub-Saharan Africa[2]. Most maternal deaths in Africa occur in low-resource settings and are preventable[3].

Neonatal health is defined as the health of children under 28 days old[4]. Like maternal death rates, infant death rates are the highest in developing countries, seeing that 50% of infants die in the first month they are born and ninety-seven percent of infant deaths occur in developing countries. These deaths are mainly caused by the mother's poor health before or during pregnancy, insterile practices or areas, lack of hygiene, and improper (or even lack of) care during pregnancy. Death of newborns is 200 times more likely and severe in developing countries than in developed countries. This is because only twenty percent of births have trained officials on the site. Simply finding a way to increase this percentage will dramatically decrease infant mortality rates. Practices such as drying infants off, covering them with a cloth, and giving them physical contact can make a world of difference in the baby's safety, as their body temperature once the birth occurs drops from 37 to 20 degrees Celsius[5].

Women in developing nations who have given birth cite inadequate equipment and staffing for their bad experiences in hospitals. They also point to lack of ambulances and other forms of transportation to government healthcare facilities as well as hostile or even abusive caretakers. In high-income or even upper middle-income countries, over ninety percent of births are made more safe with properly trained midwives, doctors, or nurses. Lower than fifty percent of births have the same care in underdeveloped nations[6].

Preeclampsia is a condition that typically starts after 20 weeks of pregnancy that can lead to serious, sometimes deadly effects, being one of the many main causes of maternal death in the world. Its properties include high blood pressure, damage to organ systems (most often liver or kidney), and protein in urine. These symptoms are hard to catch when without routine antenatal appointments, which is why developing nations have such high pre-eclampsia rates (two point eight percent of live births compared to the zero point four percent prevalence in developed nations)[7]. Most of the time, women can have preeclampsia and still deliver healthy infants and recover[8]; however, in developing nations, women are 14 times more likely to die from obstetric conditions. In order to track preeclampsia, simple procedures like checking blood pressure regularly, taking blood and urine tests, taking ultrasounds, and checking the baby's heart rate electronically can be done. Figuring out a way to get these simple procedures implemented in hospitals or even finding another way to track these symptoms will be key in decreasing death by preeclampsia in developing nations. The only way to completely treat preeclampsia is giving birth. Most women will have to give birth prematurely at about 37 weeks. To do this, they will need to undergo induced labor or a caesarean section, two processes that require much medical expertise and very specific attention, something that is simply unavailable in developing nations.

As with many global issues, Covid-19 has worsened the state of developing nations health care systems, especially involving maternal, fetal, and neonatal outcomes. Experts have witnessed an increase in stillbirths, maternal deaths, maternal depression, and ruptured ectopic pregnancies, again with higher concentrations in poorer areas. This is due to the fact that even less individuals are seeking health-care and even less emphasis is being placed on maternal care in hospitals[9]. In addition, women who are currently pregnant or have just given birth who also have Covid-19 are at an increased risk for a much worse illness, meaning needing to be placed on a ventilator, something developing countries are struggling with as well. This is because pregnancy makes the body more vulnerable to respiratory viruses and other illnesses. It is currently recommended by the CDC that pregnant women get vaccinated before or during pregnancy, but many developing nations do not have access to vaccines, especially in the global south.

United Nations Involvement

The United Nations strongly believes in the improvement of maternal and neonatal care worldwide. In 2000, during the Millenium Summit, the United Nations adopted the improvement of maternal care as its fifth goal to be reached by 2015. To reach these goals, countries came together in the Annual Ministerial Review and proposed their plans to reach these goals in voluntary presentations. Some presenters, like Jamaica, would have their plans evolve into their National Integrated and Strategic Plan for Sexual and Reproductive Health and HIV, which set a plan to increase access to family planning and increase health for women and newborn children[10]. In the same meeting, the United Nations also presented the Ministerial Declaration which created a joint response in order to follow through with the goals set out in the voluntary presentations, including the International Conference on Population and Development which planned to set out guidelines for stable population growth, including maternal and neonatal care practices, into a developing nation[11]. Following this, the UN partnered with 20 African nations in order to establish the Campaign on Accelerated Reduction of Maternal Mortality in Africa, providing a laid out plan to make sustainable funding for healthcare systems, strengthening existing healthcare systems, helping develop monitoring and evaluation systems, promoting HIV and AIDS protection, and creating family planning services for women[12].

Additionally, the United Nations Population Fund (UNFPA) proposed the Global Programme to Enhance Reproductive Health Commodity Security, outlining specific monetary funds and action plans that need to be put in place in order to establish proper maternal healthcare system[13]. The UNFPA is dedicated to working with governments, health experts, and civil society in order to train health workers, increase medicine availability, and improve reproductive health services. The following year, the UN published the Global Strategy for Women's and Children's Health, outlining specific funds a government should set aside for maternal health programs and further partnerships with NGOs in order to help accomplish their goal. In addition to this, they also provided a progress report in 2015, acknowledging the progress made and setting more goals for countries to establish to keep building their maternal health programs[14]. In 2014 the UNFPA partnered with H4+ to create the H4+ Partnership Joint Support to improve the health of women and children, outlining key objectives such as the improvement of healthcare facilities, creating better communication with UN agencies and nations, and strengthening mutual accountability programs in countries such as Cameroon and Cote d'Ivoire where they have set up healthcare facilities to encourage sustainable choices for children and mothers[15].

The UN also has worked with the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) to draft the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health. It lists out the actions and measures that need to be taken to deal with different issues of reproductive health at the bare minimum. UNFPA has partnered with IAWG stakeholders in order to implement this package and ensure that all affected populations have access to life-saving sexual and reproductive health services. Objectives of the MISP include preventing sexual violence, hauling the transmission of STIs like HIV, stopping unwanted pregnancies, and providing an international standard of care that all agencies have to follow[16]. The IAWG has also created a data booklet on reproductive health policies, which includes updated information on different governments' policies on reproductive health such as views on access to family planning, reproductive health of teenagers, abortion laws, and programs to prevent maternal mortality. It also includes information on contraceptive use, antenatal care, and the maternal mortality ratio.

In 2010, the UN MDG Summit was held, launching the Every Woman Every Child (EWEC) movement that propelled the UN to save 16 million and children from death due to reproductive issues. It currently has 280 partners and works with leaders from over 70 governments, national organizations, and the private sector. One of the projects done was the Merck for Mothers initiative which was a partnership with Merck to use its resources to decrease mortality rates of mothers by seventy-five percent using technology to do so. EWEC also worked with Nigerian local business leaders in order to make an investment fund for maternal and neonatal health. The Private Sector Health Alliance of Nigeria, for example, mobilizes national businesses in order to promote the implementation of millennium development goals surrounding maternal mortality[17]. Recently, EWEC committed itself to the 2030 Agenda for Sustainable Development, expanding its goals to ending discrimination and exclusion and aligning with the SDG 3 Global Action Plan and the Resident Coordinator System to provide maternal and neonatal healthcare on a country-level.

In 2014 during the sixty-seventh World Health Assembly, the United Nations Children's Fund and the World Health Organization formed the Every Newborn Action Plan in Resolution WHA 67.10, largely based on *The Lancet* Every Newborn Series. This was an offshoot of the Every Woman Every Child Initiative. The resolution focuses on helping countries implement and advocate for maternal and neonatal care. The resolution has led to partnerships with the Quality of Care Network, Partnership to Prevent Preterm Birth, and Breastfeeding Advocacy Initiative among others to help governments and the UN follow through with their plan. By 2016, over 50 nations had grown to hold the capability to track their growing progress in care and the following year, 48 nations had established proper national response plans and health programs in their nations for mothers and their children.

Case Study: Abortion in Africa

Annually, 21.6 million women unintentionally get pregnant. Thirty-eight percent of these women get abortions (legal or not). In Africa, the continent where maternal death rates are the highest, ninety-three percent of women of reproductive age live in countries that prohibit abortion under all circumstances (Angola, Central African Republic, and eight other countries). The African countries that do permit abortions have many restrictions on them, such as only in cases of rape, incest, and to save a mother's life. Despite this, from 2010 to 2014, approximately 8.2 million abortion cases took place annually, which is a massive increase from the 4.6 million abortion cases that occured in the years between 1990 and 1994. The proportion of women from ages 15 to 44 that undergo abortions is 34 out of 1,000, meaning many are undergoing unsafe, illegal abortions. In fact, only about 25% of abortions in Africa are safe and 9% of maternal deaths are attributed to unsafe abortions[18].

Contraceptive measures are often seen as immoral or are considered sacrilegious in Africa, which is why so many unwanted pregnancies are occurring. Over 50% of the populations of Nigeria and Ghana strongly believe contraceptive methods are morally incorrect (both with large Christian and Muslim populations). However, sub-Saharan Africa is becoming more accepting of contraceptive measures (only 15% believe contraceptives are immoral[19]). Because sex education in developing countries is lacking, many women are either unaware of or have dire misconceptions about contraceptives and are scared with myths and horror stories. Men are favored in many developing societies, leading many women to believe they are inferior and need to ask their partner's permission to use contraceptives.

The two safest methods of abortion are Medical Abortions (MA) and Vacuum Aspirations (VA). MAs come in the form of mifepristone and misoprostol pills that can be used to induce an abortion. They can be used after 24 weeks of conception and allow women to escape harmful surgeries. These pills are easily accessible, as they are often used for other purposes like gynecologic conditions, cancer, and Cushing's disease, and are successful about 96-98% of the time. VA is 95-100% successful, making use of a plastic aspirator or electric vacuum pump to completely empty the contents of the uterus manually. These two methods are best overseen by medical professionals; however, the severe lack of these in developing nations makes it difficult for women to undergo these processes.

Instead of using these two safe methods, women in nations where abortions are not easily acessible or are illegal resort to unsafe methods such as insertion of foreign objects (twigs, Coke bottles, coat hangers, etc. in an attempt to break the amniotic sac), injesting cleansers and chemicals, hitting the abdomen, or falling on purpose. Not only do most of these not work, but most of them cause life-threatening damage, such as haemorrhage, sepsis (infection), poisoning, and damage to the uterus and other internal organs[20]. This is extremely problematic in Africa where 6.2 million unsafe abortions occur annually, which is 77% of the abortions occuring in Africa. Oftentimes what will happen is an incomplete abortion, or a failure to remove all the tissue from the uterus, which can be damaging for the baby and the mother as it can result in severe bleedin,g dialation of the cervical canal, uterine rupture, and infection. Ninety-seven percent of unsafe abortions occur in developing nations, with the most concentration being in central and south Africa. For every 100,000 unsafe abortions that occur in developed nations, 30 women die, but for every 100,000 unsafe abortions that occur in developing nations, 220 women die. Some women are able to acquire "better" methods on the black market, but these are still dangerous because they are not being overseen by a medical professional, meaning there could be a problem with the drug quality or dosage.

Case Study: Pregnancy-Induced Morbidities

In a study by the US National Library of Medicine, 17.5% of women with Female Genital Mutilation (FGM) caused by pregancy have had PTSD. FGM is an extremely tramautic experience that causes depression, anxiety, flashbacks, and nightmates. To treat FGM, a plan where organizations, such as Equality Now and the World Federation for Mental Health. would provide Deinfibulation, a treatment recommended for women unable to have sex, women with difficulty urinating, and pregnant women at risk of having problems during labour. Ideally, this treatment should be done before the last two months of pregnancy. A surgery would be done that would make an incision to open scar tissue and be performed under anaesthetic. Thirty-four percent of women with FGM do not have a steady income, which leads to stress, anxiety, depression, and PTSD. Typically women who experience FGM live in troubling areas that have been destroyed by conflict.

To avoid pregnacy related deaths amongst these FGM women, an international Death by Illness Database, sponsored by the Centers for Disease Control and Prevention (CDC), would be inplaced, as it would conduct a national maternal-related mortality surveillance. This will help understand risk factors and causes of these deadly illnesses related to pregnancy.

First, data on individuals who have unfortunately passed away from common pregnancy related issues will be collected. This data would include cause of death, age, medical history, and symptoms. Then, organizations, such as the Medical and Research Foundation, would study this data to see what factors specifically led to death in a more sustainable, reliable way. They would

then create maps of the frequencies of problems in different areas, and approach these areas before they worsen within other affected individuals.

Questions to Consider

1. What is your country's stance on abortion, and how do abortion laws affect maternal mortality your country?
2. How can pregnant women without access to hospitals be safe before, during, and after pregnancy?
3. Since most maternal deaths are easily preventable, what is preventing women's access to simple treatments and oversight?
4. How do cultural norms and social stigma play a role in the high birth rate in developing nations?
5. What is the state of maternal healthcare in your country? If you are a developed nation, how can under-developed nations use your country's model in order to decrease maternal mortality?
6. Why have UN efforts to set minimum standards for maternal healthcare failed?

Endnotes

1. https://www.icrc.org/en/document/overview-humanitarian-situation-colombia
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Topic B: Humanitarian Crisis in Colombia

Background

Through years of territorial expansion and international disputes, Colombia has experienced a humanitarian crisis for decades[21]. Resulting in twenty-one mass displacement events, over 50,500 individuals suffer from displacement and a drastically low rates of humanitarian care in the past year. Compared to the 27,000 documented refugees in 2020,[22] it is evident the rates of refugees are only increasing. However, with armed conflict escalating throughout 2020 and 2021, humanitarian aid is unfortunately not a nation wide priority. With over 6.2 million people in Colombia in need of food assistance,[23] "particularly in the areas most affected by armed conflict and natural hazards" and over 6.1 million people in need of health assistance, infrastructure and the response capacity at the national level forces have inevitable limitations.[24]

In a majority of cities within Colombia, armed groups have imposed restraints against the nation's freedom, forcing Colombians' freedom of movement to be revoked, their ability for financial income destroyed, and their access to common, essential health services extremely limited[25]. With[26] rates of over 90% of individuals experiencing humanitarian crises in numerous cities,including Antioquia, Cauca, Choco, Narino, Norte de Santander, and Valle del Cauca, an upsurge in violence occurred in less dense and funded populations.[27]

Every day, thousands of people flee the country by foot. Those who stay are often employed, but they are struggling with hyperinflation that has "devalued the Colombian bolivar by several orders of magnitude while wages have fallen far behind the rate of inflation." In 2018, 55% of medical staff had either resigned or left the county due to the current state of both the hospitals and nation, which resulted in a complex humanitarian emergency, or CHE. The Columbian CHE caused a large health crisis resulting in the shortage of both medicine and staff, as the Pharmaceutical Federation of Colombia estimated there would be a shortage of more than 85% of medication and 50% of necessary medical supplies by 2018 within all national hospitals. The decrease in both staff and available survival nessestices has resulted in an increase of maternal and infant mortality rates and caused a significant increase in kidney dialysis, the spread of COVID-19, HIV, dengue fever, measles, and diphtheria. Although 25% of the population is in desperate need of assistance, President Ivan Duque Marquez refuses to admit there is a humanitarian crisis within his country and, insead, blames sanctions and existing problems from other counties.

The most influential factor of the humanitarian crisis is the rapid increase of refugees and internally displaced people (IDPs).[28] With approximately 7.7 million IDPs, Colombia is one of the countries with the highest number of IDPs across the globe. The root cause of the Colombian IDP drasticity primarily occurred within the years 1995 to 2008, when "far-right paramilitary forces embarked on a territorial expansion and usurped the lands that were abandoned by the locals.[29]" However, these displacements were most prevalent during the year 2017, as a territorial fight for control took place within the Colombian Pacific Coast region, resulting in approximately three-thousand five hundred individuals to become IDPs [30]. In 2016, due to the consistent increase in displaced individuals, the Colombian government and Colombia's largest armed group, the Revolutionary Armed Forces of Colombia (FARC),[31] signed a peace agreement when the nation's IDPs peak was beginning to occur. The peace agreement not only resolved the nation's fifty year long conflict but also created multiple, durable solutions for the nation's high

rates of IDPs.[32] However, the effect IDPS had on the nation is what ultimately increased the humanitarian crisis.

To combat the humanitarian issues rising among IDPs and to lower the IDP refugee-influenced humanitarian lows, Colombia has implemented a Reintegration Plan that is funded through humanitarian based organizations. The plan has prioritized the migration of children below the age of 13 and their families.[33] Once settled into their new region, the Colombians are transferred into a community that houses citizens from Colombia.[34] The community has provided citizens with free education from grades K-12, food stamps to supply nutritional meals daily, proper professional healthcare, and shelter. In exchange for these living conditions, at least one member from each household must work within the community. These communities support the Colombian population until they feel comfortable leaving and finding homes within their migrated nation. Although it may be questioned, citizens have the right to return back to Colombia if they feel that is what best fits their situation.

Colombia currently has 2 million cases of Covid-19, 57,000, of which, have led to death. In 2020, the economy of Colombia shrank by 6.8% due to the pandemic (a loss of $70 billion). Colombia's construction, hospitality, retail, and hotel industries were destroyed due to lockdowns all shrinking by significant margins. While things are improving in 2021, it is expected to take years to recover to the state the economy was in pre-pandemic. The Department of Policy Financing in Colombia has taken measures on the path towards recovery, strengthening the social registry to find vulnerable regions and targeting individuals of lower socioeconomic status. It has also helped individuals access short-term financing with trade guarantees and risk-sharing facilities.

United Nations Involvement

The United Nations had a strong impact on the humanitarian crisis in Colombia, as they created and put forward resolutions through the development of the United Nations Verification Mission in Colombia, including Resolution 2366, Resolution 2261, and Resolution 2381. They also held multiple international meetings regarding the nation's humanitarian issue and invoked the Inter-American Treaty of Reciprocal Assistance, or TIAR, for collective humanitarian action. The UN also has multiple organs involved in the issue, including: The Office of the United Nations High Commissioner for Human Rights, or OHCHR (showed that the socio economic crisis was unfurling even before international sanctions), the UN Development Programme (bought resources from the Colombian Central Bank to buy health care equipment, necessary medicine, and food during the pandemic), and The Food and Agriculture Organization, or FAO (gave updates on the percentage of undernourished Colombian citizens).

Additionally, through the adaptation of resolutions and pledge events, the UN has increased humanitarian supplies. Resolution 2451 depicts the importance of participation of all political people during this crisis and states that humanitarian aid should be distributed based on gender and age. It also requires that all parties enforce the Stockholm Agreements (a global treaty with the goal to protect from the adverse effects of pollutants) and abide by the timelines stated in it. All parties must respect the ceasefire agreed upon for the Hodeidah governorate. Resolution S/2019/11 was created on October 8, 2019 by the Security Council and states the concern of humanitarian aid and human rights found in South Sudan due to their economic situation. In this resolution, the Security Council encourages the Government of the Republic of South Sudan to spend the balance of pledged funds to be used to implement R-ARCSS in a way that is honest and accountable. It also requires that the government continues to provide funds for

the implementation of the peace agreement. Resolution S/RES/2505 was adopted on January 13, 2020 by the Security Council. This document reaffirms Yemen's commitment to independence, territorial integrity, sovereignty, and union with the Yemenis people. During this meeting, it is decided that the mandate of the United Nations Mission to support the Hodeidah Agreement (UNMHA) will be extended until July 15, 2020, as well as support the parties by implementing commitments filling the UNMHA.

Another way the United Nations has helped the Colombian crisis is through pledge events. In February of 2019, the UN and the Governments of Sweden and Switzerland worked together and formed the third High-Level Pledging Event for the Crisis in Colombia. The event collected around $2.6 billion in donations to ensure proper humanitarian aid for Colombian people in need. A majority of donors came from the nations Saudi Arabia, United Arab Emirates, United Kingdom, Germany, and Canada.

Furthermore, the UN has developed solutions to combat the primary causes of humanitarian aid declines, including increased Colombian IDPS and the conflict within Colombia. Addressing the problem with IDPs, The United Nations Verification Mission in Colombia was created with the purpose of "[accompanying] the parties and [verifying] their commitments regarding [multiple] points of the Final Peace Agreement [regarding the] reintegration … and [execution] of measures of protection and security for [individuals] and communities" that are the most negatively affected by the issues in Colombia. In addition, the UN has also formulated multiple resolutions to combat the crisis, such as Resolution 2366, written in July 2017, which requests UN support from Colombia's government as well as the Revolutionary Armed Forces of Colombia–People's Army (FARC-EP)." Resolution 2261 of January 2016 included a mandate allowing the UN to monitor the ceasefire and cessation and confirm the destroying/giving up of arms. Resolution 2381 from October of 2017 was formed in October 2017, with the agreement to "verify compliance with the temporary, bilateral, national ceasefire at national, regional and local level."

The UN also passed Resolution RC.30/RES, which essentially imposes sanctions on armed groups terrorizing Colombains, as well as requested an investigation of the regime's alleged illegal activities, that will be conducted by TIAR officials. However, RC.30/RES.1/19 was a key resolution towards the national crisis, as it emplaced border controls and enhanced surveillance throughout the nation, ultimately lowering the rates of armed activity.

Case Study: The Revolutionary Armed Forces of Colombia

The Fuerzas Armadas Revolucionarias de Colombia (FARC), better known to English speakers as the Revolutionary Armed Forces of Colombia, was formed in 1964 as an offshoot militant branch of the Colombian Communist Party focused in rural areas with the purpose of redistributing wealth amongst the people[35]. As the name suggests, the group often catered to violent actions in order to accomplish their goals. In September of 1996, the group carried out its first official attack against the Colombian police and military. They first attacked the Las Delicias military base, killing 54 soldiers and further injuring another 17 with just a small force of 500 freedom fighters using guerrilla warfare tactics. Meanwhile, the militant group used rockets and grenades to police and militant institutions in small towns and cities. In total, 80 Colombian police and soldiers died in the fighting which took place in just a single weekend, showing the Colombian government just how powerful and widespread the group was[36]. The group continued attacks such as car bombings and further assaults on government facilities. The

deadliest year for Colombian security personnel was 2010 when the government reported that FARC had killed over 460 members and injured a further 2,000 in their attacks[37]. The militant group also found itself heavily involved in the massive drug trade in Colombia. As estimated by the Latin American Program, around several hundred coco leaf farms were under the control of FARC, imposing their own taxes and laws as well as recruiting more members into their cause. While little evidence suggests that FARC has manufactured and distributed cocaine, Colombia's Bandas Crimanales have fostered business relations with them and have never had any conflictss[38]. The combination of attacks and pressure from the Colombian citizens forced the Colombian government to sign a peace agreement with FARC in November of 2016 in Bogota. This historic deal and victory for both sides moved Colombia into a presidential democracy while also demobilizing FARC forces[39]. However, the signing of this peace agreement failed to create a long-lasting peace, as FARC would rise again and become the Revolutionary Alternative Common Force party[40]. In September of 2021, FARC members, yet again, attacked a military base, utilizing a car bomb. While the attack claimed no lives, it injured 44, including two United States military advisors which the attack aimed to kill. That same month, members shot bullets at President Duque's helicopter in an attempt to kill the president who has been criticized for failing to abide by the 2016 peace agreement. While 10 members were arrested for their association with the attacks, they are a clear and shining example that FARC still has a huge militant presence within the nation and with recent protests, could arise once more, forcing a struggling nation to yet again face attacks by both the government and FARC[41].

Case Study: The Bogota Protests

When the second wave of the Covid-19 pandemic hit Colombia in early 2021, the government was forced to impose restrictions on the already struggling economy, implementing curfews and restricting major shopping districts in Bogota[42]. During this time the economy saw a 2.3% inflation rate and unemployment rates skyrocketed from around 9% to almost 16%[43]. Then, President Ivan Duque introduced a new tax legislation which would increase taxes on gas and wages as well as staple commodities such as coffee beans. This bill was heavily favored by the elite within Colombia as they would receive tax breaks while the middle class within the country would be punished. The protest began shortly after on April 28 on this exact bill, later expanding to incorporate the government's lack of aid to the country's poor middle-class workers. However, things soon turned violent as police began firing on protesters in the streets of Bogota with live ammunition. While the government has only confirmed the death of 18 with nine more under investigation, other reports from the Human Rights Watch suggest that an astounding 68 people were killed by police from the protests and 1,000 were arrested for crimes committed during the protest in spite of little evidence. Despite the police's actions against the people, only two officers were put on forced suspension out of a total of 170 who were investigated. Furthermore, the police have only been accused of 20 accounts of murder by the government. The failure of accountability for unlawful police action against the protesters has garnered many through the central American nation to blame President Duque's promise to prosecute and convict officers for their wrongdoings against the people[44].

Later in July, the President introduced a new tax bill in replacement of the one proposed in April. This tax bill promised a 6.3 billion dollar package that would help resume social programs within the nation that had previously been halted due to the pandemic. It would also place a greater emphasis on taxing corporations that operated Colombia while doing away with the increased sales tax of consumption goods while increasing those on fuel and

single-use plastics. However, the protests resumed again as protesters led by Colombia's Central Union of Workers argued that the proposal lacked funding for education and job creation in the struggling nation[45]. Protesters also argued that money should be used for social programs instead of the military[46], which the current government allocates around 4% of its GDP towards[47]. Needless to say, the continuation of the protest meant the continuation of violence against the people of Colombia as police would spray people with firehouses and launch teargas into a largely peaceful crowd. At this time, it is still unclear how many protesters have died so far in the July protest, but it is believed that far fewer have been killed compared to the April protests.

If the protest continues, it is believed that armed groups will slowly rise again as they did in 2019, throwing the country into another age of political instability and widespread violence within Colombia[48].

Questions to Consider

1. How do Colombian IDPs and refugees contribute to economic change, resulting in a decrease of professional medical care?
2. What are the pros and cons of Colombia relying on neighboring nations for humanitarian supplies?
3. How has COVID-19 increased the stability of humanitarian aid supplies throughout Colombia?
4. What is the primary cause of the decrease in humanitarian aid in Colombia? Explain why you believe this is the most impactful shifter.
5. How does education play a role in developing more sustainable humanitarian systems?
6. Do you believe the UN should focus on developing long term humanitarian solutions that have a greater impact, but a longer implementation process, or short term humanitarian solutions that have less of an impact, but can provide aid to Colombians at a faster rate? Explain your reasoning.

Endnotes

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