

A photograph of a busy New York City street on a foggy, rainy day. Tall brick buildings line both sides of the street, with a sign for 'WELLINGTON' visible on the left. In the foreground, a person with a black umbrella is crossing the wet street. Several yellow taxis and other vehicles are visible, their red taillights reflecting on the wet pavement. A blue semi-transparent banner is overlaid across the middle of the image, containing the text 'NHSMUN' and 'National High School Model United Nations'.

NHSMUN

National High School Model United Nations

Table of Contents

A Note on the NHSMUN Difference.....	3
Position Paper Requirements.....	4
Committee History.....	5

Topic A: Quality Care for Aging Populations.....

Introduction.....	7
History and Description of the Issue.....	7
Current Status.....	17
Bloc Analysis.....	24
Committee Mission.....	26

Topic B: Improving Early Childhood Survival.....

Introduction.....	29
History and Description of the Issue.....	30
Current Status.....	39
Bloc Analysis.....	45
Committee Mission.....	47

Research and Preparation Questions.....	48
Important Documents.....	49

A Note on the NHSMUN Difference

Esteemed Faculty and Delegates,

Welcome to NHSMUN 2027! We are Armen Bagdassarian and Sabeeh Mirza, and we are elated to serve as this year's Secretaries-General. Thank you for choosing to attend NHSMUN, the world's largest and most diverse high school Model United Nations conference. As a space for collaboration, consensus, and compromise, NHSMUN strives to transform today's brightest thinkers, speakers, and collaborators into tomorrow's leaders. We believe that an emphasis on education through simulation is paramount to the Model UN experience.

Realism and Accuracy: Although a perfect simulation of the UN is never possible, we believe that one of the core educational responsibilities of MUN conferences is to educate students about how the UN System works. We strive to invite real UN, NGO, and field experts into each committee through our committee speakers program. Moreover, we arrange meetings between students and the actual UN Permanent Mission of the country they are representing. These exclusive resources are only available due to IMUNA's formal association with the United Nations Department of Global Communications and consultative status with the Economic and Social Council. No other conference goes so far to deeply immerse students into the UN System.

Educational Emphasis: At the heart of NHSMUN lies education and compromise. Part of what makes NHSMUN special is its diverse delegate base. As such, when NHSMUN distributes awards, we strongly de-emphasize their importance in comparison to the educational value of Model UN. In particular, our daises look for and promote constructive leadership and diplomacy that strive toward consensus, as real ambassadors do in the United Nations.

Research and a Dedicated Staff: Our staffers care deeply about delegates' experiences and what they take away from their time at NHSMUN. Our Directors spend over six months preparing Background Guides, in addition to Update Briefs written to reflect the rapidly changing nature of the topics to be discussed. Our staffers are trained rigorously to provide the best conference experience possible. Our daises provide thoughtful comments on submitted position papers. Our staff aims to tailor the committee experience to delegates' reflections and research, but also to facilitate an environment where all delegates' thoughts can be heard.

Empowering Participation: The UN relies on the voices of all of its member states to create resolutions. This is our philosophy at NHSMUN too. Our Rules of Procedure and our staff focus on making every voice in the committee heard, regardless of country assignment or skill level. Additionally, unlike many other conferences, we also emphasize delegate participation after the conference. Delegates spend countless hours researching topics critical to the UN and broader international sphere.

Delegates, it is our sincerest hope that your time at NHSMUN will be thought-provoking and stimulating. NHSMUN is an incredible time to learn, grow, and embrace new opportunities. We look forward to seeing you work both as students and global citizens at the conference.

Best,

Armen Bagdassarian
Secretary-General

Sabeeh Mirza
Secretary-General

Position Paper Requirements

Delegate research and preparation is a critical element of attending NHSMUN and enjoying the debate experience. We have provided this Background Guide to introduce the topics that will be discussed in your committee. We encourage and expect each of you to critically explore the selected topics and be able to identify and analyze their intricacies upon arrival to the conference.

The task of preparing for the conference can be challenging. To assist delegates, we have updated our [Beginner Delegate Guide](#) and [Advanced Delegate Guide](#). These guides contain more detailed instructions on how to prepare a position paper and excellent sources that delegates can use for research. Use these resources to your advantage. They can help transform a sometimes overwhelming task into what it should be: an engaging, interesting, and rewarding experience.

To accurately represent a country, delegates must be able to articulate its policies. Accordingly, NHSMUN requires each delegation (the one or two delegates representing a country in a committee) to write a position paper for each topic on the committee's agenda. More information about how to write and format position papers can be found in the [Research Guide](#). To summarize, position papers should be structured into three sections.

I: Topic Background – This section should describe the history of the topic as it would be described by the delegate's country. Delegates do not need to give an exhaustive account of the topic, but rather focus on the details that are most important to the delegation's policy and proposed solutions.

II: Country Policy – This section should discuss the delegation's policy regarding the topic. Each paper should state the policy in plain terms and include the relevant statements, statistics, and research that support the effectiveness of the policy. Comparisons with other global issues are also appropriate here.

III. Proposed Solutions – This section should detail the delegation's proposed solutions to address the topic. Descriptions of each solution should be thorough. Each idea should clearly connect to the specific problem it aims to solve and identify potential obstacles to implementation and how they can be avoided. The solution should be a natural extension of the country's policy.

Each topic's position paper should be **no more than 10 pages long** double-spaced with standard margins and 12 point font size. This is a maximum; **3–5 pages per topic is often a suitable length**. The paper must be written from the perspective of your assigned country and should articulate the policies you will espouse at the conference.

Each delegation is responsible for submitting position papers on or before **February 26, 2027**. If a delegate wishes to receive detailed feedback from the committee's dais, their position paper must be submitted on or before **February 5, 2027**. The papers received by this earlier deadline will be reviewed by the committee dais and returned before February 26. Instructions on how to submit position papers will be shared directly with faculty advisors.

Submission instructions for position papers will be sent to faculty advisers via email. If delegations are unable to submit their position papers on time, please contact us at nhsmun@imuna.org.

Delegations that do not submit position papers will be ineligible for awards.

Committee History

In 1994, the United Nations convened an International Conference on Population and Development (ICPD) to discuss pertinent universal demographic issues, such as immigration, infant mortality, birth control, family planning, women's education, and protecting women from unsafe abortion practices.¹ From this Conference, a resulting Programme of Action was born. This presents actionable items in broad categories such as sustainable development, gender equity, and urbanization. These action items, and the Programme as a whole, re-envisioned population development by emphasizing individual needs instead of broad demographic and developmental goals. It assessed the intersections of economic, social, and political progress while promoting sustainable developmental growth. The Programme also focused heavily on pervasive inequalities in income, gender, education, and health.²

The General Assembly of the United Nations designated the newly named Commission on Population and Development (CPD) to provide oversight on the implementation of the Programme of Action in General Assembly Resolution 49(XLIX) on 19 December 1994.³ The Commission's responsibility is to monitor, review, and assess the implementation of the Programme of Action at national, regional, and international levels. The Commission submits non-binding recommendations to the Economic and Social Council (ECOSOC) on population trends, developmental strategies and policies on how to best follow the Programme of Action.⁴

The Commission is composed of 47 member states. These member states are elected by the Economic and Social Council for four-year periods based on geographic distribution. Member states have staggered terms that expire in different years. The Commission convenes annually at the UN Headquarters in New York. It publishes annual reports that detail research initiatives, advice, and plans of action on select themes. Non-governmental organizations (NGOs) are also welcome to attend the annual sessions and provide input for these publications.⁵ The United Nations Population Fund (UNFPA) is a frequent CPD collaborator also tasked with monitoring and implementing the ICPD.⁶ Additionally, the Commission responds to specific research and advisory questions from any country or region upon request, further emphasizing the global scale of their work.

CPD offers a forum for the international community to discuss population and demographic trends. The commission not only leads debates on these issues but also serves as an important source of research on topics discussed.⁷ With the objective of sustainable population development, the Commission has made significant contributions toward combating various forms of inequality and improving individual quality of life. Since its inception, the Commission has advised policy and prepared research on reproductive rights, reproductive health, HIV/AIDS, poverty, the environment, changing age structures, urbanization, and migratory patterns internationally and internally.

¹ "International Conference on Population and Development (ICPD)," United Nations Population Fund, accessed September 24, 2025, <https://www.unfpa.org/icpd>.

² International Conference on Population and Development, *Programme of Action* (Cairo: September 1994), ST/ESA/SER.A/149, https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/files/documents/2020/Jan/un_1995_programme_of_action_adopted_at_the_international_conference_on_population_and_development_cairo_5-13_sept_1994.pdf.

³ International Conference on Population and Development, *Programme of Action*.

⁴ "Commission on Population and Development," United Nations Population Division, accessed September 24, 2025, <https://www.un.org/development/desa/pd/content/CPD>.

⁵ "Resolutions and Decisions of the Commission on Population and Development," United Nations Population Division, accessed September 24, 2025, <https://www.un.org/development/desa/pd/content/resolutions-and-decisions-commission-population-and-development>.

⁶ CHOICE for Youth and Sexuality, *Commission on Population and Development*, (Amsterdam), <https://www.choiceforyouth.org/assets/Toolkits/youth-led-advocacy/CPD/CHOICE-CPD-Factsheet-1.pdf>.

⁷ United Nations Population Fund, "International Conference on Population and Development (ICPD)."

TOPIC A

CPD | NHSMUN 2027

Quality Care for Aging Populations



Introduction

The global population of people aged 65 and older is predicted to double to 1.6 billion by 2050.¹ This is up from about 830 million people in 2024.² The global life expectancy is also projected to rise from 73.6 years of age in 2022 to 78.1 years of age in 2050.³ Meanwhile, several countries are experiencing negative population growth, including China, Russia, Japan, Germany, Italy, Thailand, South Korea, Spain, and Poland.⁴ Population decline occurs when deaths and outward migration exceed births and inward migration, causing the total population to decrease.⁵ Declining birth rates can reduce the future number of working-age people available to finance pensions, provide healthcare, and support a growing older population. Immigration may partly offset workforce decline in some countries, although its effects depend on the number, age, and employment of migrants.

As people reach older ages, their health may decline, and older adults may experience more diseases or disability.⁶ Instead of only focusing on a person's lifespan (duration of life) and how to prevent death, quality care focuses on prolonging a person's health, or healthspan.⁷ Healthspan is the period of life during which a person remains generally healthy and free from serious disease or disability.⁸ Quality care must also be safe, effective, affordable, accessible, and responsive to the needs of a patient. This could encompass services for disease or injury prevention, treatment for chronic conditions, mental health services, social support, long-term care, and palliative or end-of-life care.

The way each country approaches aging and how to care for the aging population is different and can be affected by how people view older adults culturally. As the aging population grows over the next few decades, many countries remain insufficiently prepared to meet the changing needs of aging populations for what it means to take care of the aging population at the micro level (individuals), mezzo level (local communities and organizations), or the macro level (government, businesses, healthcare systems). At the micro level, aging care affects older adults and their families; at the mezzo level, it affects communities, healthcare providers, and local organizations; and at the macro

level, it affects national healthcare systems, labor markets, social-protection programs, and government budgets.

Since the Commission on Population and Development (CPD) reviews population trends and advises Member States on how demographic changes relate to economic and social development, population aging falls within the Commission's mandate. It affects healthcare systems, labor forces, migration, gender equality, social protection, and sustainable development. To provide good quality of care for the aging population, countries will need to decide how best to allocate resources, respect cultural boundaries, combat ageism, and initiate policies within an equitable and sustainable framework.

History and Description of the Issue

GLOBAL LIFE EXPECTANCY HISTORY

The average global life expectancy has increased substantially over the past two centuries. In 1900, the average global life expectancy was approximately 32 years.⁹ However, this low average was driven heavily by high infant and child mortality and does not mean that few adults

lived into old age. About one-third of children born died before reaching age five.¹⁰ There was also a high rate of maternal deaths. Maternal mortality was also substantially higher than it is today, although historical estimates vary by country and data source. In many present-day high-income countries, maternal mortality has fallen by more than 90 percent since the early twentieth century. However, progress remains unequal, and maternal mortality continues to be considerably higher in many low-income and conflict-affected countries.¹¹ The decline in maternal deaths is because of factors like better hygiene practices, sterilization of medical instruments, lower rate of infections, and better maternal care.¹²

Low life expectancy in the 18th and 19th centuries was also caused by infectious diseases, like scarlet fever, rheumatic fever, and typhoid.¹³ The medical community historically did not have a good understanding of how diseases were spread. Up through the late 19th century, people believed diseases were spread by breathing in “bad” or foul air until germ theory was introduced. Germ theory’s acceptance led to an increase in sanitary practices and the creation and distribution of vaccines. In the 20th century, antibiotics were also discovered and mass produced. Not only are antibiotics helpful for combating infections, they are also commonly associated with safer surgeries, childbirth, and cancer treatments.¹⁴

Another factor influencing low life expectancy in the 18th and 19th centuries was the lack of sanitation standards. Instead of the underground sewers, septic tanks, or indoor plumbing that are found in many countries today, people living in urbanized areas were exposed to open sewers and an excessive amount of garbage in the streets.¹⁵ These unsanitary conditions often led to the spread of infectious diseases, malnutrition, diarrhea, and child stunting (being too short or too light for normal growth).¹⁶ Health conditions were also impacted by the lack of access to clean, safe water.¹⁷ Eventually, cities started creating reservoirs and water

treatment plants to clean and distribute safe water supplies.¹⁸ Finally, hand-washing practices became more widespread in the mid-19th century when Dr. Ignaz Semmelweis, a doctor in Vienna, noticed more women died in hospital maternity wards when a doctor delivered a baby after they had previously performed an autopsy. Dr. Semmelweis traced these deaths back to doctors failing to wash their hands between conducting autopsies and treating maternity patients. When he started to use hand-washing practices, fewer women died.¹⁹

As sanitation practices fought the spread of infectious diseases, so did the adoption of new nutritional standards. Refrigeration and cast-iron stoves in the home impacted the way people interacted with perishable goods. People also could access more nutritious food, like vegetables, fruits, and whole grains, which promotes a healthier lifestyle and decreases the risk of malnutrition.²⁰ Other aspects of a healthy lifestyle also play a role in longer lifespans. Getting care before illness or injury is now much more common, which helps catch issues and get treatment earlier. Also, as hard labor and industrial work transitioned to more in-office jobs and managerial work, greater focus was put on physical exercise and the benefits of combating chronic diseases. Creating healthy habits of not smoking, limiting alcohol, and getting quality sleep also contributes to a healthy lifestyle. Mental and physical health are also interconnected, and poor mental health can affect a person’s physical health, ability to seek care, and overall quality of life.²¹

However, the factors increasing global life expectancy have not been distributed equally. Many inequalities persist in low-income countries or more rural areas. The Sub-Saharan African countries of the Central African Republic, Chad, and Nigeria have the lowest life-expectancy ratings in the world. Some factors that affect these countries include higher rates of infectious diseases, malnutrition, human conflict, maternal and child deaths, and inability to access healthcare.²² Malnutrition is still an

issue, as approximately 7.8 percent of the global population, nearly one in 13 people, experienced hunger in 2025.²³ Child stunting and wasting (when a child's weight is too low for their height) impact children within Africa, Southeast Asia, India, and Afghanistan.²⁴

Low-income countries also experience child deaths from diarrhea and pneumonia when children cannot access timely treatment.²⁵ Diarrhea is generally treated with oral rehydration solution and zinc, while bacterial pneumonia may require antibiotics. Childhood vaccination coverage remains uneven within and among regions, with particularly serious gaps in low-income, fragile, conflict-affected, and underserved communities because of factors such as supply interruptions, weak health systems, distance, conflict, and difficulties reaching displaced populations.²⁶

Overall, death rates are much higher in less developed countries.²⁷ They also tend to impact rural communities more than urban communities.²⁸ Disparities also exist between men and women: women tend to live longer than men globally, but this differs between countries. The death rate for boys is higher over their entire lifespan: newborn boys are more susceptible to diseases, boys in their youth tend to experience more violence and accidents, and older men tend to experience chronic health conditions.²⁹ These disparities show that population aging is not occurring equally across or within various populations. Therefore, improving care for aging populations requires policies that account for differences in income, gender, geography, healthcare capacity, and life expectancy.

CHANGES IN CARE FOR OLDER ADULTS

Family-Based Care

In a general sense, countries differ in how they view aging and older adults. Individuals within a country may also have different views than those at the societal level. This is important because how aging is perceived can translate

into how older adults are treated and cared for. Countries vary from being more collectivist and individualist, showing different degrees of each. Some cultures place a high value on the needs of the group, promoting group harmony, interdependence within members of the group, and shared responsibility for successes and failures.³⁰ On the other hand, more individualistic cultures place high value on independence, personal achievement, and self-expression.³¹

These cultural differences can influence how older adults are perceived and who is expected to care for them. In some cultures, filial piety is significant, especially to Confucian and Buddhist values. Filial piety is when people feel the moral duty to obey, care for, and respect parents and other familial elders.³² In countries such as India and Pakistan, the joint family system plays an important role, where older adults are relied on in making family decisions, upholding and imparting traditions, cultural and religious values, and are seen as mediators for familial conflicts.³³ Older adults have gained a multitude of life experiences and can impart what they have learned to younger generations. Moreover, aging is seen as a natural human process, where maturity demonstrates older adults being valued members of society, and are still relied on for support and guidance.³⁴

In other cultures, youth is prized or respected more than aging, and vitality is celebrated. Youth is also closely related to productivity, so older adults are seen as less productive and therefore are undervalued.³⁵ Older adults are also seen as being antiquated and holding onto their traditions, which is in direct opposition to the desire for innovation. Finally, independence and self-sufficiency are highly regarded. When older adults lose their independence, it shows them in a negative light that they can no longer take care of themselves. Many are viewed as burdens on their families.³⁶

Historically, older adults were cared for by their family members, as families often lived in multigenerational homes. Many of the support

systems available today did not exist centuries ago. Care for aging family members often fell to daughters and daughters-in-law. This gender imbalance continues today.³⁷ This type of care can be associated with the micro level, or care by an individual or family.³⁸ In many communities across East and South Asia, the Middle East, Africa, and Latin America, cultural traditions place substantial responsibility for long-term care on families. Adult children may feel a strong duty to provide their parents with care, companionship, and financial support. However, these expectations vary within and among countries and are changing alongside migration, urbanization, and shifting household structures.³⁹

Public Pensions and Institutional Care

It was during the Middle Ages and Renaissance when early institutions and state support for long-term care began. Christian groups in the Middle Ages provided homes and care through hospitals and almshouses, a form of charitable homes. The Renaissance saw the rise of charitable homes for older adults, which paved the way for the concept of social services.⁴⁰ In the 19th century, poorhouses and workhouses were created for older adults who were poor and did not have a home or family to care for them.

While these places were seen as charitable, they often had poor living conditions.⁴¹

During the Industrial Revolution in the 18th and 19th centuries, there was a shift away from an agrarian, or farming, lifestyle as people left the countryside to work at factories in cities. This disrupted the traditional family dynamics of living on the family farm and taking over as an adult, thus caring for the aging parents.⁴² Long-term care then began to be viewed in a different light, as a societal issue. This opened the door for the development of social security programs in the 20th century. This included retirement benefits, pension plans, health insurance for older adults, and health insurance for people with low incomes, including older adults.⁴³ One of the first senior living facilities that was not a poorhouse was opened in the 19th century in the United States. By the mid-20th century, these senior living facilities were common as the life expectancy increased.⁴⁴

As the Industrial Revolution shifted the traditional family structure, it paved the way for some cultures to become more individualistic in nature. As children grew into adults and moved out of their parents' home, independence and self-sufficiency became more valued by both adults



Residents of a US nursing home participating in a group activity

Credit: Angie Foran/USFWS

and their aging parents. As life expectancy rose during the 20th century, more older adults developed complex health needs that families could not always manage at home.⁴⁵ Although residential care may conflict with cultural expectations that families should provide care themselves, it can offer specialized support when an older adult's needs exceed what relatives can safely provide. Formal long-term care systems did not completely replace family caregiving. Instead, many countries developed mixed systems in which governments, private providers, communities, and families share responsibility.

The 20th century also saw the growth of long-term care, including nursing homes, assisted living facilities, hospice care, and home health. This type of care involves the micro, mezzo, and macro levels because individuals receive care, organizations deliver services, and governments regulate and finance care systems.⁴⁶ After the Second World War, nursing homes and other residential-care facilities expanded, particularly for older adults who needed assistance with daily activities or medical care.⁴⁷

Community and Home-Based Services

Alongside institutional care, countries have developed services that allow older adults to receive assistance within their homes and communities. Home health care has been associated with earlier systems in which healers and then nurses would care for the sick at home. One of the first hospice facilities to care for the terminally ill was founded in Ireland in the 19th century. What is known as modern-day hospice was introduced in England in the 20th century.⁴⁸

Hospice care and home health care can be associated with the mezzo level, or care occurring in the community.⁴⁹ Home health also expanded into other forms of community support, like adult daycare centers, senior centers, and meals delivered at home.⁵⁰ These services can help older adults remain connected to communities while reducing the responsibility placed solely on family members. However, access to community and home-based services varies considerably. Governments must decide which services should be publicly funded, who qualifies to receive them, and how community organizations should coordinate with healthcare providers and families. Countries must also determine how to support informal caregivers, including through financial assistance, training, respite care, or employment protections.

Person-Centered/Integrated Care

Greater attention has recently been paid to whether care reflects an individual's needs and preferences. This is especially important as elder-care systems expand. Person-centered care means considering an individual's needs and preferences and including them in decisions about their care. This involves older adults in decisions about their health, housing, daily activities, and long-term support. This approach recognizes older adults as active participants in their care, preserving their dignity and autonomy rather than treating them only as patients or dependents. The World Health Organization has similarly emphasized that older adults should receive quality and affordable healthcare tailored to their individual needs.⁵¹

Many countries developed mixed systems in which governments, private providers, communities, and families share responsibility

Integrated care coordinates services that might otherwise operate separately. The aim is that older adults and families do not have to navigate primary healthcare, specialist care, mental health services, housing programs, transportation services, social services, and long-term care independently. Since older adults may need assistance from multiple systems at once, coordinating healthcare, social care, and long-term care can create a more continuous and higher-quality care experience.⁵²

Person-centered, integrated care can involve the micro, mezzo, and macro levels simultaneously. Individuals and families participate in care decisions at the micro level. Healthcare providers and community organizations coordinate services at the mezzo level. Governments establish funding systems, quality standards, and national policies at the macro level. The UN Decade of Healthy Ageing identifies the delivery of person-centered, integrated care and primary health services responsive to older people as one of its four main areas of action.⁵³ Care should not merely be available. It should also be coordinated, affordable, accessible, culturally appropriate, and respectful of older adults' dignity and autonomy.

Aging in Place and Technological Support

Similar to home health, a current trend in long-term care is “aging in place,” or receiving personalized, safe care at home. This allows older adults to maintain independence and a sense of dignity in their own home. Aging in place may involve home healthcare, assistance from relatives, housing modifications, community services, transportation, and technology that allows providers or caregivers to monitor and support older adults remotely.⁵⁴

In many countries where families have traditionally provided care, adult children are leaving their rural homes to find better education and jobs in the cities so they can provide financially for their aging parents. However, this means there is less support at home for the older adults, as adult children traditionally lived with

and took care of them. This has been occurring in countries such as Thailand, Kenya, and China.⁵⁵

Globally, women have traditionally been caregivers for family members. However, these dynamics are changing with more women entering the workforce, and more men becoming caregivers.⁵⁶ A major current issue is also declining fertility, which contributes to population aging and, in some countries, population decline.⁵⁷ This may reduce the number of family members and professional workers available to care for older adults. Moreover, current and projected shortages of caregivers, home health aides, nurses, and doctors may limit the care and support available to growing older populations.⁵⁸

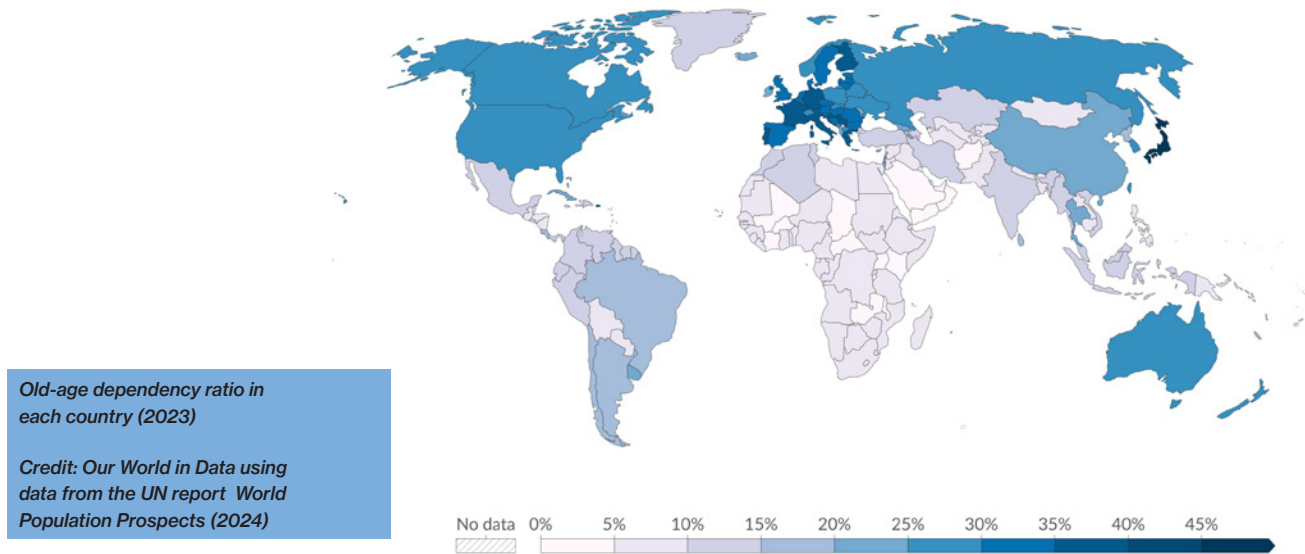
Technology can support aging in place through telehealth, remote patient monitoring, wearable devices, and medication reminders.⁵⁹ These tools may help older adults stay independent and allow providers or caregivers to identify health risks remotely. However, their value depends on affordability, reliable internet access, accessible design, digital literacy, privacy protections, and continued access to human and in-person care.⁶⁰ Technology should support human care rather than automatically replace contact with caregivers and healthcare professionals.

DEMOGRAPHIC, WORKFORCE, AND FINANCIAL PRESSURES

The global decline in fertility rates has been influenced by several factors, including increased educational and employment opportunities for women, greater access to family planning and contraceptives, low wages, inflexible work schedules, and insufficient parental leave.⁶¹ Lower fertility rates and population aging can reduce the relative size of the working-age population. This may reduce the number of family members who can care for older adults and may cause a decline in the number of people entering the workforce.

Population aging and population decline are

Number of people aged 65+ per 100 people aged 15-64.



related but distinct. A population may continue growing while its proportion of older adults increases, and a population may decline without immediately developing an extremely old age structure. The old-age dependency ratio compares the number of older people with the working-age population. “Older people” in this comparison usually means those aged 65 and above. This does not directly measure how many people require care, but it helps show potential pressure on workers, public revenues, pensions, and care systems.⁶² In 2023, the global old-age dependency ratio was approximately 15.4, meaning there were about 15 older adults for every 100 working-age people, or one older adult for every 6.5 working-age people.⁶³ As the global population aged 65 and older continues to grow, countries may face increasing pressure to recruit enough professional and family caregivers as well as finance pensions and healthcare.

The UN projects that lower- and middle-income countries will hold two-thirds of the age 60+ population by 2050.⁶⁴ The rate of aging in lower- and middle-income countries has increased significantly. It took countries like England and France 100 years to double their aged 65+

populations, while it is estimated that countries like China and Brazil will only take 25 years to do the same.⁶⁵ This is concerning, because these countries are not ready for this change. They do not yet have adequate systems in place or resources. Cultural practices, areas of high conflict, and political issues can also have a negative impact on developing adequate healthcare systems in these countries. Many lower- and middle-income countries are aging before they have developed the fiscal and institutional capacity available to wealthier countries.⁶⁶

The continent of Africa has a young population, as it has a high rate of youth under age 15 and working ages of 15-64. While many African countries must continue investing in children’s education and health, they can also prepare for population aging by training young people to enter healthcare and caregiving professions. This will be especially important to combat the “brain drain,” or migration of professionals to higher-income countries.⁶⁷ These professionals leave their countries searching for better pay, job opportunities, technology, quality of life, living standards, or safety from high conflict areas.

This is troubling because the professionals who migrate often receive extensive education in their home countries, but that investment is effectively lost if they do not return to serve their communities. On the other hand, sometimes not enough education opportunities exist in lower- and middle-income countries, so people will migrate to higher-income countries to start their education and not return home.⁶⁸

At the same time, changes in immigration policy can affect countries that depend heavily on migrant healthcare providers and long-term care workers. Many immigrants work in healthcare, especially caring for older adults in places like hospitals, senior living facilities, and at home.⁶⁹ This is a large issue considering the projected growth of the global older adult population, as there may not be enough healthcare professionals to care for them. Lower- and middle-income countries will want to focus on providing more opportunities for their working population within their countries, as related to healthcare.

In all cases, addressing workforce shortages requires more than recruiting additional workers. Training, compensation, working conditions, staff-to-patient ratios, and employee retention can all affect the safety, consistency, and quality of care older adults receive. Countries that recruit healthcare workers internationally must also consider how language differences, professional licensing, cultural competency, and continuity of care may affect service quality. These trained workers will be integral in helping reduce the over 70 percent of deaths that occur in these countries due to non-communicable diseases like heart disease, stroke, diabetes, respiratory diseases, and cancer.⁷⁰ The public health systems in these countries more often focus on combating infectious diseases, so further development is needed for combating the high percentage of non-communicable diseases.⁷¹

The older adult populations in lower- and middle-income countries experience more inequalities with regard to healthcare accessibility, which

impacts longevity. People in these countries may not be able to access quality healthcare, which then leads to a lack of health education and an increase in unhealthy behaviors such as smoking, drinking alcohol, and inactive lifestyles causing obesity. They also may have little income and find it difficult to pay for necessary treatments.⁷² If needed, they also may not have access to affordable long-term or home care.⁷³ People in these countries also have lower life expectancies, only to experience faster aging and more years spent in poor health.⁷⁴

Women face more inequalities in aging than men do: they may live longer than men, but they tend to live longer with disabilities, experience more non-communicable diseases, and do not have as much income or resources to take care of their medical issues. Having less income may be a result of their caregiving duties, which hurts their ability to have outside employment. This can affect their health negatively.⁷⁵ A big issue globally is how to be financially secure in retirement. There is an imbalance between the growing number of older adults versus the shrinking number of working adults. In some countries, population aging is placing growing financial pressure on public pension and insurance systems, raising questions about contribution rates, benefit levels, retirement ages, and long-term sustainability. In addition, lower- and middle-income countries only provide publicly funded pensions to a small percent of their populations, oftentimes for workers in specific industries like the public sector or military. These countries also have limited resources and may be focused on how to fund other priorities like education, infrastructure, and security. Thus, inequities for retirement planning exist for people with low wages, older workers, and widows in these countries.⁷⁶

SOCIAL IMPACTS OF AGING

Even as people's lifespans are increasing, people are not necessarily living healthier – especially at the end of their lives.⁷⁷ In fact, the number of

years lived in poor health increased within WHO Member States from an average of 8.5 years in 2000 to an average of 9.6 years in 2019.⁷⁸ The goal is not only to live longer but also to spend more years in good health. This is a concept known as “healthspan.” The gap between lifespan and healthspan has been growing. Notably, women spend an average of 2.4 more years in poor health than men.⁷⁹

There are a number of factors that influence this gap, including mental and substance use disorders, non-communicable diseases, musculoskeletal conditions, chronic conditions, injuries, infectious diseases, nutritional conditions, and maternal/child health.⁸⁰ While genetics play a small part in how long someone lives, the factors people can influence in their lives play a much bigger part. Examples include eating healthy food, getting regular exercise, avoiding smoking, limiting alcohol intake, getting quality sleep, managing stress levels, maintaining social connections, and getting routine medical care.⁸¹

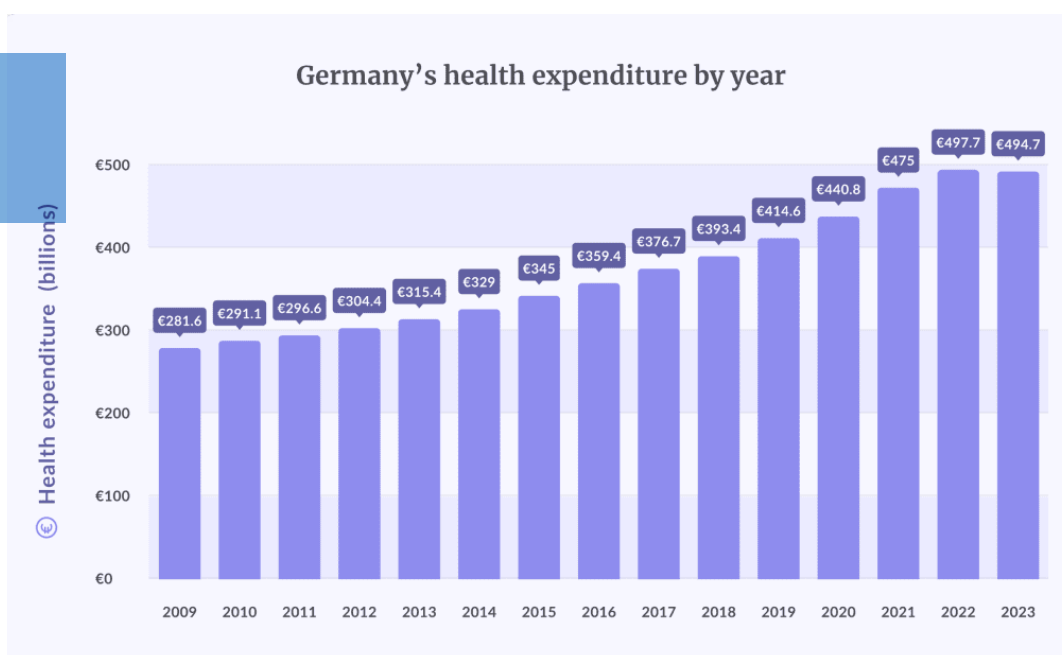
There are inequalities in the ability to influence these factors because of socioeconomic, demographic, and environmental barriers. This has to do with factors like how and where

people are born, live, grow, work, and age. Their access to money, resources, and influence determines how healthy they are and their quality of life. These social determinants of health are impacted by the systems in place within a community or larger government and by broader policies, decisions, social norms, and structures within society itself. Inequalities exist within countries and between countries, where people with lower socioeconomic status have poorer health outcomes (like higher instances of illness and death) as they may not have stable housing, quality education, or access to enough job opportunities. Access alone also does not guarantee quality care. Services may be physically available but remain unaffordable, culturally inappropriate, inaccessible to people with disabilities, or poorly coordinated with other forms of support.⁸²

Further, these social determinants of health can be placed in five categories: economic stability, access to education, access to healthcare, neighborhood environment, and community support.⁸³ The following are examples of some inequalities older adults face within each category. As older adults age, they may experience more non-communicable diseases or

In Germany and many other countries, healthcare expenditures have been growing rapidly in the last decade

Credit: Feather



normal aging health issues, such as hearing loss, cataracts, arthritis, bone loss, and memory loss.⁸⁴ Managing these health issues can be expensive, and with a fixed or low income, many older adults find it hard to pay for their treatments or health insurance. They also may not be able to pay for affordable housing or nutritious food if they are within a food desert.⁸⁵ A food desert is where people have limited or no access to nutritious food because there are no nearby grocery stores.⁸⁶

Older adults may struggle with health literacy, or being able to research, understand, and use health information to make informed decisions. They also may struggle with filling out medical forms, advocating for themselves, or using online resources. For people living in rural areas, being able to access healthcare may be difficult because they often travel long distances to see their healthcare providers or cannot find reliable transportation to their appointments.⁸⁷ As older adults age, they also may experience mobility issues like muscle weakness, imbalance, weak bones, joint stiffness, or partial paralysis.⁸⁸ This is why making adjustments to the environment inside the home and outside in the community is important to tackle these mobility issues.

However, not everyone has enough money to make age-related modifications to their homes, which is why many older adults with lower incomes are not as likely to be able to age in place.⁸⁹ Older adults may also live in apartments that do not have modifications like outdoor railings, ramps, chair lifts, door handles, and faucets.⁹⁰ Community improvements for mobility, like wheelchair-accessible sidewalks, trails, green spaces, and public transportation, may not be as popular to fund as other community initiatives. Finally, social isolation and loneliness can also hurt older adults' health, and people who live in rural areas tend not to have as many social supports.⁹¹ It is important for countries to address the social determinants of health in order to promote health equity, so everyone can achieve their highest level of health in a fair way.⁹²

Older adults also experience other demographic and environmental barriers to healthy living. Financial instability can also lead to higher rates of illness and early death for racial and ethnic minority groups compared with majority populations.⁹³ A study in the United Kingdom on people ages 60 and older found that the financially insecure were more likely to be unmarried, racial minorities, and women.⁹⁴ Accordingly, women are disproportionately affected by health disparities than men. As noted previously, women may live longer than men, but, on average, live longer years in poor health. In Organisation for Economic Co-operation and Development (OECD) member states, both men and women have high rates of cardiovascular disease, but their experiences differ greatly. For example, women are not often believed about their symptoms, leading to more misdiagnoses and delay of accurate treatment.⁹⁵

Older adults may also receive lower-quality care when providers dismiss their concerns as a normal part of aging. Women experience higher rates of depression and anxiety due to several factors including social roles where women are displayed as weak, unpaid work, caregiver burden, lower incomes, and not being able to afford mental health care. Older adult women are more likely to experience neurological disorders like dementia and Alzheimer's Disease, as well as musculoskeletal conditions like osteoporosis and arthritis. Neurological disorders are the largest contributors to older adults becoming disabled and dependent.⁹⁶

Historically, more men have been involved in healthcare research, and as a direct result, some treatments are not as effective for women. Similarly, there has been a lack of funding for female-specific medical conditions, such as menopause, menstrual disorders, reproductive and urinary disorders, and pregnancy-related issues.⁹⁷ Finally, where people live and the environmental conditions they experience can affect their overall health. Limited access to green spaces, unsafe neighborhoods, and high levels of air pollution may discourage

outdoor activity and contribute to poorer health outcomes.⁹⁸

On a larger scale, older adults are severely affected by climate change. As the global average temperature rises, there has been a steady increase in severe weather events, including hurricanes, typhoons, wildfires, heat waves, droughts, flash floods, and ice storms. Older adults are especially susceptible to extreme heat as their bodies cannot effectively regulate their core temperatures. This means they can experience heatstroke, dehydration, heart issues, hospital admissions, and death.⁹⁹ Chronic diseases and medications can increase sensitivity to heat for older adults too. Older adults may not have access to air conditioning. This is the case in Europe, where heatwaves can be deadly for older adults, especially if they live in “heat islands” within cities.¹⁰⁰

Electricity loss also has a large impact on older adults. They may not be able to use their electric-powered wheelchairs, beds, or medical equipment. Elevators being out could also affect evacuation or access to food, and people who depend on oxygen tanks could face a life-threatening situation.¹⁰¹ Poor air quality like air pollution and high pollen levels can increase the risk of heart attacks, COPD, and asthma. Older adults also have weaker immune systems. Thus, changing environmental conditions may increase exposure to vector-borne diseases such as West Nile disease and Lyme disease.¹⁰² Decreased mobility, such as not being able to walk or a lack of transportation in rural areas, impacts the ability to evacuate. Likewise, lack of social support, living alone, or cognitive impairment can

contribute to older adults not being able to care for themselves effectively in the aftermath of a severe weather event.¹⁰³

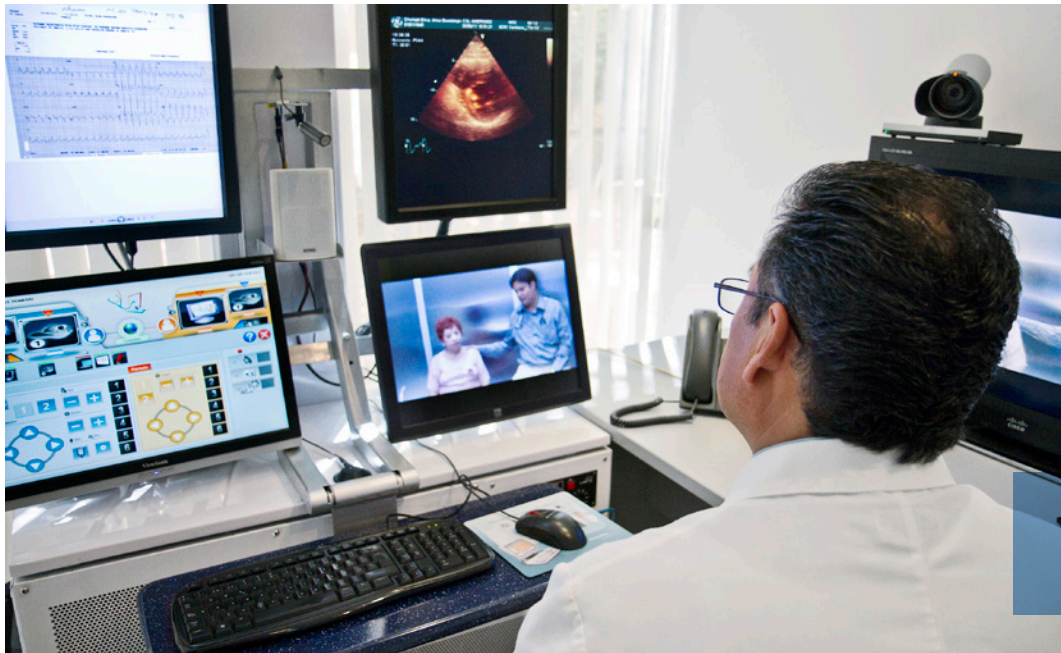
Current Status

TECHNOLOGICAL ADVANCEMENTS

There have been many advancements in telemedicine, artificial intelligence (AI), health monitoring, and robotics. Telemedicine is where patients get remote healthcare from their providers. During the COVID-19 pandemic, telemedicine became more popular, as it provided a safe way for people to interact with their providers. Today, telemedicine continues to be an effective mode for appointments and care in-between appointments, as well as saving time and money.¹⁰⁴

Remote patient monitoring can also help with managing chronic conditions and identifying complications that need immediate medical attention. Moreover, telehealth can also encompass mental health services, public health communication, provider continuing education, online patient portal access, and patient education online and on phone apps. Telehealth is also important to address provider shortages and underserved populations like the elderly in prison.¹⁰⁵ Additionally, telehealth also helps care for people with dementia. A recent study of older adults with dementia living in Europe found using telehealth services decreased depression, anxiety, and feelings of loneliness. It also found that telehealth increased inclusion within the

Older adults are especially susceptible to extreme heat as their bodies cannot effectively regulate their core temperatures.



A doctor in Mexico remotely conducts a pre-op consultation with a patient

Credit: Intel Free Press

community, and reduced caregiver stress.¹⁰⁶

Another emerging trend is using AI and robotics to care for older adults. AI can be found in many goods and services, though more research is needed in the coming years to analyze AI's impact on quality care outcomes. Today, AI is helping combat the rising rates of chronic illness, loneliness, and caregiver shortages for older adults. Specifically for older adults, it can detect risk factors like falls, assist with the accuracy of diagnoses, predict disease progression, and create individualized treatment plans. For example, AI is involved in research for Alzheimer's disease, drug discovery, genetic studies, and cancer care. AI is also used to identify people who are at high risk for disease development, such as stroke or coronary artery disease. Moreover, AI is used to manage chronic disease through chatbots and voice assistants to help with medication management, scheduling doctor appointments, and providing health education.¹⁰⁷ Other new AI technologies being developed include one that can use audio to analyze the home environment from the background to detect illness, distress or cognitive decline. Other developing AI technologies include ones that give

reminders, engage socially, recommend wellness activities, and assists with dementia care through conversation, familiar routines, and adapting to the user's needs.¹⁰⁸

Similarly, mobile health (mHealth) that uses mobile devices like smartphones, tablets, and wireless sensors, has helped provide quality care for older adults. Most mHealth is found in apps that can monitor vital signs, forecast health issues, remind about medications, alert families to emergencies like falls or GPS tracking, communicate with providers, coordinate care, and promote social connectedness through video calls and virtual communities.¹⁰⁹ Furthermore, there are many new assistive technologies that have been invented to help care for older adults. Wearable devices and sensors can monitor vital signs, movement, sleep, blood glucose, fall risk, and other health patterns. Assistive and socially assistive robots such as Pepper, Paro, and Zora have been used in some long-term-care facilities in Japan, Norway, and Finland to support rehabilitation, provide social interaction, and reduce agitation among people experiencing dementia.¹¹⁰ These technologies may expand access and support an individual's independence.

However, their availability does not necessarily mean that they improve care. Governments and healthcare providers must evaluate whether technologies are accurate, safe, accessible, and effective. Also, technology should improve outcomes without unnecessarily replacing human interaction.

However, barriers and inequalities exist in technology access and digital literacy for older adults. Telemedicine research tends to happen more in higher-income countries, whereas lower- and middle-income countries face widespread barriers like infrastructure limitations and digital literacy gaps.¹¹¹ One study in India found that older adults living in urban areas were more educated in using AI and telemedicine than older adults who lived in rural areas and were less educated. But older adults also dealt with barriers such as cost, low trust, and privacy concerns, which affected their usage.¹¹² Older adults may experience anxiety when expected to use unfamiliar technology without enough instruction or support. For some older adults, vision and cognitive declines can affect their device or telehealth usage, as a study found people with visual impairment were less likely to know how to use a cellphone or computer, and people with cognitive impairment often need assistance with their telehealth appointments.¹¹³

Globally, about 68 percent of people used the internet in 2024, while internet access was lower in lower- and middle-income countries and rural areas.¹¹⁴ Quality assistive technology should therefore be accessibly designed, protect personal health data, and still allow for continued access to in-person services for older adults who cannot or do not wish to use digital systems.

CURRENT FINANCIAL POLICY DEBATE

With the projected increase of older adults in the next few decades, there is a big debate about how to pay for their long-term care. Healthcare is usually funded through private or public methods. Private healthcare can include concierge (membership) medicine, long-

term care insurance, and insurance through employment or direct purchase. Public healthcare is where the government is responsible for paying for healthcare and insurance, mostly through taxes. Many countries offer both public and private healthcare, where public healthcare may be used for general medical services, and private healthcare can fill in the gaps public healthcare does not provide.¹¹⁵ Countries use different combinations of taxes, mandatory insurance, private insurance, personal payments, and government subsidies to finance long-term care. The following examples demonstrate how governments divide costs among the state, employers, workers, older adults, and their families.

In the United States, public health insurances like Medicare and Medicaid can help pay for long-term care, though Medicare only covers medical and nursing care for short-term treatment. Medicaid may cover nursing-facility care and certain home- and community-based services for eligible people with limited income, though coverage and eligibility requirements vary by state. While there is private long-term care insurance in the United States, it may be accessible only for people with higher incomes, and it does not cover every aspect of long-term care. Various federal government policies for long-term care insurance have been introduced but have not proven successful over time.¹¹⁶ In 2023, Washington state introduced the first state-operated long-term care insurance program in the United States, funded through payroll contributions. Employees started contributing in 2023, and on July 1, 2026, people started claiming these benefits after meeting a contribution requirement and care needs requirement. Participants will qualify for a lifetime benefit of USD 36,500, to rise with inflation, and participants can still contribute and qualify if they move out of state.¹¹⁷

In Japan, residents aged 40 and older are enrolled in and contribute to the public long-term-care insurance system. People aged 65 and older may receive benefits when they are assessed as

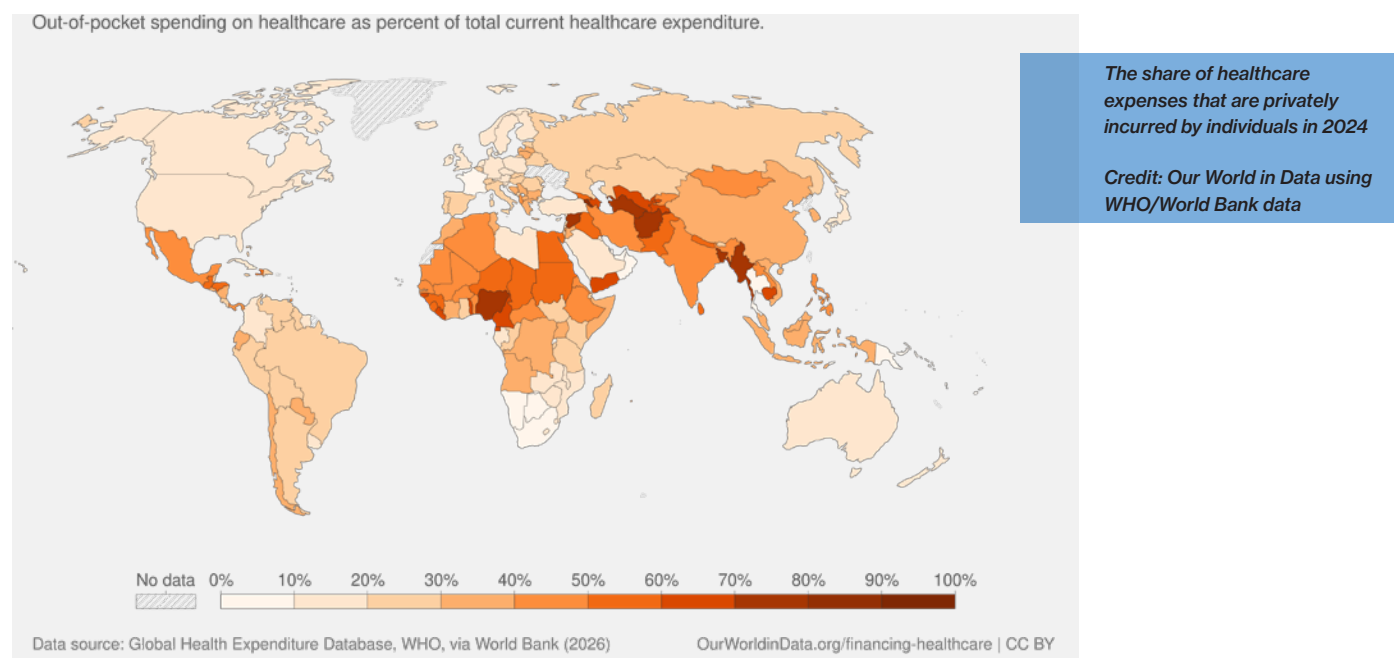
needing care, while people aged 40–64 qualify only when their care needs result from specified age-related diseases. Eligible users generally pay between 10 and 30 percent of service costs, depending partly on income.¹¹⁸ In the Netherlands, people have universal healthcare coverage, which has included long-term care for decades. There are two public insurances: one pays for skilled nursing care and institutions, and the other pays for in-home nursing care. The country does not have any private long-term care insurance.¹¹⁹ In England, medical care through the NHS is usually free, but help with daily activities, such as bathing, dressing, or living in a care home, may cost money. The amount someone pays depends on their income and savings.¹²⁰

Singapore's CareShield Life program automatically covers Singapore citizens and permanent residents born in 1980 or later once they turn 30. Participation is generally optional for citizens and permanent residents born in 1979 or earlier, although particular enrollment rules apply to some groups. Finally, Canada's long-term care system is separate from their healthcare system, and they pay for long-term care through tax revenue. However, there may not be enough money budgeted for all services, so care may be

only given to those most in need. There is great variability of services, subsidy amounts, and out-of-pocket pay between the provinces and territories.¹²¹

The way long-term care is financed can affect its availability and quality. Systems that lack adequate funding may experience staff shortages, long waiting lists, limited specialized services, and inconsistent oversight. According to the Urban Institute's 2025 Well-Being and Basic Needs Survey, 11.3 percent of US adults aged 60 and older reported unmet needs for personal assistance. Among older adults with disabilities, this figure rose to 24 percent.¹²² Similarly, the United Kingdom's State of Health and Care of Older People 2025 reported that the number of district nurses providing care in patients' homes had fallen by 19 percent since 2014.¹²³ These examples show that public coverage does not guarantee access when services lack sufficient funding or workers.

For OECD countries, long-term care spending is projected to double the rate of GDP from 1.5 percent to 2.8 percent, along with a rise in public pension spending, from 8.8 percent to 10 percent of GDP, and public health spending, from 5.5 percent to 8.8 percent of GDP, by



2050. Therefore, government policy strategies are needed to sustain long-term care services. One paper describes three possible policy scenarios to help offset these projected spending increases: cost pressure, healthy ageing and enhanced productivity. Cost pressure is where publicly funded measures are meant to increase the income and support for personal care attendants and family caregivers, thereby recruiting more workers to provide support to older adults.¹²⁴ The OECD estimates that the number of long-term-care workers would need to increase by 60 percent, approximately 13.5 million additional workers across OECD countries, by 2040 merely to maintain the current ratio of care workers to older people.¹²⁵

Another OECD report gives a few more possible policy options. First, countries may want to look for additional funding sources like taxes, private sector funds, consolidating current long-term care funds into one main budget, or spreading out the funds generationally from less youth and more older persons. Second, countries could better allocate their existing long-term care funds to older adults who need it the most: those with higher needs and lower incomes. Third, countries may want to make their current long-term care systems more efficient, like focusing on prevention services or incorporating sustainable pricing of long-term care services.¹²⁶ Preventive approaches may include home visits, fall-risk screening, housing adaptations, expanded home healthcare, rehabilitation at home, vaccination and health-screening programs, accessible transportation, and better coordination among health, social, and long-term-care services. These measures may help older adults remain independent and reduce avoidable hospitalization or institutional care.¹²⁷

A central question is how long-term care costs should be divided among national governments, local governments, public or private insurance systems, employers, individuals, and families. Systems that rely heavily on private payments may limit access for lower-income older adults, while publicly funded systems require sustainable

revenue and sufficient numbers of trained workers to provide long-term care.

GLOBAL INITIATIVES

UN Member States adopted the 2030 Agenda for Sustainable Development in 2015, which went into effect on January 1, 2016, and established targets to be pursued through 2030.¹²⁸ There are 17 Sustainable Development Goals (SDGs) for countries to work towards achieving as a global effort.¹²⁹ Closely aligned with the SDGs, the UN's Decade of Healthy Ageing (2021-2030) was introduced by the UN General Assembly at the end of 2020. This is another global effort, specifically to improve the lives of older adults and the communities they live in.¹³⁰

The Decade of Healthy Ageing builds on the World Health Organization's 2016-2020 "Global strategy and action plan on ageing and health," and the United Nations 2002 'Madrid International Plan of Action on Ageing.'¹³¹ The "Madrid International Plan of Action on Ageing" was designed around the challenge of how to build a society for all ages. It focuses on three priority areas for action: older persons and development, advancing health and well-being into old age, and ensuring enabling and supportive environments.¹³² Recommended actions include social participation, poverty reduction, health access, caregiver support, age-friendly housing, disability inclusion, and protection from neglect and abuse.¹³³ Every five years it is reviewed globally on the progress made and challenges still faced. The latest review was in 2022, which found the rate of implementation varied between regions and that age-based discrimination is still an issue.¹³⁴ The next review is in the data-collection phase.

At the 2016 World Health Assembly, the "Global strategy and action plan on ageing and health" was adopted. The vision of this strategy was that every person could live a long and healthy life. The associated goals were to use evidence-based approaches over the five years to

implement the Decade of Healthy Ageing (2021-2030). There were five strategic objectives: commitment to action on Healthy Ageing in every country; developing age-friendly environments; aligning health systems to the needs of older populations; developing sustainable and equitable systems for providing long-term care; and improving measurement, monitoring and research on Healthy Ageing.¹³⁵ The first objective focused on establishing national frameworks and policy between government and non-government groups. The second objective focused on how older adults could age in a safe environment while retaining their autonomy and remaining free from poverty. The third objective focused on older adults receiving quality and affordable healthcare, tailored to their individual needs. The fourth objective focused on creating a sustainable and equitable long-term care system that maintained a capable workforce and supported caregivers. And the fifth objective focused on providing robust research on the health issues faced by older adults, and evidence-based interventions as solutions.¹³⁶

The World Health Organization was tasked with leading the implementation of the UN Decade of Healthy Ageing (2021-2030). The Plan of Action outlines four areas of action to be addressed: change how we think, feel and act towards age and ageing; ensure that communities foster the abilities of older people; deliver person-centered integrated care and primary health services responsive to older people; and provide access to long-term care for older people who need it.¹³⁷

The first area focuses on combating ageism, or the negative stereotypes and discrimination

against older adults. The second area focuses on how communities can promote the abilities of older adults, specifically improving the physical, social and economic environments in both rural and urban areas. The third area focuses on strengthening equitable access to primary and dental healthcare as well as taking a holistic approach when incorporating all kinds of healthcare. The fourth area focuses on creating quality long-term care by implementing formal care methods like adult day care, in-home care, or skilled nursing facilities, and increasing support for informal care and caregivers.¹³⁸ To evaluate the implementation of the four areas of action, three triannual progress reports will be published. The first progress report was published in 2023 and evaluated the years 2021-2023. The next two reports will be published in 2026 and 2029.

Out of the 194 Member States, 136 submitted data for the 2023 report. Key data found there was an increase from 60 percent to 83 percent of countries that have national legislation on age-based discrimination. There was also an increase from 52 percent to 77 percent of countries that have a national program to modernize cities and communities to be age-friendly and an increase from 48 percent to 71 percent of countries that have a national policy for assessing the health and social needs of older adults. Finally, there was an increase from 67 percent to 78 percent of countries that have a long-term care policy.¹³⁹ A major challenge was a lack of adequate resources to achieve goals in the four areas, where, on average, just under one-third of countries had enough resources. While it is

The World Health Organization was tasked with leading the implementation of the UN Decade of Healthy Ageing (2021-2030).

Ministers in India mark the International Day of Older Persons

Credit: Indian Ministry of Social Justice and Empowerment



encouraging that more older adults are being included in the conversation, there is room for growth to ensure that marginalized populations provide their input too, as well as creating a systematic approach for older adults to engage.

One such way could be celebrating the UN's International Day of Older Persons annually on October 1. This observance day raises awareness about aging populations to highlight the rights and well-being of older adults. Each year celebrates a theme, and the theme of the 2026 United Nations International Day of Older Persons is "The Age of Longevity: Rethinking Systems for Longer Lives."¹⁴⁰ As the decade progresses, there are still many goals to work toward. Some examples include how to bring all the aspects of building age-friendly cities and communities together, addressing older adults' comprehensive health to include often-neglected topics, prioritizing solutions on how to publicly fund long-term care and increase support for caregivers, incorporating end-of-life care in the long-term care discussion, and targeting efforts on increasing actions in lower- and middle-income countries.¹⁴¹

After the 2023 progress report was published, it was determined that countries needed a more standardized monitoring and evaluation system for assessing their progress. Thus, a framework was published in 2024: "Measuring the progress and impact of the UN Decade of Healthy Ageing (2021–2030)."¹⁴² Finally, WHO launched a stakeholder survey on 18 March 2026, with responses accepted through May 15, 2026, to inform the 2026 UN General Assembly progress report and priorities for the second half of the Decade. The survey was open to governments, civil society, academia, the private sector, and anyone else working on healthy aging goals. As of August 2026, the stakeholder survey had closed, and its findings were expected to inform the 2026 progress report and actions during the remaining years of the Decade.¹⁴³ Member States of the CPD can use demographic data and share policy approaches while debating how international cooperation should support countries with different population structures, economic resources, healthcare systems, and cultural expectations surrounding long-term care.

Bloc Analysis

POINTS OF DIVISION

Countries approach healthy aging and provide quality care for their aging populations differently based on their economic resources, public policy frameworks, and cultural norms. These core factors influence how countries fund, organize, and deliver support for older adults. Economic resources shape how countries pay for formalized long-term care, healthcare systems, insurance and pensions. Thus, the first point of division is financing. Some countries support universal public long-term care, while others rely more heavily on private insurance, out-of-pocket payments, or unpaid family caregiving. At the same time, as the number of retirees grows and birth rates decline, countries are facing more pressure on how to balance funding healthcare and long-term care while also addressing other budgetary needs. Public policy frameworks shape the laws that set up long-term care insurance, retirement age, and pension security.

While some frameworks prioritize broad safety nets for older adults, others rely on privatized care. The second division concerns where care should be delivered. In the absence of formalized care, countries may rely more on familial and community support. This is closely associated with cultural norms, where collectivistic cultures value filial piety and joint family systems, which promote family and community care of older adults. Countries with established formal care systems may focus on financing, maintaining, and expanding those systems as their populations age. Countries that rely more on families and communities may prioritize caregiver support, workforce training, and community-based care. Countries with younger populations and limited healthcare infrastructure may focus on building basic capacity and addressing other urgent development needs. Governments must also decide whether to increase domestic training, recruit foreign care workers, expand support for unpaid caregivers, use assistive technology,

or combine these approaches. Recruiting foreign workers also raises questions about licensing, language requirements, migrant worker protections, and the loss of healthcare workers from origin countries.

These groups are not absolute, and countries may support policies associated with more than one bloc. While state sovereignty should be respected, it will be necessary for future success to have international cooperation on caring for aging populations.

COUNTRIES PRIORITIZING LONG-TERM ELDER CARE AND ASSOCIATED COSTS

Countries in this bloc may include Japan, Italy, and Finland. Japan has one of the world's oldest populations, as its median age is 49.8 years.¹⁴⁴ While Monaco has the world's oldest population with 36 percent of people aged 65 and older, Japan has the world's second oldest population at just about 30 percent of people aged 65 and older.

Europe is the world's oldest continent, with most countries, especially in the south and east, having high percentages of people aged 65 and older. This is seen in countries like Italy, Portugal, Greece and Germany, where one in five people are aged 65 and older. This reflects population aging, as low fertility and longer life expectancy increase the proportion of older adults relative to younger and working-age populations.¹⁴⁵ Countries in this bloc are likely to prioritize maintaining and expanding services for their large older populations by providing long-term care and developing sustainable methods of financing it.

These countries often already have formal long-term care systems in place, though their coverage and reliance on family care may vary. Japan is at the forefront of both long-term care services and financing long-term care. As previously mentioned, Japan has mandatory long-term care insurance for people aged 40 and older, plus taxation and user coinsurance.

The national government is responsible for operational policies, whereas municipal governments are responsible for planning and distributing long-term care insurance. Once an older adult is determined to have care or support needs, a needs assessment is administered to determine the appropriate type of care, including residential, in-home, or community-based services.¹⁴⁶

Likewise, Finland's national government oversees long-term care legislation, and 21 wellbeing services counties and the city of Helsinki are responsible for organizing and implementing long-term care services. Finland funds long-term care mainly through taxation, supplemented by user fees. All citizens are entitled to the public long-term care system, where a needs assessment is administered to determine what publicly organized community or residential-based care is applicable.¹⁴⁷ Countries in this bloc will likely support policies to address the formal care worker shortages, exacerbated by the overall decline in working-age populations. Differences may arise over the recruitment of foreign care workers and how countries balance workforce shortages with language and licensing requirements, migrant-worker protections, and investment in domestic training.¹⁴⁸

COUNTRIES PRIORITIZING CAREGIVER SUPPORT

Countries in this bloc may include Lebanon, Vietnam, Panama, and Bolivia. Population aging is increasing at higher rates in Latin America and the Caribbean, where it is expected that the number of adults aged 65 and older will double by 2050, thus outpacing the number of children ages 15 and younger.¹⁴⁹ In many countries within this bloc, cultural expectations place more responsibility for long-term care on families. In many of these countries, cultural expectations and limited formal services place substantial responsibility for older-adult care on families and communities. However, caregiving traditions and government support vary both among and within

countries.

Culturally, there is a reliance on family members, specifically children, to care for aging parents or other aging family members. Women disproportionately work as family caregivers and are usually unpaid. Formal long-term care systems may also have limited coverage or remain underfunded, including residential facilities, in-home services, caregiver-support programs, and public pension systems.¹⁵⁰ Moreover, countries in this bloc may have shortages of trained health professionals and long-term care workers, as well as limited geriatric specialists.¹⁵¹ Countries in this bloc will likely focus on helping older adults age safely within their homes or communities by strengthening professional services and support for family caregivers. This bloc will also likely support policies that strengthen assistance for unpaid and paid caregivers, increase training for healthcare professionals, and broaden community care. A detailed report on how to support caregivers in Latin America and the Caribbean presents a few solutions, including providing more information, training, emotional support, financial compensation, and a healthier work-life balance.¹⁵² Research has found gaps in the level of care older adults receive in the Eastern Mediterranean Region, where more training and professional development are needed, especially in long-term care and chronic disease management.¹⁵³ Some promising community-based long-term care systems have been introduced as community care hubs in Indonesia, active aging hubs in Mongolia, and a case management system in Vietnam.¹⁵⁴

COUNTRIES PRIORITIZING CAPACITY-BUILDING

Countries in this bloc may include Niger, the Democratic Republic of the Congo, and Yemen. These countries have young and rapidly growing populations due to high fertility rates, young populations with median ages in the mid- to late-teens, and lower life expectancy rates.¹⁵⁵

However, the number of older adults is also increasing across Africa because of population growth and longer life expectancy. In countries where fertility is declining, the proportion of older adults will also gradually increase. This will translate into a major increase of adults aged 60 and older in African countries, from 74 million in 2020 to a projected 235 million in 2050.¹⁵⁶

Countries in this bloc generally wish to focus on caring for their current large populations of children, including education, child and maternal health, employment, and building infrastructure. At the same time, countries also want to focus on preparing for sustainable future care of older adults. Many older adults in African countries experience poverty or live in rural areas, where there is limited access to healthcare. As a result, health conditions are largely undetected and untreated. Moreover, older adults in these areas contend with a high prevalence of infectious diseases and a growing prevalence of non-communicable diseases like dementia.

Public support programs and public pension programs are scarce and underfunded as well, and for this reason families have traditionally cared for older adults.¹⁵⁷ Other challenges include health systems that must prioritize infectious diseases and maternal and child health, shortages of geriatric specialists, limited national aging programs, and disruptions to international assistance.¹⁵⁸ While some countries in Africa have created national plans to address aging, implementation has been uneven.¹⁵⁹ Countries in this bloc will likely support policies to promote healthcare in rural areas, create pension programs, train healthcare workers in the needs of older adults, improve resources for dementia care and non-communicable diseases, expand education and training for the future long-term care workforce.

Committee Mission

The Commission on Population and Development

(CPD) is a functional commission of the United Nations Economic and Social Council. It was originally established as the Population Commission in 1946 and renamed in 1994. The CPD monitors, reviews, and assesses implementation of the Programme of Action adopted at the 1994 International Conference on Population and Development. The CPD is responsible for researching and advising on population issues, trends, and development policies, programs, and strategies. Once established as CPD, this body began meeting annually to evaluate implementation of the Programme of Action and advise ECOSOC.¹⁶⁰

Population growth and changing age structures, including population aging, are key issues addressed through the Programme of Action.¹⁶¹ CPD's work on healthy aging aligns with Sustainable Development Goal 3, "Good Health and Well-Being," and the UN Decade of Healthy Ageing (2021–2030). The latest review of the Programme of Action occurred in 2024, where reports of the Secretary-General noted increasing population aging and population decline.¹⁶²

To address population aging and decline, these reports recommended countries strengthen their employment policies to be more inclusive of older adults who still want to work, including fostering lifelong learning, offering flexible work schedules, and implementing age-friendly work environments. Other recommendations included strengthening long-term care systems, increasing social protection like pensions, and combating ageism, especially for older adults.¹⁶³ Reports of the Secretary-General prepared for the 2025 CPD session recommended investing in age-friendly infrastructure, expanding community-based services, increasing the number of qualified healthcare workers, and strengthening prevention throughout people's lifespan.¹⁶⁴ Additionally, reports of the Secretary-General prepared for the 2026 CPD session recommended reducing the cost of assistive technologies, expanding internet access, and improving digital literacy.¹⁶⁵

The CPD must develop solutions that ensure equitable and sustainable care for aging populations. Its policies should focus on how to strengthen international cooperation, balance competing priorities, and promote innovative yet accessible approaches. Combating ageism, championing healthy aging, and improving the lives of older adults will have far-reaching effects, helping younger generations build the kind of society in which they will eventually grow older.

TOPIC B

CPD | NHSMUN 2027

Improving Early Childhood Survival



Introduction

Early childhood survival refers to the health and survival of children from birth until their fifth birthday. It is very important to consider the time during and after a mother's pregnancy related to childhood outcomes. Prenatal (pre-birth) health is important because the conditions during pregnancy affect development and have a large impact in early childhood. The neonatal period refers to the first 28 days of a baby's life. Neonatal deaths account for approximately 47 percent of all deaths among children under five.¹⁶⁶ Finally, perinatal survival refers to the survival of a baby a few weeks before and after their birth. Though perinatal care is often where survival is the most fragile, children under five overall are among the most vulnerable populations in the world.

Early childhood survival remains a challenge in many areas around the world. Sub-Saharan Africa and Southern Asia are examples of areas where early childhood mortality is among the highest in the world. There were 75.8 under-five deaths per 1,000 live births in sub-Saharan Africa in 2025.¹⁶⁷ In comparison, the global average in 2024 was 37.4 deaths per 1,000 live births.¹⁶⁸ In the same year, about 85 percent of all global early childhood deaths were reported in sub-Saharan Africa and Southern Asia. Yet, only 60 percent of global births occurred in these areas.¹⁶⁹ This contrast emphasizes the severe need to improve early childhood survival around the world. Beyond these regional statistics, the global rate of early childhood mortality is alarming on its own. Even in countries with the most advanced medical care, neonatal and early childhood mortality still remain problematic.

While recognizing that improvement is still needed globally, gradual progress has been made over the past few decades. In 1990, one in eleven children died before reaching age five. In 2024, this number decreased to one in 27.¹⁷⁰ Slovenia, with the lowest infant mortality rate in 2024, had 1.5 deaths per 1,000 live births.¹⁷¹ These rates have improved due to various factors. Increased access to medicine, vaccines, food, water, and other similar resources are all among the most important factors in improving early childhood survival. However, areas that provide resources

like healthcare and child support will not be able to be as effective without basic access to food and water. Armed conflicts, natural disasters, and humanitarian emergencies can reverse progress by disrupting healthcare, vaccination, nutrition, clean water, sanitation, housing, and family support. Improving early childhood survival therefore requires an understanding of both the immediate and underlying causes of preventable deaths.

Improving early childhood survival is among the most important issues facing the United Nations (UN) today. Providing care to our youngest and most vulnerable populations is also providing care to our future generations. It is necessary, but it can be challenging because of how vulnerable young children are. Children under the age of five are entirely reliant on those who support them. Whether that support is governmental, community based, or in a family setting, they need a support system no matter what. This only further emphasizes the importance of improving early childhood survival, especially as a united, global effort.

History and Description of the Issue

HISTORY OF IMMUNIZATION

One of the highest risks to childhood survival is disease. To combat disease, vaccines are critical. Between 1974 and 2024, an estimated 154 million lives were saved by vaccines. About 95 percent of these lives were children under five.¹⁷² Immunization is the process where a person becomes protected from a disease by getting a vaccine. This process has seen significant development in past decades, showing the effort that has been put into increasing early childhood survival.

Polio is an example of a disease that has almost been eliminated.¹⁷³ In the early 1900s, polio was one of the most dangerous diseases a family could face. Parents would often not let their children out of their homes for fear of catching polio. The introduction of the polio vaccine changed medical history. It showed the potential and importance of vaccines in preventing millions of yearly child deaths. Yet, the process of immunization against polio also shows the differences in progress between countries. Today, vaccination has eliminated wild poliovirus from most countries, although transmission and outbreaks have not been completely stopped. But it took time to reach this point. The vaccine was not instantly globally accessible. It took until the late 2000s and 2010s to stop outbreaks in areas like Southeast Asia and Sub-Saharan Africa. Thus, immunization against polio shows the importance of vaccines but also the difficulty of making them accessible for all countries.

Modern-day travel further shows how important vaccines are. As people travel, they can spread infectious diseases. This was shown in the COVID-19 pandemic. In this instance, children under the age of five were not at high risk compared to other age groups. However, this does not mean the vaccine did not help children.

Vaccines limit the spread of diseases in general. Thus, vaccination helped reduce severe illness and, particularly during some stages of the pandemic, reduced the likelihood of infection and transmission.

Rotavirus is a major cause of severe diarrheal disease in children under the age of five. Its vaccine has reduced the number of children in hospitals for rotavirus by 40 percent. The vaccines have also lowered the global death rate from rotavirus-induced diarrhea by 25 percent.¹⁷⁴ The rotavirus is an example of a vaccine that should be given to infants.¹⁷⁵ The reduction in death rates as a result of the vaccine was also reflected in the decrease in emergency room visits due to rotavirus. Reducing preventable emergency room visits means more doctors are available to help other patients. The vaccine, therefore, had massively positive ripple effects, not only saving lives from rotavirus, but also saving lives from reducing the over-crowding of medical facilities.

Measles and diphtheria have posed some of the biggest threats to childhood survival in recent history. Though vaccination has greatly reduced illness and death from both diseases, they continue to demonstrate the danger of diseases to children under five. They also show how important vaccines are. The first measles vaccine was introduced in 1963 and eventually developed into the MMR (measles, mumps, and rubella) vaccine in 1971. Even though these vaccines were introduced decades ago, they are still saving the lives of children today. Worldwide, an estimated 57 million deaths have been prevented by the measles vaccine between 2000 and 2020.¹⁷⁶ Similar to measles, diphtheria has become far less common in countries with consistently high vaccination coverage. Countries with access to vaccines for it have had almost zero cases since 2004, but areas without vaccines have higher rates of diphtheria.¹⁷⁷

Recently, there has been a rise in fear toward vaccines. This has led some to decide against vaccinating their children. Although parents

An infant receiving a polio vaccine

Credit: Samicupid



may have questions about vaccine safety, widespread misinformation and declining trust have contributed to lower vaccination coverage and renewed measles outbreaks. In some states in the US, the percentage of parents that trusted vaccines dropped from 94 percent in 2001 down to only 69 percent in 2024.¹⁷⁸ Lower trust can result in fewer vaccinations. The decrease in vaccinations means fewer children are immune and more are contracting measles.

This shift is dangerous because it threatens herd immunity against these diseases. Herd immunity describes when enough of a population is immune to a disease that it no longer poses the threat of a major epidemic. To keep herd immunity against measles, 95 percent of the population needs to be vaccinated.¹⁷⁹ The last few years have seen some fluctuations in reaching this required percentage. In some areas, specifically in the United States, the percentage of children vaccinated has dropped below the threshold for herd immunity.¹⁸⁰ For example, in the state of Idaho, almost 15 percent of children have claimed exemption from getting required vaccines for elementary schools, including the MMR vaccine.¹⁸¹ This means the state is

particularly susceptible to a large outbreak of one of the world's most infectious viruses.

The topic of vaccination has become increasingly divided in recent years. This can be seen through the decreases in measles vaccination rates, as well as other diseases previously thought to be eradicated. There are many reasons for the fears behind vaccines. Some of these include religious, personal, philosophical, and safety reasons. "Vaccine hesitancy" refers to the reluctance of parents to vaccinate their children for any one of these reasons.¹⁸² Decreased trust in vaccines is a global phenomenon. For example, in the United Kingdom, trust in vaccines dropped from 90 percent in 2018 down to only 70 percent in 2023.¹⁸³

Facing a modern pandemic as severe as COVID-19 caused a lot of concern worldwide. Varying stories and rumors were spread during the pandemic, and distrust in healthcare systems was created. People are hesitant to receive COVID-19 and influenza vaccines specifically because of concerns over safety, a lack of trust, believing vaccination is unnecessary, and cultural reasons.¹⁸⁴ Despite this hesitancy, the COVID-19

vaccine was one of the fastest designed and produced vaccines ever. Its production allowed for lockdowns and travel bans to be lifted.¹⁸⁵

THE IMPACT OF MATERNAL HEALTH ON BABIES

Maternal mortality and stillbirth remain major global health challenges, particularly in countries with limited access to quality prenatal, childbirth, and postnatal care.¹⁸⁶ Definitions of stillbirth vary among countries and organizations. For international comparisons, the World Health Organization generally emphasizes babies born with no signs of life at or after 28 weeks of pregnancy.¹⁸⁷ The health of babies both before and after birth is very dependent on the health of their mother. A pregnant person's health is so important during pregnancy because any harm to them will also directly impact their child. For example, if they do not have access to food or water, then the baby will not receive as many essential nutrients.

A pregnant person's physical health can significantly affect fetal growth and development. The amount of nutrition the baby receives determines their ability to grow and reach the proper development stages before they are born. Additionally, in some cases, a person may not be physically able to carry their baby to their full term. Child pregnancies are an example of this. A child's body may not be developed enough to properly carry a baby.¹⁸⁸ Pregnancy during adolescence is associated with increased health risks for both the pregnant adolescent and the baby.

Access to proper medical care is also crucial during pregnancy for the survival of a baby. Proper medical care allows access to information on the baby that can prepare both parents and doctors for potential complications. If conditions of the baby and pregnant person can be identified early on, then the parents can pursue the necessary medical care to ensure the baby's safety and health.¹⁸⁹ For example, prenatal examinations can help identify multiple pregnancies, fetal positioning, growth problems, and other conditions that may require additional monitoring or medical intervention. It prepares doctors for potential procedures that will need to follow the birth, for either parent or child. Proper medical care also prevents minor issues from becoming severe. For example, infections during pregnancy or following childbirth may become life-threatening when antibiotics, sanitation, and trained medical assistance are unavailable. Infectious diseases are treatable, and yet thousands of mothers and babies are still dying as a result of them.¹⁹⁰ Access to medical care is also important for check-ups.¹⁹¹ Routine check-ups ensure a baby is growing properly and healthily. Without access to check-ups, issues can go unnoticed and negatively impact the baby.

The leading causes of death in newborns are preterm birth, birth complications, congenital issues such as underdeveloped body organs, and lower respiratory infections.¹⁹² Many of these affect both the mother and the baby. Every two minutes, a woman dies during childbirth or pregnancy.¹⁹³ For mothers, the main cause of maternal death is hemorrhaging.¹⁹⁴ The potential for hemorrhage is another reason medical care

Every two minutes, a woman dies during childbirth or pregnancy.

is so important. Maternal hemorrhage is when a person loses a large amount of blood during or after childbirth, specifically 1,000 mL or more of blood.¹⁹⁵ Complications during the birthing process are incredibly dangerous and often require medical intervention to prevent them from becoming fatal. Potential issues with the umbilical cord, the positioning of the baby, and the baby's access to oxygen are all possible complications that pregnant mothers could face during childbirth. These risks and causes of death, for both the baby and the parent, can be largely reduced with proper access to medical care.

A simple yet crucial aspect of medical care is sanitation. Without proper sanitation, both the mother and the baby are at higher risk of infectious diseases.¹⁹⁶ This is especially relevant when giving birth in conflict zones. Hospitals in conflict zones are often overburdened with several patients in critical condition while also lacking the materials and ability to keep their hospitals clean and smoothly running. The lack of sanitation and stability can cause infectious diseases to easily spread. Hence, pregnancy and childbirth become increasingly risky in these environments.

Pregnant people need accurate health

information, prenatal care, and access to a trained birth attendant. Complications may arise even during pregnancies that initially appear low-risk, making emergency referral systems and transportation important for births occurring outside hospitals. All pregnant people should be able to obtain appropriate care before, during, and after childbirth.

Before giving birth, both the mental and physical health of a pregnant person determines the health of a baby. Mental illness can change how a person treats themselves while pregnant. Issues like depression can arise during and after pregnancy. This can often lead to excessive stress, relationship problems, or even self harm and suicidal thoughts in pregnant people.¹⁹⁷ Similarly, factors like alcoholism can lead to a person drinking alcohol while pregnant. Consuming alcohol during pregnancy can increase the risk of a miscarriage, early birth, or stillbirth. It can also lead to fetal alcohol syndrome, which can cause a variety of disabilities for babies from birth as a result of this alcohol exposure.¹⁹⁸ The mental health of the mother thus has direct impacts on early childhood survival.

Following birth, the mental health of parents

A maternal health clinic in Nepal, which has seen maternal mortality decline by 45% since 1990.

Credit: USAIDNepal



continues to play a critical role in early childhood survival. Postpartum depression and postpartum psychosis are separate conditions that can occur after a person gives birth. Postpartum depression can involve persistent sadness, anxiety, exhaustion, or difficulty bonding with the baby. Postpartum psychosis is rarer but can involve confusion, hallucinations, delusions, and an urgent risk of harm.¹⁹⁹ This can cause the parent to become distant or unresponsive to their baby and other children after childbirth. Postpartum depression can include experiencing a range of symptoms, such as a lack of eating, inability to sleep, or constant crying and frustration. The impacts of postpartum depression can lead to infants weighing less or having higher infant mortality rates. This occurs primarily in lower-resource countries.²⁰⁰

When looking to improve early childhood survival, the health of the parent cannot be overlooked. Especially during pregnancy and birth, a baby's health is directly tied to the health of their parent. A parent's health, nutrition, environment, access to care, and genetic factors can all influence a child's health and development. It is the responsibility of governments and healthcare systems to ensure that parents and children have access to proper medical care, mental health support, family planning, and basic necessities before, during, and after childbirth.

THE RELEVANCE OF PUBLIC HEALTH SYSTEMS AND INFRASTRUCTURE

Access to healthcare allows the health of both the parents and baby to be monitored throughout pregnancy. During birth, proper healthcare systems are often required for medical assistance and various other procedures. Immediately after birth, babies often need additional care. This is also a time when access to healthcare is most important for both emergency and non-emergency situations. Some of the most crucial forms of help for newborns include thermal and nurturing care.²⁰¹ Thermal help can be as simple as a blanket provided by a

nurse. Nurturing support can be a nurse helping a mother hold their baby to their chest. Though both seem simple, new mothers are not always in a position to do this by themselves for their babies after going through labor. With access to healthcare, mothers can receive medical support to help them immediately after labor. For a majority of mothers, access to even basic healthcare makes childbirth safer and more comfortable.

Childbirth can have many complications. Some complications can be predicted during pregnancy, but some are not obvious until labor and birth. These emergencies can be threats to both the mother and the baby. Mothers can face threats like hemorrhaging, infection, or physical tearing.²⁰² Babies can also be injured during birth due to struggles moving through the birth canal, incorrect positioning when coming out, or having a low birth weight.²⁰³ Often at home, or anywhere outside a hospital, average parents will not have the tools nor the knowledge to solve these issues on their own. Thus, access to proper medical care during the childbirth process is extremely valuable.

Proper access to public health systems must include the ability to access accurate medical and childcare information. Parents are the primary caregivers during early childhood. Beyond access to healthcare facilities, their access to basic medical information could be lifesaving for their baby.²⁰⁴ Whether it be digital access, physical books, in-person classes, or online classes, early childhood survival relies on medical information being easily accessible. For example, something new mothers may not know is the benefit of delayed cord clamping. Waiting at least 60 seconds to clamp a baby's umbilical cord can help infant hematocrit and infant iron deficiency between zero and six months.²⁰⁵ Infant hematocrit is a measure of how many red blood cells in ratio to plasma make up a baby's blood.²⁰⁶ This is important for monitoring how much oxygen can be carried in a baby's blood.²⁰⁷ An example of a more simple piece of medical information parents need is what temperature

A municipal volunteer in New York distributing face masks during the COVID-19 pandemic

Credit: Metropolitan Transportation Authority of the State of New York



a baby should be at and how much sleep they should be getting. Knowing these two pieces of information can help parents identify issues like fevers, illnesses, or other internal problems. Threats to their child's health can be assessed more quickly and easily if parents have the tools to learn about it and identify it.

However, access to healthcare is often limited by the region a child is in. Rural areas often have fewer medical resources than urban areas. The lack of easy access to healthcare in rural areas is especially important because rural lifestyles often lead to increased needs for this healthcare. Many rural areas around the world have limited sanitation resources. Access to clean drinking water can be limited, leading to people drinking water that has not been sanitized. This can lead to the spread of severe diseases, which can quickly become life-threatening. These diseases are especially threatening during early childhood when immune systems are not fully developed. Beyond sanitation and healthcare, the specialization of hospitals is also less common in rural areas. There is often a lack of resources within rural areas to prioritize building hospitals and medical facilities with specific focuses.

Even in regions with hospitals and healthcare facilities, there may not be pediatric facilities. Pediatric facilities know how to treat younger patients properly. Though general hospitals are also incredibly helpful for early childhood survival, it is not as effective as hospitals with specific pediatric centers. Finally, the ability for emergency services to reach some rural areas is very difficult. It can take ambulances a long time to get to certain areas. A child experiencing a medical emergency needs immediate medical help, but in rural areas, this is not always possible. This underscores why access to convenient and immediate healthcare is so important during early childhood. A lack of it can quickly become fatal.

Access to healthcare is often limited by financial barriers, such as an inability to afford hospital fees. Systemic issues within states lead to these potentially fatal situations. An often systemic issue in countries that limit access to healthcare is poor insurance systems. Universal healthcare focuses on access to medical care with little financial burden for each individual.²⁰⁸ Universal healthcare has been achieved using various insurance systems in different countries. The most common is the single-payer method,

where the government uses tax revenues to cover national medical costs.²⁰⁹ The World Health Organization (WHO) has called for countries to pursue universal health coverage, meaning that everyone can access needed health services without experiencing financial hardship.²¹⁰ This falls under the UN's Sustainable Development Goal 3. In countries such as South Korea and Slovenia, life expectancy after birth went up by three to five years following the establishment of universal healthcare.²¹¹ Many other countries have also followed this trend. Universal health coverage can improve access to preventive services, prenatal and neonatal care, vaccination, and treatment, although national health outcomes are also influenced by income, education, housing, nutrition, sanitation, and other factors.²¹²

Without quality insurance, medical costs can quickly become unaffordable. This can lead to families avoiding hospitals out of fear for the cost. If medical visits are consistently avoided, small, solvable issues can quickly grow out of hand.²¹³ Transportation to and from hospitals can also be difficult to afford. Not everyone can afford a car, and ambulances are often only viewed as a last resort due to their costs. This is further exacerbated by differences between urban and rural areas. Roads to, from, and within rural areas are often less common and less maintained. Limited urban-rural linkages means access to emergency services and healthcare facilities, which are often in urban areas, can be incredibly difficult both physically and financially in rural areas. These factors increasingly limit rural access to healthcare.

An example of an area where access to healthcare is severely impacted by medical fees is Sub-Saharan Africa. More than three million children die each year from preventable causes, due to a lack of affordable primary healthcare.²¹⁴ Specifically, a main cause of this increased early childhood mortality was the cost of immunization fees.²¹⁵ Immunization is essential for early childhood survival, yet it continues to be financially limited. Other simple yet highly effective medical resources are essential in improving early childhood survival, but they may be out of reach because of cost concerns.

POLICY FRAMEWORKS AND INTERNATIONAL COOPERATION FOR EARLY CHILDHOOD SURVIVAL

Governments use laws, policies, and public-health standards to improve early childhood survival. These measures may address vaccination, food and water safety, healthcare access, sanitation, and the protection of children during conflict. Although national approaches vary, most countries have adopted policies intended to protect children's health and safety. International organizations can support these efforts through research, technical assistance, funding, and policy recommendations.

One of the most important existing international legal frameworks for child protection is the Convention on the Rights of the Child.²¹⁶ Children during early childhood are among the most vulnerable groups in the world.²¹⁷ Importantly, the Convention is the most widely ratified human rights treaty in history in relation to child

Universal health coverage can improve access to preventive services, prenatal and neonatal care, vaccination, and treatment.

welfare.²¹⁸ However, ratification alone does not guarantee that these rights will be protected. Governments may need financial resources, trained personnel, reliable institutions, and international assistance to implement the Convention effectively.

Protecting children's rights provides an important foundation for improving early childhood survival. The Convention contains 54 articles addressing children's civil, political, economic, social, cultural, health, and protection rights. These include the rights to life, survival, and development; healthcare; an adequate standard of living; and protection from violence.²¹⁹ The UN Committee on the Rights of the Child reviews reports submitted by governments and issues recommendations about how they can improve implementation.²²⁰ CPD can complement this work by examining how population trends, healthcare capacity, poverty, displacement, and development policies affect young children.

Governments also use different policies to increase vaccination coverage. These may include routine childhood immunization programs, school-entry requirements, public-information campaigns, vaccine registries, and requirements for certain healthcare workers. During public health emergencies, some governments have introduced broader vaccination requirements. However, countries may disagree over mandates, exemptions, enforcement, public trust, and how to ensure that vaccines remain affordable and accessible.²²¹ CPD can discuss how demographic data and international assistance can help governments identify and reach populations with low vaccination coverage.²²²

Public-health and safety standards can also affect early childhood survival. Food-safety regulations, building standards, injury-prevention policies, and sanitation requirements can reduce children's exposure to preventable risks. For example, India launched the Swachh Bharat Mission in 2014 to expand access to safe toilets and end open defecation.²²³ During the program's first phase, approximately 500 million people in

more than 110 million households gained access to and began using household toilets. UNICEF reports that infant mortality has declined in districts where toilets have been constructed and used.²²⁴ UNICEF also evaluates sanitation programs and shares lessons between India and other countries, demonstrating how international cooperation can support national public-health efforts.

Infrastructure improvements like water purification have a large impact on childhood mortality. This stems from the fact that access to clean drinking water is one of the most important factors in a person's health.²²⁵ Limited sanitation infrastructure can restrict access to clean water. Countries have different levels of technical knowledge, funding, and resources for improving water and sanitation systems. International cooperation, including funding, technical assistance, and knowledge sharing, can support nationally directed efforts to improve early childhood survival.²²⁶

Armed conflict can also undermine efforts to improve early childhood survival. Conflicts can often destroy resources, infrastructure, and tools necessary for early childhood survival and the facilities that support it. Both the conflict and the following impacts actively harm young children.²²⁷ Being physically harmed in active conflict, developing infections from small or large wounds, and a lack of food and water can all lower childhood survival rates. International humanitarian law establishes protections for civilians, children, healthcare workers, and medical facilities during armed conflict. However, violations continue, and governments and international organizations may lack the access or capacity needed to protect affected populations.²²⁸

Hundreds of millions of children live in areas affected by armed conflict, while millions of children and families have been displaced.²²⁹ Millions more are surviving within fifty kilometers of an armed conflict.²³⁰ During early childhood, children rely entirely on their parents or other

close relatives, friends, or other capable individuals. Conflict puts this support system entirely at risk. Children are often separated from their support systems and orphaned during conflict. They become highly vulnerable when their family is divided during conflict or when trying to flee from conflict or even when their guardian becomes a casualty of the war. Conflict may also force children to assume responsibilities beyond their age when parents or other caregivers are killed, injured, separated from them, or unable to provide consistent care. For young children, the loss of caregivers, healthcare, food, clean water, shelter, and other basic services can create immediate threats to survival and long-term development.

International humanitarian law provides protections for civilians, wounded and sick people, healthcare workers, and medical facilities during armed conflict. The Geneva Conventions prohibit attacks on protected medical personnel and facilities, although that protection may be lost under limited circumstances if they are used to commit harmful acts outside their humanitarian function.²³¹ CPD cannot enforce these rules, but it can examine how conflict, displacement, damaged health systems, and population movements affect early childhood survival. It can also recommend international cooperation to restore health services, collect population data, and support affected governments and communities.

Current Status

THE STATE OF MODERN HEALTHCARE AND HOUSING INFRASTRUCTURE

The state of global healthcare has significantly improved in recent decades. Since 2000, global deaths of children under five have fallen by more than half.²³² Better medicine, new technology, and wider access to care have all helped lower early childhood death rates. Even so, progress has begun to slow. Since 2015, the pace of improvement has declined by more than 60 percent.²³³ In 2024, about 4.9 million children died before the age of five, including 2.3 million newborns. Many of these deaths could have been prevented with proven, low-cost treatments and access to quality care.²³⁴ Modern medicine has built many tools that can save lives, but those tools only work if families can access them. There needs to be a more sustained effort towards building strong healthcare systems with trained workers, clean facilities, reliable water and power, and safe homes.

Global healthcare coverage shows the gap between medical progress and actual access. The Universal Health Coverage Service Coverage Index measures access to basic health services on a scale from zero to 100. The global score has risen from 54 in 2000 to 71 in 2023.²³⁵ As with child mortality rates, there is major progress, but the rate of improvement has slowed. In 2023, about 4.6 billion people were still not fully covered by essential health services. In 2022, about 2.1 billion people faced financial hardship because of out-of-pocket healthcare costs.²³⁶

In 2023, about 4.6 billion people were still not fully covered by essential health services.

At the current pace, the global service coverage score is expected to reach only 74 by 2030. This means that about 26 percent of the world's population may still face financial hardship from healthcare costs. Major barriers still remain for families trying to provide consistent care for young children.

One aspect that limits access to care is the shortage of healthcare workers. Hospitals and clinics need trained workers such as doctors, nurses, midwives, and more to function. The World Health Organization projects a global shortage of about 11 million health workers by 2030.²³⁷ Most of this shortage is expected to affect low- and lower-middle-income countries. Shortages largely stem from the lack of time and resources to train healthcare workers and the inability to keep them after they have been trained. Many skilled workers leave their home countries for other opportunities. For example, according to a 2026 Alliance for Economic Research and Ethics report, about 16,000 doctors left Nigeria within five years, leaving only 55,000 medical practitioners to cater to more than 230 million Nigerians.²³⁸ These shortages are not unique to Nigeria or even Africa. Sometimes, a clinic may exist in a community, but without enough trained staff, it may still be unable to provide the care that children need.

The condition of healthcare facilities is another major issue. Safe care depends on clean water, sanitation, hygiene, waste management, and regular cleaning. In 2025, 85 percent of global healthcare facilities had basic water service and 72 percent had basic hygiene services. Although 89 percent had some sort of sanitation, only 40 percent met the full standard for basic sanitation.²³⁹ This is often due to the facility not meeting requirements because of a lack of menstrual hygiene facilities and accessible toilets. The lack of water, sanitation, and hygiene services poses an increased risk to women during childbirth, newborns, and young children. Those groups are especially vulnerable to developing severe illnesses.²⁴⁰

Environmental cleaning is also important within healthcare facilities. In 2025, only 59 percent of healthcare facilities met the basic standard for environmental cleaning. This standard includes both clear cleaning procedures and properly trained cleaning staff. In least developed countries, only 24 percent of facilities met the standard.²⁴¹ Poor cleaning can raise the risk of infections spreading inside hospitals and clinics. This is similarly especially dangerous for newborns and young children because their immune systems are still developing. In general, a hospital or clinic cannot provide the safest care for children if it does not have the systems to keep patients and staff clean.

Childhood vaccination rates can be analyzed to show whether healthcare systems are reaching children specifically. Vaccine administration requires clinics, workers, supplies, and follow-ups to receive the care. In 2025, about 90 percent of infants received at least one dose of the diphtheria, tetanus, and pertussis vaccine, known as DTP. Diphtheria, tetanus, and pertussis are serious bacterial infections. The DTP vaccine, which is typically given in a three-dose series, helps protect individuals against these infections.²⁴² Overall, about 85 percent of people completed all three doses. Global coverage of these vaccines was still one point below 2019 levels, partially due to the COVID-19 pandemic, which severely impacted healthcare capacities. DTP coverage has stayed in the same narrow vaccination level range since 2009.²⁴³ This shows that the world has made progress, but reaching the remaining 10-15 percent of children poses the most difficult challenge. These children are often the same ones living in areas where healthcare systems are already under the greatest strain.

In 2025, about 13.5 million total children did not receive a single routine vaccine during their first year of life. This was about 750,000 fewer children than the year before.²⁴⁴ However, this progress does not reflect the children who begin a vaccine series but do not finish it. In 2025, 84 percent of children received the first measles vaccine dose and 77 percent received

the second. Both rates are below the 95 percent level needed to prevent major outbreaks.²⁴⁵ For young children, incomplete vaccinations can leave them exposed during one of the most vulnerable stages of life. Effective health systems therefore must stay connected with families through several visits and doses, which poses a great difficulty.

Conditions inside a home can also affect child survival. Healthcare systems can treat illness, but housing conditions can shape how often children are exposed to health risks in the first place. A major household condition that affects child health is household air pollution. Around 2.1 billion people still cook with open fires or inefficient stoves that burn fuels such as kerosene, wood, charcoal, or coal.²⁴⁶ These fuels can create harmful smoke inside and around the home. For babies and young children who spend long periods near parents or caregivers while food is prepared, this can mean repeated exposure to harmful chemicals. Young children are especially vulnerable to polluted air. In 2023, about 676,000 deaths of children under five were connected to air pollution, with household air pollution linked to around 75 percent of these deaths. This accounted for 27 percent of all global deaths in that age group.²⁴⁷ Children face greater risks because their lungs, brains, organs, and immune systems are still developing. They also breathe in more air relative to their body size than adults do. In general, these risks are often highest in rural communities, where clean fuels and modern stoves are harder to afford.²⁴⁸ Therefore, housing infrastructure can affect survival even when medical care is available nearby.

The current state of healthcare and housing infrastructure shows that better medicine alone cannot solve early childhood mortality. Billions of people still lack full health coverage, shortages of trained workers remain severe, and many health facilities do not meet basic sanitation or cleaning standards. For young children, these gaps can mean missed checkups, delayed treatment, greater exposure to infection, and fewer opportunities to receive preventative care.

Outside clinics and hospitals, unsafe household conditions such as air pollution continue to put young children at risk. Improving childhood survival requires stronger systems that can bring safe and affordable care to every child.

EARLY CHILDHOOD SURVIVAL IN CONFLICT ZONES AND DISASTERS

Living in a conflict zone is among the largest threats to early childhood survival. Armed conflicts and natural disasters account for some of the largest mass casualty events around the world. A mass casualty incident can be defined as one where the number of patients caused by a single event overloads the capacity of nearby hospitals and medical facilities.²⁴⁹ The impacts of such extreme events are vast. Physical, psychological, political, systemic, and many other issues arise following any form of mass casualty event. Conflict zones are effectively a mass casualty incident prolonged over months and even years.

A major armed conflict is a category of conflict defined by having 10,000 or more conflict-related fatalities in the same year.²⁵⁰ A high-intensity armed conflict is one with 1,000–9,999 conflict-related deaths within a year. In 2023, there were four conflicts considered major armed conflicts: Ukraine, Palestine, Myanmar, and Sudan.²⁵¹ As of 2026, there are now 20 countries projected to face major armed conflict, political unrest, and/or humanitarian crises. All four major armed conflicts classified at the highest intensity level in 2023 remained active in 2026, while several newer conflicts also became more severe. The four maintained conflicts are those in Palestine, Sudan, Ukraine, and Myanmar. The conflict in the Occupied Palestinian Territory remained high among the conflicts posing the greatest danger to civilians. Ukraine has been re-classified down to a high-intensity conflict, but remains the most deadly conflict in the world.²⁵²

Palestine is classified as an extreme conflict because of the danger posed to civilians. While it may not be as deadly as Ukraine, the danger



A young girl in Gaza walking to get food

Credit: Jaber Jehad Badwan

faced by civilians in Palestine makes it the most dangerous place in the world.²⁵³ Early childhood survival is at the highest risk in conflicts where civilians are in explicit danger. As of July 2026, 243 children have been killed by Israeli security forces in the West Bank since October 2023.²⁵⁴ Within this same period of time, 21,000 more children have been killed by Israeli attacks in Gaza.²⁵⁵ Though there have been various attempts at ceasefires throughout this conflict, hundreds of Palestinian child deaths have been documented during these periods of ceasefire.²⁵⁶ What this conflict illustrates is the danger posed to children during conflict involving opposing military forces. Even if a conflict is not the most deadly, children are among the most vulnerable of a population. Therefore, forces not inherently intended to be deadly for adult soldiers can be fatal for child civilians.

In addition to all of this is the lack of medical care.²⁵⁷ Lack of sanitation and severe malnutrition have both escalated the severity of wounds that could otherwise be manageable. This is made even worse by the destruction of most medical facilities throughout Gaza. As of 2026, only half of all medical facilities in Gaza are even partially

functional, and the partially functioning parts of these hospitals can only prioritize the most critical of patients.²⁵⁸

Ukraine is currently the most deadly conflict in the world when measured by total battle-related deaths.²⁵⁹ Since 2022, over 3,500 Ukrainian children have been killed or injured in the conflict between Russia and Ukraine.²⁶⁰ Beyond child deaths caused by Russian attacks are deaths caused by the massive infrastructure damage that has occurred throughout the conflict. Harsh Ukrainian winters, combined with limited shelter and medical care, means the freezing temperatures can quickly become lethal, especially for young children.²⁶¹ Even if shelter has not been destroyed, attacks often leave large areas without power. The lack of power means a lack of critical heating during the winter, threatening the health and survival of young children.²⁶² There are also between one to six million children living in Russian occupied Ukraine. Some of these children are enrolled in potentially dangerous military training schools as early as elementary school. The physical and psychological toll of this inherently influences the early childhood survival rates of these children.²⁶³

The Democratic Republic of the Congo (DRC) remains as another example of a severe humanitarian crisis. The overlapping issues of conflict, internal displacement, famine, disease, and more put millions of young children in the DRC at risk. Over 26 million people in the DRC face severe food insecurity. That is one third of the entire population. On top of this, almost six million people are internally displaced as they try to escape and find safety from the armed conflicts.²⁶⁴ Each of these threats increases the risks faced by young children, in part because their parents face those same dangers. When children lose their parents in conflict, they also lose their main source of support.

A lack of access to medical care only heightens the issues brought on by all of these factors.²⁶⁵ The armed conflicts in the east of the DRC have driven all of these risk factors. The conflict has increased mortality rates, further limited access to food and healthcare, and forced many out of their homes searching for safer areas to live. As a result, the DRC has one of the highest child mortality rates in the world, currently standing at 53 deaths per 1,000 live births.²⁶⁶ The humanitarian crisis in the DRC shows how all of these different risk factors have overlapped to make early childhood survival increasingly difficult. In these situations, children under five face particular risks from malnutrition, infectious disease, interrupted vaccination, unsafe water, displacement, and the collapse of maternal and neonatal healthcare.

Severe natural disasters have also resulted in similar levels of destruction and casualties as armed conflicts. Whether it be severe typhoons and tropical storms, widespread wildfires, earthquakes, or any other type of natural disaster, the ability to combat them remains complicated. Climate change has particularly increased the chances and severity of multiple forms of natural disaster. Climate change is increasing the frequency or severity of several hazards, including extreme heat, heavy rainfall, drought, and conditions that contribute to wildfires.²⁶⁷ From wildfires in Canada, Chile, and Australia,

to flash floods in Indonesia and Bangladesh, to the severe winters in the United States and Japan, climate change has worsened previously manageable disasters.²⁶⁸ These disasters have and will continue to worsen early childhood survival. Extreme temperatures at any point in the year inherently endanger young children. Increased heat in the summer has spurred droughts, which in turn limit access to water and all other resources that rely on it. This includes livestock, crops, hydroelectric resources, and many other valuable resources. Extreme weather can also interrupt vaccination, prenatal care, food distribution, clean-water systems, electricity, transportation, and access to emergency medical treatment.

PROTECTING SEPARATED AND UNACCOMPANIED CHILDREN

Children whose home lives are unstable or who are missing one or both parents may face particular risks. During early childhood, children are almost entirely reliant on their parents. When it comes to learning the most basic concepts, a child's parent is the default teacher. Whether it be walking, talking, eating, or even sitting up and standing, a child relies on their support system for this learning. Beyond education, they also rely on their parents for survival itself. Access to food, milk, and water, as well as shelter and warmth, leave children dependent on their guardian. Recognizing the importance of this relationship, there are systems in place around the world that try to help the most vulnerable populations, but further improvements are still necessary.

Some countries use safe-haven laws or designated locations where parents can relinquish infants without leaving them in unsafe conditions.²⁶⁹ These policies may prevent dangerous abandonment, but they do not address the economic hardship, violence, stigma, lack of reproductive healthcare, or absence of social support that may lead a parent to relinquish a child in the first place.²⁷⁰ Safe-haven laws exist to help prevent babies from being

A safe surrender site in San Francisco, USA

Credit: Alexander Klink



abandoned in dangerous situations, and they appear to work: between 2008 and 2017, infant deaths dropped 66.7 percent in states with these laws in place.²⁷¹

Parents who abandon their babies are often very young and from lower socioeconomic backgrounds. They also tend to identify with religions which oppose abortion and contraception.²⁷² Together, these factors demonstrate the importance of reproductive healthcare, confidential counseling, and financial and social support for parents. Various countries in Europe have had baby boxes for decades, but they still remain far from widespread.²⁷³ Supporters argue that these policies provide a safer alternative to abandonment, while critics raise concerns about children's identity rights, family tracing, and whether anonymous relinquishment prevents parents from receiving needed support.

One form of essential support for parents is women's shelters. Some of the first women's shelters opened as rape crisis shelters.²⁷⁴ Domestic-violence shelters and other emergency services can protect caregivers and young

children from abuse, homelessness, and family separation. Many seeking refuge in these shelters have very little economic means, especially if they have to fully cut off those they were previously living with.²⁷⁵ These shelters have largely transitioned to serving as domestic abuse shelters instead of just women's shelters, to serve more people in need. Though essential, these services require sustainable funding, trained staff, safe housing, legal assistance, healthcare, and child-sensitive support.

Early childhood survival becomes even more complex in cases where children have no parents. Whether a baby was abandoned, their parent passed away during birth, their parents were casualties of war, or any other number of reasons, their immediate and most important support system is gone. International efforts to protect children without parental care remain uneven. Coordinated efforts to support children without parental care may be slowed down by socio-cultural and legal disagreements.²⁷⁶ Support systems for orphans remain limited in many countries. International and non-governmental organizations can help governments provide young children without

parental care with the services and support they need, but there is much strain on these systems to provide food, water, and shelter.²⁷⁷ These systems need mass improvements to properly care for these children and improve childhood outcomes.

Many children are also separated from their parents for reasons other than death. Families can be torn apart by natural disasters, armed conflicts, or migration. In these situations, children can easily be separated from their parents. In these circumstances, the children are not officially orphans, but they are left without the care of their parents, even if it is only temporary.²⁷⁸ UNICEF generally supports family tracing and reunification, kinship care, foster care, and other family or community-based arrangements. Institutional or residential care should generally be temporary and used only when appropriate family-based care is unavailable.²⁷⁹ This ensures their safety in situations young children would not otherwise be able to survive in.

Protecting children requires both preventing unnecessary family separation and providing safe care when separation occurs. Countries may need to strengthen support for vulnerable families, emergency family-tracing systems, reunification services, and family- or community-based alternative care. International cooperation can provide funding, training, and technical assistance, but national and local authorities should help determine how these programs operate in specific country contexts. For CPD, the central question is how governments can use population data and development policies to

identify children without parental care and ensure that they receive protection, healthcare, nutrition, and stable long-term support.

Bloc Analysis

POINTS OF DIVISION

Although global childhood mortality has declined, survival rates remain sharply unequal between and within countries. National income, healthcare infrastructure, conflict, colonial legacies, and household poverty all affect whether children can access essential care. For example, a child born in sub-Saharan Africa is up to 18 times more likely to die before age five than a child born in Australia or New Zealand.²⁸⁰ Inequalities also exist within countries, where healthcare costs and limited rural services can prevent some families from receiving care.²⁸¹

Conflict represents another major division. Nearly half of under-five deaths occur in fragile or conflict-affected settings, although these settings account for only about one quarter of global births.²⁸² Political relationships also affect whether countries can obtain international funding, medical supplies, technical knowledge, and assistance during emergencies. Similarly, natural disaster areas have strained resources and disrupted infrastructure.

Economic and political divisions also affect international assistance. Donor countries may disagree over how much funding to provide, whether assistance should be distributed through

UNICEF generally supports family tracing and reunification, kinship care, foster care, and other family or community-based arrangements.

governments or international organizations, and whether funding should prioritize emergency relief or long-term healthcare systems. Recipient countries may support international assistance while opposing conditions that limit national control over health policy.²⁸³

STATES PRIORITIZING HUMANITARIAN ACCESS AND EMERGENCY CARE

Countries affected by conflict, displacement, or natural disasters, or other humanitarian emergencies are likely to prioritize keeping children alive and maintain services during an immediate crisis.²⁸⁴ WHO reports that fragile, conflict-affected, and vulnerable settings account for 60 percent of preventable maternal deaths, 53 percent of deaths among children under five, and 45 percent of infant deaths.²⁸⁵ To reach populations with little or no access to healthcare, WHO and its partners deploy mobile medical teams and maintain stockpiles of essential supplies and medicines.²⁸⁶ This bloc would thus likely support mobile clinics, protected medical facilities, emergency vaccination campaigns, nutrition screening, and international funding to address the immediate health needs of children.

This bloc may include countries experiencing active conflict or displacement, such as Sudan, Yemen, Ukraine, the Democratic Republic of the Congo, and Syria, as well as neighboring countries hosting large refugee populations displaced by these conflicts.²⁸⁷ Countries such as the Philippines, Bangladesh, Haiti, Pakistan, and small island developing states also face severe natural disaster damage. These countries may share an immediate need for humanitarian support, but their roles and priorities will differ. Crisis-affected countries may focus on preserving or rebuilding national health services, while neighboring host countries may seek additional funding for healthcare systems serving both refugees and local communities.

Conflict and disaster can also increase disease, food insecurity, medicine shortages, and limited

access to clean water.²⁸⁸ The destruction of government offices, healthcare facilities, and public infrastructure limits the ability of national authorities and humanitarian organizations to protect young children. Government institutions may help track populations, identify unmet needs, coordinate services, and document where international assistance is needed.²⁸⁹ When these institutions lose capacity during an emergency, governments may need outside organizations to help maintain essential services.

However, these countries may disagree over how assistance should be delivered. International organizations may need to provide services when national institutions cannot, but involving many organizations can fragment care.²⁹⁰ States may therefore debate how to provide urgent assistance while coordinating with local institutions and preserving national control.

STATES PRIORITIZING TECHNOLOGY, PREVENTION, AND SPECIALIZED CARE

Countries in this bloc generally have broader healthcare coverage, stronger medical infrastructure, and greater capacity to invest in research and specialized care. Countries such as Finland, Japan, and Sweden have achieved low infant and under-five mortality rates through combinations of prenatal care, skilled birth attendance, neonatal services, vaccination, preventive healthcare, and broad access to medical treatment.²⁹¹ These states are likely to support further investment in disease surveillance, digital health systems, medical research, specialized neonatal care, and advanced training for healthcare professionals.

North Macedonia demonstrates how targeted investment in maternal and neonatal care can reduce preventable deaths. After its under-five mortality rate reached 11.1 deaths per 1,000 live births in 2015, its Ministry of Health worked with WHO, UNICEF, and the United Nations Population Fund to strengthen care.²⁹² By 2024, the rate had fallen to 2.8. Kosovo also reduced its neonatal mortality rate from 10.3 to 6.6 and its under-five

mortality rate from 14.3 to 8.7 between 2015 and 2024.²⁹³ These examples may encourage countries with greater capacity to support technical assistance, training, and knowledge transfer to other countries facing high infant mortality and other child health issues.

As countries in this bloc generally have relatively low childhood mortality rates and greater financial, medical, or technological capacity, they are likely to emphasize prevention and early intervention during pregnancy, childbirth, the neonatal period, and the first five years of life.²⁹⁴ Their proposals may include prenatal and newborn screening, specialized neonatal facilities, vaccination, disease surveillance, digital health records, medical research, and training exchanges. The WHO Global Strategy on Digital Health 2020-2027 encourages international cooperation, technical assistance, capacity building, knowledge transfer, and national digital-health strategies adapted to each country's circumstances. It also emphasizes governance and equitable access so that digital technologies strengthen health systems, including in countries with limited access to digital goods and services.²⁹⁵ However, states may disagree over the cost of these programs, technology and knowledge transfer, data privacy, national control over health information, and what exactly international funding should prioritize.

STATES PRIORITIZING BASIC HEALTH SYSTEM CAPACITY AND INTERNATIONAL ASSISTANCE

Countries in this bloc are likely to prioritize building a healthcare system that can provide reliable care over time.²⁹⁶ Many may argue that advanced medical technologies will have limited reach and impact when countries lack the trained personnel, supply systems, maintenance capacity, and basic infrastructure needed to deploy them successfully and integrate them into routine care.²⁹⁷ These states may therefore support international funding to train healthcare workers, expand community health programs and rural clinics, strengthen medical supply chains,

and improve access to affordable medicines and vaccines.

Some states may also emphasize health sovereignty. Because many potential members of this bloc continue to experience economic and institutional inequalities linked to colonialism, they may argue that international assistance should strengthen national health institutions, local primary-care systems, healthcare workforces, and domestic supply capacity rather than create long-term dependence on external providers.²⁹⁸ This approach would balance outside assistance with national autonomy while improving countries' long-term ability to meet their populations' health needs. These states may support partnerships that give national and local governments a role in directing international funding.²⁹⁹ This is the case in Uganda, where the Ministry of Health sought to align the government, international donors, and program implementers under a shared national health plan. The approach encouraged pooled funding and coordinated planning, while giving local governments a greater role in allocating resources and making decisions. Working through existing public-health systems in this way allowed for greater autonomy.³⁰⁰

Recent WHO Pandemic Agreement negotiations show how some members of this bloc may connect international assistance with health sovereignty.³⁰¹ Several developing-country groups supported binding agreements requiring pharmaceutical manufacturers to share vaccines, treatments, and diagnostic tools developed from pathogen information provided by states. These countries wanted guaranteed access to medicines and vaccines instead of depending on companies to donate them. They also wanted more control over how their health information was used.

Limited access to healthcare, clean water, sanitation, and immunization can leave children vulnerable to preventable diseases. They may also lack nutrition services or treatment for conditions like malaria, pneumonia, and diarrhea.³⁰² Rural communities may face long

travel distances, high costs, transportation problems, and healthcare worker shortages.³⁰³ Indigenous communities may face additional geographic, economic, discriminatory, and cultural barriers.³⁰⁴ These states may therefore prioritize primary healthcare and programs developed with underserved communities over immediate investment in specialized facilities or advanced digital systems.

However, members of this bloc may disagree about how to accept international assistance. Some may prefer funding through national governments, while others may support programs led by UN agencies, local organizations, or private partners. They may also disagree over funding conditions, the responsibilities of pharmaceutical companies, control over health information, and whether funding should address immediate needs or long-term development. Still, these states are likely to agree that international assistance should strengthen basic healthcare systems, respect national priorities, and reach underserved communities.

Committee Mission

ECOSOC established the Population Commission in 1946. Following the 1994 International Conference on Population and Development, ECOSOC renamed it the Commission on Population and Development and expanded its role in monitoring implementation of the ICPD Programme of Action. Since its founding, the mission of CPD has been based on three main goals.

The first main objective of CPD is to organize the advising of and studies of population trends and developments. Within that, CPD aims to provide support to developing countries or countries with transitioning economies when requested.³⁰⁵ Where countries often require, and likely request, support is in improving early childhood survival. Reducing preventable deaths among children under five is essential to protecting human rights,

improving public health, and supporting equitable and sustainable development. Improved child survival should not be treated merely as a means of increasing population size. Consistent with the ICPD Programme of Action, policies should prioritize individual health, rights, dignity, and well-being rather than demographic targets.

The Commission's second main mission is focused on oversight. It largely concerns the monitoring of the International Conference on Population and Development's (ICPD) Programme of Action.³⁰⁶ The ICPD was adopted by 179 countries when it was introduced. It underscored the importance of prioritizing human rights to achieve sustainable development.³⁰⁷ The Programme of Action connects population and sustainable development policies with health, human rights, gender equality, and individual dignity while recognizing national circumstances.³⁰⁸ When monitoring the Programme of Action, they assess where there is success and failure and the reasons why. The ICPD's Programme of Action serves as an invaluable tool to monitor the success of initiatives set in place to improve early childhood survival rates. States can and must utilize it as such. To improve early childhood survival, countries must understand why and where some initiatives fail. Understanding the issues with their initiatives will prevent the replication of potentially harmful actions.

The final mission of CPD is to provide recommendations to ECOSOC based on the reports and issues related to the ICPD Programme of Action.³⁰⁹ This is what helps keep CPD tied into the UN, and what puts the goals of the Commission into action. Using the support of ECOSOC and the UN as a whole is essential to achieving the goals of CPD. Improving early childhood survival advances CPD's broader work on health, human rights, population trends, and sustainable development. Solutions should respect national circumstances while promoting sustainable financing, reliable data collection, international cooperation, and equitable access to proven health interventions.

Research and Preparation Questions

Your dais has prepared the following research and preparation questions as a means of providing guidance for your research process. These questions should be carefully considered, as they embody some of the main critical thought and learning objectives surrounding your topic.

TOPIC A

- 1 How is your country's population expected to age over the next several decades, and what economic and social challenges could these demographic changes create?
- 2 How does your country currently finance healthcare and long-term care for older adults? Who bears most of the cost: the government, private insurance, individuals, or families?
- 3 What role do families and communities play in caring for older adults in your country, and what policies could better support unpaid caregivers?
- 4 Does your country have enough healthcare and long-term-care workers to meet future needs? How should it address shortages through training, improved working conditions, technology, or international recruitment?
- 5 How could telehealth, assistive technologies, and artificial intelligence improve care for older adults in your country? What barriers involving cost, accessibility, digital literacy, privacy, or human contact must be addressed?
- 6 How do income, gender, disability, geography, or migration status affect an older person's access to quality care in your country?
- 7 What forms of international cooperation should CPD recommend to help countries prepare for population aging while respecting different economic resources, healthcare systems, and cultural approaches to long-term care?

TOPIC B

- 1 Does your country have any government policies or laws in place to support parents with medical care and early child care (eg. Pediatric healthcare, affordable and accessible daycare, etc...)?
- 2 How and why have early childhood mortality rates fluctuated in recent years?
- 3 Has your country been involved in any recent conflicts? How has this contributed to lowering (or increasing) early childhood survival rates?
- 4 Does your country have any policies in place to support access to basic necessities like food and water?
- 5 What are the statuses of your country's foster and orphanage systems? How much national focus and funding is allocated to young orphans?
- 6 Does your country have any government laws or regulations enforcing vaccinations?
- 7 How did the COVID-19 pandemic affect early childhood survival? How have its effects lasted following the pandemic?

Important Documents

TOPIC A

- Organisation for Economic Co-operation and Development. Future Long-Term Care Expenditure Trajectories Across OECD Countries. OECD Health Working Papers, no. 194. April 10, 2026. https://www.oecd.org/en/publications/future-long-term-care-expenditure-trajectories-across-oecd-countries_800aba3e-en.html.
- United Nations Department of Economic and Social Affairs. Madrid International Plan of Action on Ageing. 2002. <https://social.desa.un.org/issues/ageing/madrid-plan-of-action-and-its-implementation-main/madrid-plan-of-action-and-its>.
- United Nations Department of Economic and Social Affairs. World Social Report 2023: Leaving No One Behind in an Ageing World. 2023. <https://social.desa.un.org/sites/default/files/publications/2023-02/WorldSocialReport2023.pdf>.
- United Nations. Programme of Action of the International Conference on Population and Development. September 1994. https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf.
- World Health Organization. Global Strategy and Action Plan on Ageing and Health. 2017. <https://www.who.int/publications/i/item/9789241513500>.
- World Health Organization. Progress Report on the United Nations Decade of Healthy Ageing, 2021–2023. 2023. <https://www.who.int/publications/i/item/9789240079694>.
- World Health Organization. UN Decade of Healthy Ageing: Plan of Action, 2021–2030. 2020. <https://cdn.who.int/media/docs/default-source/decade-of-healthy-ageing/decade-proposal-final-apr2020-en.pdf>.

TOPIC B

- Ann-Beth Moller et al., “Five decades of advancing global maternal and newborn health and rights: Milestones and initiatives,” *International Journal of Gynecology and Obstetrics* 172, no. 1 (June 2025): 149-162, <https://doi.org/10.1002/ijgo.70344>.
- “Commission on Population and Development,” United Nations, accessed July 25, 2026, <https://www.un.org/development/desa/pd/content/CPD>.
- “Conflict Index,” Armed Conflict Location & Event Data, last modified 2026, <https://acleddata.com/series/acledd-conflict-index>.
- “Diseases,” History of Vaccines, accessed June 9, 2026, <https://historyofvaccines.org/diseases/>.
- Hannah Ritchie, “Where in the world are babies at the lowest risk of dying?” Our World in Data, last modified May 12, 2025, <https://ourworldindata.org/where-are-babies-at-lowest-risk-of-dying>.
- “Maternal and newborn health,” United Nations Children’s Fund, accessed June 9, 2026, <https://www.unicef.org/health/maternal-and-newborn-health>.
- United Nations Children’s Fund, THE UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD – THE CHILDREN’S VERSION (United Nations Children’s Fund, July 10, 2019), <https://childrightsconnect.org/wp-content/uploads/2019/08/un0331962.pdf>.

About the Authors

TOPIC A: ELINOR TUHY

Elinor Tuhy received her Bachelor of Science in Psychology and her Master of Social Work degrees. She is licensed at the Master's level of Social Work in Virginia. She has worked with the older adult population in various settings, including skilled nursing, hospice, and dialysis. She has been working in the public health sector for the last few years; her current role involves Virginia's disease surveillance system. In her spare time, she enjoys reading, being in nature, singing in choirs, and crafting projects. She lives and works in Fredericksburg, Virginia.

TOPIC B: GRACE FARLEY

Grace Farley is an undergraduate at Kenyon College, where she studies Chinese and International Studies with a focus on East Asia. Grace was born in Denver, Colorado, but raised in multiple countries in East Asia, following their parents' work from South Korea, to China, to Taiwan. He has been doing Model United Nations since 2019 as a delegate, often in the Human Right Council and other human rights based committees. Building from receiving multiple delegate awards to chairing a variety of conferences with schools attending from all around Asia. Grace has taken up leadership in Kenyon's Model United Nations and KEEP programs. They have also attended NHSMUN multiple times as both a delegate and in leadership positions. She looks forward to studying international politics in the future.

Additional writing by Katelyn Shen

Edited by Adam Allibhoy, Armen Bagdassarian, Ana Margarita Gil, Paxton Hemmingway, Olivia Keller, Sabeeh Mirza, Althea Turley, and Olivia Woodard

Endnotes

- 1 "World Social Report 2023: Leaving No One Behind in an Ageing World," United Nations Dept. of Economic and Social Affairs, 2023, [social.desa.un.org/sites/default/files/publications/2023-02/WorldSocialReport2023.pdf](https://desa.un.org/sites/default/files/publications/2023-02/WorldSocialReport2023.pdf).
- 2 Simon van Teutem, "The global number of people aged 65 years and older is set to double within the next thirty years," Our World in Data, November 15, 2024, ourworldindata.org/data-insights/by-2060-the-number-of-people-aged-65-and-older-will-be-more-than-four-times-what-it-was-in-2000.
- 3 "Global life expectancy to increase by nearly 5 years by 2050 despite geopolitical, metabolic, and environmental threats, reports new global study," Institute for Health Metrics and Evaluation, May 17, 2024, www.healthdata.org/news-events/newsroom/news-releases/global-life-expectancy-increase-nearly-5-years-2050-despite.
- 4 "World Population by Country 2026 Statistics & Facts," The World Data, June 4, 2026, theworlddata.com/world-population-by-country/.
- 5 Jacques Poot, "The Economics of Negative Population Growth: Global to Local Perspectives," *New Zealand Economic Papers* (2026): 1–42. doi.org/10.1080/00779954.2026.2665600.
- 6 Guy C Brown, "Living too long: the current focus of medical research on increasing the quantity, rather than the quality, of life is damaging our health and harming the economy," *EMBO Reports* 16, no. 2 (2014): 137-141, doi.org/10.15252/embr.201439518.
- 7 Eileen M Crimmins, "Lifespan and Healthspan: Past, Present, and Promise," *The Gerontologist* 55, no. 6 (2015): 901-911, doi.org/10.1093/geront/gnv130.
- 8 Howard E LeWine, "Lifespan vs. healthspan: Why how you age matters more than how long you live," Harvard Health Publishing, April 22, 2026, www.health.harvard.edu/healthy-aging-and-longevity/lifespan-vs-healthspan-why-how-you-age-matters-more-than-how-long-you-live.
- 9 Bastian Herre, "Global average life expectancy has more than doubled since 1900," Our World in Data, February 4, 2025, ourworldindata.org/data-insights/global-average-life-expectancy-has-more-than-doubled-since-1900.
- 10 "How Did Humans Come to Live Longer and Healthier Lives?," Council on Foreign Relations Education, July 24, 2026, education.cfr.org/learn/learning-journey/contemporary-history-pre-1900-introduction/how-did-humans-come-to-live-longer-and-healthier-lives.
- 11 Robert L Goldenberg, and Elizabeth M McClure, "Maternal Mortality," *American Journal of Obstetrics and Gynecology* 205, no. 4 (2011): 293-295, doi.org/10.1016/j.ajog.2011.07.045.
- 12 Irvine Loudon, "Maternal mortality in the past and its relevance to developing countries today," *The American Journal of Clinical Nutrition* 72, no. 1 (2000), 241S-246S, doi.org/10.1093/ajcn/72.1.241S.
- 13 Sharon Basaraba, "The Average Life Expectancy From 1800 to Today," VeryWell Health, June 20, 2026, www.verywellhealth.com/longevity-throughout-history-2224054#citation-24.
- 14 Saloni Dattani et al., "Antibiotics and Antibiotic Resistance," Our World in Data, 2024, ourworldindata.org/antibiotics.
- 15 Council on Foreign Relations Education, "How Did Humans Come to Live Longer and Healthier Lives?."
- 16 Hannah Ritchie, Fiona Spooner, and Max Roser, "Sanitation," Our World in Data, January 2024, ourworldindata.org/sanitation.
- 17 Hannah Ritchie, Fiona Spooner, and Max Roser, "Clean Water," Our World in Data, January 2024, ourworldindata.org/clean-water.
- 18 Institute of Medicine (US) Committee for the Study of the Future of Public Health, *The Future of Public Health*, (Washington, DC: National Academies Press, 1988, www.ncbi.nlm.nih.gov/books/NBK218224/).
- 19 Council on Foreign Relations Education, "How Did Humans Come to Live Longer and Healthier Lives?."
- 20 Friedman, "Why Life Expectancy Skyrocketed in Early 20th-Century America."
- 21 Gale, "What three things boosted life expectancy?."
- 22 The World Data, "World Population by Country 2026."
- 23 Food and Agriculture Organization of the United Nations, "UN Report: Global Hunger Levels Ease for Third Consecutive Year as Regional Disparities Persist," news release, July 21, 2026, <https://www.fao.org/newsroom/detail/un-report--global-hunger-levels-ease-for-third-consecutive-year-as-regional-disparities-persist/>.
- 24 Hannah Ritchie, Pablo Rosado, and Max Roser, "Hunger and Undernourishment," Our World in Data, 2023, ourworldindata.org/hunger-and-undenourishment?insight=many-children-suffer-from-stunting-or-wasting-due-to-poor-nutrition#key-insights.
- 25 Dattani et al., "Antibiotics and Antibiotic Resistance."
- 26 Fiona Spooner et al., "Vaccination."
- 27 Hannah Ritchie, Fiona Spooner, and Max Roser, "Sanitation," Our World in Data, January 2024, ourworldindata.org/sanitation.
- 28 Ritchie, Spooner, and Roser, "Clean Water."
- 29 Saloni Dattani et al., "Life Expectancy," Our World in Data, 2023, ourworldindata.org/life-expectancy?insight=women-tend-to-live-longer-than-men-but-this-gap-has-changed-over-time#key-insights.
- 30 Lillian J Breckenridge, "Collectivism," EBSCO, 2024, www.ebsco.com/research-starters/psychology/collectivism.
- 31 Amitabh Vikram Dwivedi, "Individualism," EBSCO, 2022, www.ebsco.com/research-starters/literature-and-writing/individualism.
- 32 Eirini Potamianou, "Inter-cultural perspectives on aging," *World Journal of Advanced Research and Reviews* 23, No. 02 (2024): 281-286, doi.org/10.30574/wjarr.2024.23.2.2348.
- 33 Aqsa Qandeel and Muhammad Arif Saeed, "Perspective Chapter: Policy Frameworks for Active Aging in Pakistan – Reviewing Existing Policies and Proposing Recommendations for Improvement," *IntechOpen*, August 28, 2025, www.intechopen.com/chapters/1216946.
- 34 Assisting Hands, "What Can We Learn About Aging from Other Cultures?" *Senior Care* (blog), September 14, 2025, assistinghands.com/84/nevada/sclasvegas/blog/what-can-we-learn-about-aging-from-other-cultures/.
- 35 Assisting Hands, "What Can We Learn About Aging from Other Cultures?."
- 36 Potamianou, "Inter-cultural perspectives on aging."
- 37 Richard Smith, "With whom did older persons reside in the past?" *Top of the Campops*, February 20, 2025, www.campop.geog.cam.ac.uk/blog/2025/02/20/with-whom-did-older-persons-reside/.
- 38 "Blog: The 3 Levels of Social Work Explained: Micro, Mezzo, Macro," Diana R. Garland School of Social work Baylor University, July 24, 2026, socialwork.web.baylor.edu/blog-3-levels-social-work-explained-micro-mezzo-macro.
- 39 "How Different Cultures View Aging Services," McGregor PACE, August 20, 2024, mcgregorpace.org/how-different-cultures-view-aging-services/.
- 40 "The Comprehensive History of Elder Care," Yodda, June 21, 2024, www.yodda.care/post/history-of-elder-care.
- 41 Rae Booth, "The History of Elder Care," *Elder Care* (blog), January 1, 2019, silverbellhomestead.com/the-history-of-elder-care/.
- 42 Brad Breeding, "Mind the Gap: Seniors with Nowhere to Turn for Support," *MyLifeSite Blog*, May 14, 2018, mylifesite.net/blog/post/mind-gap-seniors-nowhere-turn-support.
- 43 Mark J. M. Sullman and Reza Mohammadinasab, "The Evolution of Aging and Gerontology: A Historical Odyssey," *International Journal of Aging* 1, no. 1 (2025): 1-6, doi.org/10.34172/ija.2025.e6.

- 44 Booth, "The History of Elder Care."
- 45 McGregor PACE, "How Different Cultures View Aging Services."
- 46 Course Hero, "Macro-Level, Meso-Level, and Micro-Level Analysis."
- 47 Alyssa LaFaro, "Aging with Care," UNC Research, May 19, 2025, research.unc.edu/story/aging-with-care/.
- 48 Bonnie Blackburn Penhollow, "The History of Hospice is One of Compassion," Stillwater Hospice Blog (blog), January 7, 2025, stillwater-hospice.org/blog/the-history-of-hospice-is-one-of-compassion/.
- 49 Course Hero, "Macro-Level, Meso-Level, and Micro-Level Analysis."
- 50 Samantha Cox, "The History of Elder Home Care Services," Seniors Home Care (blog), January 25, 2021, www.seniorshomecare.com/blog/archives/2021/01/25/the-history-of-elder-home-care-services/.
- 51 "Global strategy and action plan on ageing and health," World Health Organization, January 2, 2017, www.who.int/publications/item/9789241513500.
- 52 World Health Organization, "Global Strategy and Action Plan."
- 53 "WHO's work on the UN Decade of Healthy Ageing (2021–2030)," World Health Organization, July 30, 2026, www.who.int/initiatives/decade-of-healthy-ageing.
- 54 Maggie Ratnayake et al. "Aging in Place: Are We Prepared?" Delaware Journal of Public Health 8, no. 3: 28–31. August 31, 2022, doi.org/10.32481/djph.2022.08.007.
- 55 Ruth A. Weinclaw, "Caring for the Elderly: Global Perspectives," EBSCO, 2021, www.ebsco.com/research-starters/ethnic-and-cultural-studies/caring-elderly-global-perspectives.
- 56 Diana Pacheco Barzallo et al., "Gender Differences in Family Caregiving. Do female caregivers do more or undertake different tasks?" BMC Health Services Research 24, no. 730 (2024). doi.org/10.1186/s12913-024-11191-w.
- 57 Linda Geddes, "The tipping point: what happens when deaths outnumber births?" The Guardian, May 2, 2026, www.theguardian.com/world/ng-interactive/2026/may/02/what-happens-when-deaths-outnumber-births.
- 58 Chenlu Hong et al., "Response of Global Health Towards the Challenges Presented by Population Aging," China CDC Weekly 5, no. 39 (2023): 884–887, doi.org/10.46234/ccdcw2023.168.
- 59 Carylee Gali, "History of Telemedicine: 150 Years of Remote Patient Care," Curogram, July 9, 2026, curogram.com/blog/history-of-telemedicine.
- 60 Ayat Ashour and Ghada Othman Elkhawaga, "Innovations in geriatric care: leveraging technology to meet the needs of an aging world, a narrative review," Journal of the Egyptian Public Health Association 101, no. 2 (2026). doi.org/10.1186/s42506-025-00203-0.
- 61 Poot, "Economics of Negative Population Growth."
- 62 "Age Groups," International Organization for Standardization, July 24, 2026, www.iso.org/foresight/age-groups.html.
- 63 United Nations, Department of Economic and Social Affairs, Population Division, World Population Prospects 2024, processed by Our World in Data, "Old-Age Dependency Ratio," accessed August 30, 2026, ourworldindata.org/grapher/age-dependency-ratio-old.
- 64 "Ageing and Health," World Health Organization, October 1, 2025, www.who.int/news-room/fact-sheets/detail/ageing-and-health.
- 65 "Ageing," World Health Organization African Region, July 24, 2026, www.afro.who.int/health-topics/ageing.
- 66 Maw Pin Tan, "Healthcare for older people in lower and middle income countries," Age and Ageing 51, no. 4 (2022): afac016. doi.org/10.1093/ageing/afac016.
- 67 The World Data, "World Population by Country 2026."
- 68 Sunita Dodani and Ronald E LaPorte, "Brain drain from developing countries: how can brain drain be converted into wisdom gain?" Journal of the Royal Society of Medicine 98, no. 11 (2005): 487–491, doi.org/10.1177/01410768050980107.
- 69 A Martinez, "TPS work permit loss could deepen healthcare staffing shortages," National Public Radio, July 10, 2026, www.npr.org/2026/07/10/nx-s1-5887613/tps-work-permit-loss-could-deepen-healthcare-staffing-shortages.
- 70 "Unlocking the Power of Healthy Longevity: Demographic Change, Non-communicable Diseases, and Human Capital," World Bank Group, September 12, 2024, www.worldbank.org/en/topic/health/publication/unlocking-power-healthy-longevity#3.
- 71 Tan, "Healthcare for Older People."
- 72 World Bank Group, "Unlocking the Power of Healthy Longevity."
- 73 "Ageing," World Health Organization African Region.
- 74 Tan, "Healthcare for Older People."
- 75 World Bank Group, "Unlocking the Power of Healthy Longevity."
- 76 Masa Higo and Hafiz TA Khan, "Global population aging: Unequal distribution of risks in later life between developed and developing countries," Global Social Policy 15, no. 2 (2015): 146–166, doi.org/10.1177/1468018114543157.
- 77 The Health News Team, "Study finds Americans are living longer but not healthier," Sharp Healthcare, February 13, 2025, www.sharp.com/health-news/study-finds-americans-are-living-longer-but-not-healthier.
- 78 Armin Garmany and Andre Terzic, "Global Healthspan-Lifespan Gaps Among 183 World Health Organization Member States," JAMA Network Open 7, no. 12 (2024): e2450241, doi.org/10.1001/jamanetworkopen.2024.50241.
- 79 Garmany and Terzic, "Global Healthspan-Lifespan Gaps Among 183 World Health Organization Member States."
- 80 Armin Garmany and Andre Terzic, "Healthspan-lifespan gap differs in magnitude and disease contribution across world regions," Communications Medicine 5, no. 381 (2025), doi.org/10.1001/jamanetworkopen.2024.50241.
- 81 LeWine, "Lifespan vs. healthspan: Why how you age matters more than how long you live."
- 82 "Social determinants of health," World Health Organization, July 24, 2026, www.who.int/health-topics/social-determinants-of-health#tab=tab_1.
- 83 Katarina Vrtikapa, Farhana Hoque Urmy, Farzana Hoque, "Social Determinants of Health: The Impact of This Overlooked Vital Sign," Journal of Brown Hospital Medicine 4, no. 3 (2025): 138072, doi.org/10.56305/001c.138072.
- 84 Shinichi Noto, "Perspectives on Aging and Quality of Life," Healthcare (Basel, Switzerland) 11, no. 15 (2023): 2131, doi.org/10.3390/healthcare11152131.
- 85 Social Determinants of Health and Older Adults, prepared by the Office of Disease Prevention and Health Promotion (Washington, DC, 2026), odphp.health.gov/our-work/national-health-initiatives/healthy-aging/social-determinants-health-and-older-adults.
- 86 "Food Deserts," Food Empowerment Project, July 24, 2026, foodispower.org/access-health/food-deserts/.
- 87 Office of Disease Prevention and Health Promotion, Social Determinants of Health.
- 88 Jay Sabo, "What Are the 5 Best Ways to Overcome Mobility Challenges When Caring for the Elderly?," Instacare Home Health Solutions, January 17, 2025, instacarehome.com/what-are-the-5-best-ways-to-overcome-mobility-challenges-when-caring-for-the-elderly/.
- 89 Clara Bolster-Foucault et al., "Social inequity in ageing in place among older adults in Organisation for Economic Cooperation and Development countries: a mixed studies systematic review," Age and ageing 53, no. 8 (2024): 166, doi.org/10.1093/ageing/afae166.
- 90 Hafiz T A Khan, Kwaku Mari Addo, Helen Findlay, "Public Health Challenges and Responses to the Growing Ageing Populations," Public health

- challenges 3, no. 3 (2024): 213, doi.org/10.1002/puh2.213.
- 91 Office of Disease Prevention and Health Promotion, Social Determinants of Health.
- 92 Social Determinants of Health (SDOH), (Centers for Disease Control and Prevention: Washington, DC, 2024), www.cdc.gov/about/priorities/why-is-addressing-sdoh-important.html.
- 93 Darcy Jones McMaughan, Oluyomi Oloruntoba, Matthew Lee Smith, "Socioeconomic Status and Access to Healthcare: Interrelated Drivers for Healthy Aging," *Frontiers in Public Health* 8, no. 1 (2020): 231, doi.org/10.3389/fpubh.2020.00231.
- 94 "The tale of two 60s: The gulf between the have and have-nots in a decade of change," Centre for Ageing Better, June 25, 2026, ageing-better.org.uk/news/tale-two-60s-gulf-between-decade-change.
- 95 "Health at a Glance 2025 OECD Indicators: 2. Which diseases affect men and women differently – and why this matters," Organisation for Economic Co-Operation and Development, November 13, 2025, www.oecd.org/en/publications/health-at-a-glance-2025_8f9e3f98-en/full-report/which-diseases-affect-men-and-women-differently-and-why-this-matters_c7602de9.html#section-d1e2879-773c53eaa6.
- 96 Yumiko Kamiya, Vladimira Kantorova, and Siqi Wu, "Gender Matters In An Ageing World: The Case For Gender-Responsive Policies," United Nations Department of Economic and Social Affairs, February 2026, www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/undesapd_2026_pb186_gender_matters_in_an_ageing_world.pdf.
- 97 OECD, "Which diseases affect men and women differently – and why this matters."
- 98 "Understanding the Impact of Health Inequalities in the UK," Four Eyes Insight, July 25, 2026, www.foureyesinsight.com/articles/understanding-the-impact-of-health-inequalities-in-the-uk/.
- 99 "Climate Change and Aging," Cornell Initiative for Research on Climate & Aging, July 25, 2026, climateaging.bctr.cornell.edu/learn/climate-change-and-aging.
- 100 Bruce A Carnes, David Staats, Bradley J Willcox "Impact of Climate Change on Elder Health," *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences* 69, no. 9 (2014): 1087-1091, doi.org/10.1093/gerona/glt159.
- 101 Climate Change and the Health of Older Adults, (United States Environmental Protection Agency: Washington, DC, 2016), 19january2017snapshot.epa.gov/sites/production/files/2016-10/documents/older-adults-health-climate-change-large-fonts_0.pdf.
- 102 Cornell Initiative for Research on Climate & Aging, "Climate Change and Aging."
- 103 Patrick Boyle, "Why older adults are especially vulnerable to climate change," Association of American Medical Colleges, October 31, 2024, www.aamc.org/news/why-older-adults-are-especially-vulnerable-climate-change.
- 104 Gali, "History of Telemedicine: 150 Years of Remote Patient Care."
- 105 NEJM Catalyst, "What is Telehealth?," *The New England Journal of Medicine*, February 1, 2018, catalyst.nejm.org/doi/full/10.1056/CAT.18.0268.
- 106 Israel Júnior Borges do Nascimento et al., "An Overview of Reviews on Telemedicine and Telehealth in Dementia Care: Mixed Methods Synthesis," *JMIR Mental Health* 12, no. 1 (2025), doi.org/10.2196/75266.
- 107 Ashour and Elkhawaga, "Innovations in Geriatric Care."
- 108 CM Rubin, "AI Companions Are Redefining Elder Care: 3 Ways They Fight Loneliness, Boost Safety And Scale Support," *Forbes*, May 19, 2025, www.forbes.com/sites/cathyrubin/2025/05/16/ai-companions-are-redefining-elder-care-3-ways-they-fight-loneliness-boost-safety-and-scale-support/.
- 109 Ashour and Elkhawaga, "Innovations in Geriatric Care."
- 110 Ashour and Elkhawaga, "Innovations in Geriatric Care."
- 111 Arboleda, Moreira, and Sousa, "Telemedicine in Elderly Care."
- 112 Sameen Rafi, "Artificial intelligence and telemedicine in elderly healthcare."
- 113 Leff et al., "Addressing Barriers to Equitable Telehealth."
- 114 Ashour and Elkhawaga, "Innovations in Geriatric Care."
- 115 "Private vs Public Healthcare Explained: Overcoming Challenges for Better Care," *WorldClinic*, January 31, 2025, worldclinic.com/blog/private-vs-public-healthcare/.
- 116 Jordan Rau and Reed Ableson, "'Financial Ruin Is Baked Into the System': Readers on the Costs of Long-Term Care," *KFF Health News-New York Times*, December 15, 2023, kffhealthnews.org/aging/dying-broke-reader-reaction-long-term-care-crisis/.
- 117 Paula Span, "A New Option for Long-Term Care Costs, KFF Health News, July 10, 2026, kffhealthnews.org/syndicate/long-term-care-costs-washington-state-payroll-option/.
- 118 Jordan Rau, "What Long-Term Care Looks Like Around the World," *KFF Health News-New York Times*, November 14, 2023, kffhealthnews.org/aging/dying-broke-long-term-care-other-countries/.
- 119 Rau, "What Long-Term Care Looks Like Around the World."
- 120 Rau, "What Long-Term Care Looks Like Around the World."
- 121 Rau, "What Long-Term Care Looks Like Around the World."
- 122 Michael Karpman and Susan J. Popkin, "One in Four Older Adults with Disabilities Had Unmet Needs for Personal Assistance in 2025," *Urban Institute*, July 2026, www.urban.org/sites/default/files/2026-07/One_in_Four_Older_Adults_with_Disabilities_Had_Unmet_Needs_for_Personal_Assistance_in_2025.pdf.
- 123 Chloe Reeves, Dr Aisha Islam, Tom Gentry, "The State of Health and Care of Older People in England 2025," *Age UK*, September 2025, www.ageuk.org.uk/siteassets/documents/reports-and-publications/reports-and-briefings/health--wellbeing/state-of-health-and-care/state-of-health-care-of-older-people-in-england-2025.pdf.
- 124 Thomas Blavet, Luca Lorenzoni, Thomas Rapp, "Future longterm care expenditure trajectories across OECD countries," *OECD Health Working Papers* No. 194, April 10, 2026, www.oecd.org/en/publications/future-long-term-care-expenditure-trajectories-across-oecd-countries_800aba3e-en.html.
- 125 Aristeidis Tsitiridis et al., "From Integrated Care to Learning Systems." *Healthcare* 14, no. 12 (2026): 1612, doi.org/10.3390/healthcare14121612.
- 126 "Is Care Affordable for Older People?" *OECD Health Policy Studies*, October 29, 2024, www.oecd.org/en/publications/is-care-affordable-for-older-people_450ea778-en.html.
- 127 "The Economic Benefit of Promoting Healthy Ageing and Community Care," *OECD Health Policy Studies*, October 8, 2025, www.oecd.org/en/publications/the-economic-benefit-of-promoting-healthy-ageing-and-community-care_0f7bc62b-en.html.
- 128 "Transforming our world: the 2030 Agenda for Sustainable Development," *United Nations Dept. of Economic and Social Affairs*, July 29, 2026, sdgs.un.org/2030agenda.
- 129 "The 17 Goals," *United Nations Dept. of Economic and Social Affairs*, July 29, 2026, sdgs.un.org/goals.
- 130 "Decade of Healthy Ageing: 2021-2030," *United Nations Dept. of Economic and Social Affairs*, July 29, 2026, social.desa.un.org/sdn/decade-of-healthy-ageing-2021-2030.
- 131 "World Assembly on Ageing," *United Nations Conferences: Ageing*, July 29, 2026, www.un.org/en/conferences/ageing.
- 132 "Madrid Plan of Action and its Implementation," *United Nations Dept. of Economic and Social Affairs*, July 29, 2026, social.desa.un.org/

issues/ageing/madrid-plan-of-action-and-its-implementation-main/madrid-plan-of-action-and-its

133 UN DESA, "Madrid Plan of Action and its Implementation."

134 Karoline Schmid, "Madrid International Plan of Action on Ageing and the 2030 Agenda for Sustainable Development," *International Journal of Public Health* 69, no. 1 (2024): 1607078, doi.org/10.3389/ijph.2024.1607078.

135 World Health Organization, "Global Strategy and Action Plan."

136 World Health Organization, "Global Strategy and Action Plan."

137 "WHO's work on the UN Decade of Healthy Ageing (2021–2030)," World Health Organization, July 30, 2026, www.who.int/initiatives/decade-of-healthy-ageing.

138 "UN Decade of Healthy Ageing: Plan of Action," United Nations and World Health Organization, July 30, 2026, cdn.who.int/media/docs/default-source/decade-of-healthy-ageing/decade-proposal-final-apr2020-en.pdf?sfvrsn=b4b75ebc_28.

139 "Progress report on the United Nations Decade of Healthy Ageing, 2021–2023," World Health Organization, November 22, 2023, www.who.int/publications/i/item/9789240079694.

140 "International Day of Older Persons," RELX: SDG Resource Centre, August 8, 2026, sdgresources.relx.com/events/international-day-older-persons.

141 WHO, "Progress report on the United Nations Decade of Healthy Ageing, 2021–2023."

142 "Measuring the progress and impact of the UN Decade of Healthy Ageing (2021–2030)," WHO Technical Advisory Group, 2024, iris.who.int/items/05624051-50e3-4d7c-9643-421bbd018eff.

143 "Stakeholder Survey to Shape the Second half of the UN Decade of Healthy Ageing," World Health Organization, March 18, 2026, www.who.int/news-room/articles-detail/stakeholder-survey-to-shape-the-second-half-of-the-un-decade-of-healthy-ageing.

144 The World Data, "World Population by Country 2026."

145 Iswardi Ishak, "Mapped: Countries With the Most Seniors," *Visual Capitalist*, June 26, 2026, www.visualcapitalist.com/cp/countries-with-the-most-seniors/.

146 Ruru Ping and Takashi Oshio, "Long Term Care System Profile: Japan," *Global Observatory of Long-Term Care*, 2023, goltc.org/system-profile/japan/.

147 Leena Forma and Emilia Leinonen, "Long Term Care System Profile: Finland," *Global Observatory of Long-Term Care*, 2024, goltc.org/system-profile/finland/.

148 Forma and Leinonen, "Long Term Care System Profile: Finland."

149 "Long-term care services in selected countries of the Americas," *International Social Security Association*, March 14, 2024, www.issa.int/analysis/long-term-care-services-selected-countries-americas.

150 "Who will care for Latin America's elderly? A looming crisis," *University of Bath IPR (blog)*, June 23, 2026, blogs.bath.ac.uk/iprblog/2026/06/23/who-will-care-for-latin-americas-elderly-a-looming-crisis/.

151 Luis Miguel Gutiérrez Robledo, Carlos Cano-Gutiérrez, Enrique Vega Garcia, "Healthcare for older people in Central and South America," *Age Ageing* 51, no. 5 (2022), doi.org/10.1093/ageing/afac017.

152 Marco Stampini et al., "Who Cares? How to Support and Ensure Recognition for Caregivers for Older People in Latin America and the Caribbean," *Inter-American Development Bank*, October 2025, dx.doi.org/10.18235/0013724

153 Salim Ahmed Alshehri et al., "Health workforce planning models for older adults in the WHO Eastern Mediterranean Region: a mixed methods systematic review," *Human Resources for Health* 24, no. 38 (2026), doi.org/10.1186/s12960-026-01077-9.

154 "Innovations in Community-Based Care Support Aging in Place," *Southeast Asia Development Solutions*, February 24, 2026, seads.adb.org/articles/innovations-community-based-care-support-aging-place

155 The World Data, "World Population by Country 2026."

156 Wan He, "Increases in Africa's Older Population Will Outstrip Growth in Any Other World Region," *United States Census Bureau*, April 13, 2022, www.census.gov/library/stories/2022/04/why-study-aging-in-africa-region-with-worlds-youngest-population.html

157 Madeline E. Duhon et al., "Preparing For An Aging Africa: Data-Driven Priorities For Economic Research And Policy," *National Bureau of Economic Research Working Paper* 31750, October 2023, www.nber.org/system/files/working_papers/w31750/w31750.pdf

158 Matt Sedensky, "Aging Africa: A wave of longevity is sweeping across the continent. It isn't ready," *The Associated Press*, August 5, 2026, apnews.com/projects/africa-aging-demographics/

159 "Toolkit: Database Of Action Plans For Aging," *AARP International and FP Analytics*, August 5, 2026, www.aarpinternational.org/resources/healthy-aging/toolkit#database

160 "Commission on Population and Development," *United Nations*, August 6, 2026, www.un.org/development/desa/pd/content/CPD.

161 "Programme of Action," *United Nations International Conference on Population and Development*, September 1994, www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf.

162 Commission on Population and Development, *Report of the Secretary General: Assessing the status of implementation of the Programme of Action of the International Conference on Population and Development and its contribution to the follow-up and review of the 2030 Agenda for Sustainable Development during the decade of action and delivery for sustainable development* (UN Economic and Social Council, February 2024), https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/undesapd_2024_e_cn.9_2024_2_advance-unedited.pdf.

163 Commission on Population and Development, *Report of the Secretary General: Assessing the status of implementation of the Programme of Action of the International Conference on Population and Development and its contribution to the follow-up and review of the 2030 Agenda for Sustainable Development during the decade of action and delivery for sustainable development*.

164 Commission on Population and Development, *Ensuring healthy lives and promoting well-being for all at all ages: Report of the Secretary-General* (UN Economic and Social Council, January 2025), https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/undesapd_2025_cpd58_e-cn.9-2025-2-report-ensuring-healthy-lives-advance-unedited.pdf.

165 Commission on Population and Development, *Programmes and interventions on population, technology and research in the context of sustainable development: Report of the Secretary-General* (UN Economic and Social Council, January 2026), https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/undesapd_2026_cpd59_cn.9_2026_3_sg-report-on-programmes.pdf.

166 "Child mortality (under 5 years)," *World Health Organization*, last modified May 1, 2026, https://www.who.int/news-room/fact-sheets/detail/child-mortality-under-5-years.

167 Atalay Liknaw Birhanie et al., "Under-five mortality and its associated factors in sub-Saharan Africa: a multilevel analysis of recent demographic and health surveys data based on Bayesian approach," *BMC pediatrics* 25, no. 1 (February 2025), https://doi.org/10.1186/s12887-025-05454-6.

168 "Under-five mortality," *United Nations Children's Fund*, last modified March 2026, https://data.unicef.org/topic/child-survival/under-five-mortality/.

169 World Health Organization, "Child mortality (under 5 years)."

170 United Nations Children's Fund, "Under-five mortality."

171 D. Clark, "Ranking of the 20 countries* with the lowest infant mortality rate in 2024," Statista, last modified Apr 9, 2025, https://www.statista.com/statistics/264717/countries-with-the-lowest-infant-mortality-rate/?srsltid=AfmBOooY6FN2QA6fS83BNJKW6vqWMT8GBAy4hgBeuy3ui3n_bHdslPXE.

172 Steven Woolf and Jill Rosenthal, Childhood Vaccination Has Saved Millions of Lives, but Rising Hesitancy Could Reverse Decades of Progress, (Washington, D.C.: Center for American Progress, January 8, 2025), <https://www.americanprogress.org/article/childhood-vaccination-has-saved-millions-of-lives-but-rising-hesitancy-could-reverse-decades-of-progress/>.

173 "Diseases," History of Vaccines, accessed June 9, 2026, <https://historyofvaccines.org/diseases/>.

174 "Rotavirus," The College of Physicians of Philadelphia, last modified April 18, 2022, <https://historyofvaccines.org/diseases/rotavirus/>.

175 "Rotavirus Vaccination," Centers for Disease Control, last modified July 19, 2024, <https://www.cdc.gov/rotavirus/vaccines/index.html#:~:text=Rotavirus%20spreads%20easily%20among%20infants,stomach%20pain%20caused%20by%20rotavirus.>

176 History of Vaccines, "Diseases."

177 "Diphtheria" History of Vaccines, accessed June 18, 2026, <https://historyofvaccines.org/history/diphtheria/overview/>.

178 Woolf and Rosenthal, Childhood Vaccination Has Saved Millions of Lives, but Rising Hesitancy Could Reverse Decades of Progress.

179 Woolf and Rosenthal, Childhood Vaccination Has Saved Millions of Lives, but Rising Hesitancy Could Reverse Decades of Progress.

180 Woolf and Rosenthal, Childhood Vaccination Has Saved Millions of Lives, but Rising Hesitancy Could Reverse Decades of Progress.

181 Woolf and Rosenthal, Childhood Vaccination Has Saved Millions of Lives, but Rising Hesitancy Could Reverse Decades of Progress.

182 Chephra McKee and Kristin Bohannon, "Exploring the Reasons Behind Parental Refusal of Vaccines," *The journal of pediatric pharmacology and therapeutics : JPPT : the official journal of PPAG* 21, no. 2 (2016): 104-9, <https://doi.org/10.5863/1551-6776-21.2.104>.

183 Jim Reed, "Rise of vaccine distrust - why more of us are questioning jabs," BBC News, last modified January 15, 2025, <https://www.bbc.com/news/articles/c1jgrlxx37do>.

184 Simran Kumar, Zayna Shah, and Sara Garfield, "Causes of Vaccine Hesitancy in Adults for the Influenza and COVID-19 Vaccines: A Systematic Literature Review," *Vaccines* 10, no. 9, (September 2022), <https://doi.org/10.3390/vaccines10091518>.

185 Shivaji Kashte et al., "COVID-19 Vaccines: Rapid Development, Implications, Challenges and Future Prospects," *Human Cell* 34, no. 3 (May 2021): 711-733, <https://doi.org/10.1007/s13577-021-00512-4>.

186 Ann-Beth Moller et al., "Five decades of advancing global maternal and newborn health and rights: Milestones and initiatives," *International Journal of Gynecology and Obstetrics* 172, no. 1 (June 2025): 149-162, <https://doi.org/10.1002/ijgo.70344>.

187 "About Stillbirth," U.S. Centers for Disease Control and Prevention, last modified August 26, 2026, <https://www.cdc.gov/stillbirth/about/index.html>.

188 "Adolescent pregnancy," United Nations Population Fund, accessed September 3, 2026, <https://www.unfpa.org/adolescent-pregnancy>.

189 Mohammed Nasser Albarq, "The Impact of Prenatal Care on the Prevention of Neonatal Outcomes: A Systematic Review and Meta-Analysis of Global Health Interventions," *Healthcare (Basel, Switzerland)* 13, no. 9 (May 2025): 1076, <https://doi.org/10.3390/healthcare13091076>.

190 "Maternal and newborn health," the United Nations Children's Fund, accessed June 9, 2026, <https://www.unicef.org/health/maternal-and-newborn-health>.

191 Albarq, "The Impact of Prenatal Care on the Prevention of Neonatal Outcomes: A Systematic Review and Meta-Analysis of Global Health Interventions," 1076.

192 Moller et al., "Five decades of advancing global maternal and newborn health and rights: Milestones and initiatives," 149-162.

193 The United Nations Children's Fund, "Maternal and newborn health."

194 Moller et al., "Five decades of advancing global maternal and newborn health and rights: Milestones and initiatives," 149-162.

195 "Postpartum Hemorrhage," American College of Obstetricians and Gynecologists, last modified 2024, <https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/10/postpartum-hemorrhage>.

196 Hannah Blencowe et al., "Clean birth and postnatal care practices to reduce neonatal deaths from sepsis and tetanus: a systematic review and Delphi estimation of mortality effect," *BMC Public Health* 11, no. S11 (April 2011), <https://doi.org/10.1186/1471-2458-11-S3-S11>.

197 Ankit Chauhan and Jyotsna Potdar, "Maternal Mental Health During Pregnancy: A Critical Review," *Cureus* 14, no. 10 (October 2022), <https://doi.org/10.7759/cureus.30656>.

198 "About Alcohol Use During Pregnancy," Centers for Disease Control, last modified April 2, 2026, [https://www.cdc.gov/alcohol-pregnancy/about/index.html#:~:text=Alcohol%20use%20during%20pregnancy%20is,alcohol%20spectrum%20disorders%20\(FASDs\)](https://www.cdc.gov/alcohol-pregnancy/about/index.html#:~:text=Alcohol%20use%20during%20pregnancy%20is,alcohol%20spectrum%20disorders%20(FASDs)).

199 Mandy Rich, "What is postpartum depression?" UNICEF Parenting, accessed September 3, 2026, <https://www.unicef.org/parenting/mental-health/what-postpartum-depression>.

200 Lorraine O Walker, "Maternal postpartum health and its impact on health and development of young children," *Womens Health Nurs.* 30, no. 2 (May 2024): 96-100, <https://doi.org/10.4069/whn.2024.03.30>.

201 "Essential newborn care," The World Health Organization, accessed June 26, 2026, www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/newborn-health/essential-newborn-care.

202 American College of Obstetricians and Gynecologists, "Postpartum Hemorrhage."

203 "Birth Injury," Cleveland Clinic, last modified May 12, 2025, <https://my.clevelandclinic.org/health/diseases/birth-injury>.

204 Meghan May, "Why Parents Seek Care for Acute Illness in the Clinic or the ED: The Role of Health Literacy," *Academic Pediatrics* 18, no. 3 (April 2018): 289-296, <https://doi.org/10.1016/j.acap.2017.06.010>.

205 Li Jiang et al., "Immediate Care for Common Conditions in Term and Preterm Neonates: The Evidence," *Neonatology* 122, no. 1 (2025): 106-128, <https://doi.org/10.1159/000541037>.

206 "Hematocrit," Benioff Children's Hospital, last modified November 3, 2024, <https://www.ucsfbenioffchildrens.org/medical-tests/hematocrit#>.

207 "Hematocrit Test," Cleveland Clinic, last modified May 12, 2025, <https://my.clevelandclinic.org/health/diagnostics/17683-hematocrit>.

208 "Universal health coverage," World Health Organization, accessed September 3, 2026, https://www.who.int/health-topics/universal-health-coverage#tab=tab_1.

209 Michael J Boyle, "Universal Healthcare Coverage Explained: Types and Benefits," Investopedia, last modified January 8, 2026, <https://www.investopedia.com/terms/u/universal-coverage.asp>.

210 Chhabi L Ranabhat et al., "The Influence of Universal Health Coverage on Life Expectancy at Birth (LEAB) and Healthy Life Expectancy (HALE): A Multi-Country Cross-Sectional Study," *Frontiers in pharmacology* 9, no. 960 (September 2018), <https://doi.org/10.3389/fphar.2018.00960>.

211 Chhabi L Ranabhat et al., "The Influence of Universal Health Coverage on Life Expectancy at Birth (LEAB) and Healthy Life Expectancy (HALE): A Multi-Country Cross-Sectional Study."

212 Sarah Galvani-Townsend et al., "Is life expectancy higher in countries and territories with publicly funded health care? Global analysis of health care access and the social determinants of health," *Journal of Global Health* 12 (November 2022), <https://doi.org/10.7189/jogh.12.04091>.

213 Ryan A Simmons, Rebecca Anthopolos, and Wendy Prudhomme O'Meara, "Effect of health systems context on infant and child mortality in sub-Saharan Africa from 1995 to 2015, a longitudinal cohort analysis," *Scientific reports* 11, no. 1, (August 2021), <https://doi.org/10.1038/s41598->

- 021-95886-8.
- 214 Simmons, Anthopolos, and Prudhomme, "Effect of health systems context on infant and child mortality in sub-Saharan Africa from 1995 to 2015, a longitudinal cohort analysis."
- 215 Simmons, Anthopolos, and Prudhomme, "Effect of health systems context on infant and child mortality in sub-Saharan Africa from 1995 to 2015, a longitudinal cohort analysis."
- 216 "Convention on the Rights of the Child," United Nations Children's Fund, accessed June 28, 2026, <https://www.unicef.org/child-rights-convention>.
- 217 "Children's Rights," United Nations Global Compact, accessed June 28, 2026, <https://unglobalcompact.org/what-is-gc/our-work/social/childrens-rights>.
- 218 United Nations Children's Fund, "Convention on the Rights of the Child."
- 219 "Children's version of the Convention on the Rights of the Child," United Nations Children's Fund, accessed September 3, 2026, <https://www.unicef.org/child-rights-convention/convention-text-childrens-version>.
- 220 "UNICEF's role in promoting and supporting the Convention on the Rights of the Child," United Nations Children's Fund, accessed June 28, 2026, <https://www.unicef.org/child-rights-convention/unicef-role>.
- 221 Emily Cameron-Blake et al., "A panel dataset of COVID-19 vaccination policies in 185 countries" *Nature Human Behaviour* 7 (July 2023), <https://doi.org/10.1038/s41562-023-01615-8>.
- 222 "Requirements and Laws," Centers for Disease Control, last modified July 30, 2024, <https://www.cdc.gov/vaccines/php/requirements-laws/index.html>.
- 223 UNICEF, "Transforming Sanitation in India," UNICEF India, accessed September 22, 2026, <https://www.unicef.org/india/transforming-sanitation-india>.
- 224 UNICEF, "Transforming Sanitation in India."
- 225 "About Global WASH," U.S. Centers for Disease Control and Prevention, accessed September 3, 2026, <https://www.cdc.gov/global-water-sanitation-hygiene/about/index.html>.
- 226 Sarah Macdonald, "Water purifying system could save lives in developing countries," *BMJ* (Clinical research ed.) 326, no. 7388 (March 2003): 520, <https://doi.org/10.1136/bmj.326.7388.520/c>.
- 227 Ayesha Kadir, Sherry Shenoda, and Jeffrey Goldhagen, "Effects of armed conflict on child health and development: A systematic review," *PLoS One* 14, no. 1 (January 2019), <https://doi.org/10.1371/journal.pone.0210071>.
- 228 "Even in times of conflict children's rights are not optional," United Nations Human Rights Office of the High Commissioner, September 29, 2025, <https://www.ohchr.org/en/stories/2025/09/even-times-conflict-childrens-rights-are-not-optional>.
- 229 Kadir, Shenoda, and Goldhagen, "Effects of armed conflict on child health and development: A systematic review."
- 230 Raul Duarte, "How Armed Conflict Devastates Women's and Children's Health Globally: CID Faculty Research Insights," Harvard Center for International Development, last modified April 23, 2025, <https://www.hks.harvard.edu/centers/cid/voices/how-armed-conflict-devastates-womens-and-childrens-health-globally-cid-faculty>.
- 231 International Committee of the Red Cross, *Respecting and Protecting Health Care in Armed Conflicts and in Situations Not Covered by International Humanitarian Law*, (Geneva: ICRC, May 2012), https://www.icrc.org/sites/default/files/document/file_list/health-care-law-factsheet-icrc-eng.pdf.
- 232 World Health Organization, "Progress in Reducing Child Deaths Slows as 4.9 Million Children Die Before Age Five," World Health Organization, March 18, 2026, <https://www.who.int/news/item/18-03-2026-progress-in-reducing-child-deaths-slows-as-4.9-million-children-die-before-age-five>.
- 233 United Nations Inter-agency Group for Child Mortality Estimation, *Levels & Trends in Child Mortality: Report 2025* (New York City: United Nations Children's Fund, 2026), <https://data.unicef.org/resources/levels-and-trends-in-child-mortality-2025>.
- 234 World Health Organization, "Progress in Reducing Child Deaths Slows."
- 235 World Health Organization and World Bank, *Tracking Universal Health Coverage: 2025 Global Monitoring Report* (Geneva: World Health Organization and the International Bank for Reconstruction and Development/The World Bank, 2025), <https://www.worldbank.org/en/topic/universalhealthcoverage/publication/2025-global-monitoring-report-gmr>.
- 236 World Health Organization and World Bank, *Tracking Universal Health Coverage: 2025 Global Monitoring Report*.
- 237 World Health Organization, "Health Workforce," World Health Organization, accessed August 21, 2026, <https://www.who.int/health-topics/health-workforce>.
- 238 Merit Ibe, "Oye: Brain Drain Leaves Nigeria with Only 55,000 Doctors for 230m People," *The Sun Nigeria*, July 13, 2026, <https://thesun.ng/oye-brain-drain-leaves-nigeria-with-only-55000-doctors-for-230m-people/>.
- 239 World Health Organization, "WHO/UNICEF Report Highlights Gaps in Health Facility Sanitation," World Health Organization, August 18, 2026, <https://www.who.int/news/item/18-08-2026-who-unicef-report-highlights-gaps-in-health-facility-sanitation>.
- 240 World Health Organization, "WHO/UNICEF Report Highlights Gaps in Health Facility Sanitation."
- 241 World Health Organization, "WHO/UNICEF Report Highlights Gaps in Health Facility Sanitation."
- 242 U.S. National Library of Medicine, "Tetanus, Diphtheria, and Pertussis Vaccines," MedlinePlus, last updated August 13, 2024, <https://medlineplus.gov/tetanusdiphtheriaandpertussisvaccines.html>.
- 243 "Global Childhood Immunization Coverage Inches Forward Despite Conflict and Hesitancy," World Health Organization and UNICEF, July 15, 2026, <https://www.who.int/news/item/15-07-2026-global-childhood-immunization-coverage-inches-forward-despite-conflict-and-hesitancy---unicef--who>.
- 244 World Health Organization and UNICEF, "Global Childhood Immunization Coverage Inches Forward."
- 245 World Health Organization and UNICEF, "Global Childhood Immunization Coverage Inches Forward."
- 246 World Health Organization, "Household Air Pollution," World Health Organization, December 16, 2025, <https://www.who.int/news-room/fact-sheets/detail/household-air-pollution-and-health>.
- 247 "Impacts on Children Under Five," State of Global Air, accessed August 21, 2026, <https://www.stateofglobalair.org/hap/impacts-on-children>.
- 248 State of Global Air, "Impacts on Children Under Five."
- 249 Mike M. Mallah et al., *Open Manual of Surgery in Resource-Limited Settings, Management of Mass Casualty* (Kenya: AIC Kijabe Hospital, June 2023), https://www.vumc.org/global-surgical-atlas/sites/default/files/public_files/PDF/Mass%20Casualty%20.pdf.
- 250 Maurizio Bonati, "Child mortality following armed conflict: how long does it take to reduce to pre-conflict level?" *BMJ paediatrics open* 9, no. 1 (April 2025), <https://doi.org/10.1136/bmjpo-2025-003379>.
- 251 Bonati, "Child mortality following armed conflict: how long does it take to reduce to pre-conflict level?"
- 252 "Conflict Index," Armed Conflict Location & Event Data, last modified 2026, <https://acledata.com/series/acled-conflict-index>.
- 253 Armed Conflict Location & Event Data, "Conflict Index."
- 254 UNRWA, "UNRWA Situation Report #230 on the Humanitarian Crisis in the Gaza Strip and the Occupied West Bank, including East

Jerusalem," UNRWA, last modified July 16, 2026, <https://www.unrwa.org/resources/reports/unrwa-situation-report-230-humanitarian-crisis-gaza-strip-and-occupied-west-bank>.

255 "Surviving childhood under occupation – The catastrophic harm facing Palestinian children [EN/AR]," Office of the United Nations High Commissioner for Human Rights (OHCHR), June 12, 2026, <https://www.un.org/unispal/document/surviving-childhood-under-occupation-the-catastrophic-harm-facing-palestinian-children-en-ar/>.

256 Office of the United Nations High Commissioner for Human Rights (OHCHR), "Surviving childhood under occupation – The catastrophic harm facing Palestinian children [EN/AR]."

257 "Occupied Palestinian Territory: WHO Health Emergency Appeal 2026," World Health Organization (WHO), February 2, 2026, <https://www.un.org/unispal/document/occupied-palestinian-territory-who-health-emergency-appeal-2026/>.

258 World Health Organization (WHO), "Occupied Palestinian Territory: WHO Health Emergency Appeal 2026."

259 Armed Conflict Location & Event Data, "Conflict Index."

260 Rebecca Sers, "Child health and wellbeing in Ukraine," *The Lancet* 408, no. 10551 (July 2026): 202-204, [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(26\)01421-2/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(26)01421-2/fulltext).

261 Maryanne Buechner, "Under Fire and Freezing: Children in Ukraine Need Help," United Nations Children's Fund, last modified January 21, 2026, <https://www.unicefusa.org/stories/under-fire-and-freezing-children-ukraine-need-help>.

262 Buechner, "Under Fire and Freezing: Children in Ukraine Need Help."

263 Sers, "Child health and wellbeing in Ukraine," 202-204.

264 "Democratic Republic of the Congo," Humanitarian Action, last modified November 30, 2022, <https://humanitarianaction.info/article/democratic-republic-congo-0>.

265 Tshimbombu, Tshibambe Nathanael et al., "Demographic and Clinical Factors Affecting Pediatric Survival in South Kivu, the Democratic Republic of the Congo," *The American journal of tropical medicine and hygiene* 108, no. 1, (November 2022): 231-234, <https://doi.org/10.4269/ajtmh.22-0455>.

266 "Mortality rate, infant (per 1,000 live births) - Congo, Dem. Rep.," World Bank Group, last modified 2024, <https://data.worldbank.org/indicator/SP.DYN.IMRT.IN?locations=CD>.

267 "Is climate change increasing the risk of disasters?" World Wildlife Fund, last accessed July 16, 2026, <https://www.worldwildlife.org/resources/explainers/is-climate-change-increasing-the-risk-of-disasters/>.

268 Sudhanshu Malhotra, "Climate emergencies photos of 2026 so far," Greenpeace, last modified April 14, 2026, <https://www.greenpeace.org/international/story/82686/climate-emergencies-photos-of-2026-so-far/>.

269 "Frequently Asked Questions," National Safe Haven Alliance, accessed July 17, 2026, <https://www.nationalsafehavenalliance.org/faq>.

270 Steven R. Roeser, "Safe Haven Laws – A Safe Place to Leave a Newborn," SS&R Law Corporation, accessed July 17, 2026, <https://stimmel-law.com/articles/safe-haven-laws-safe-place-leave-newborn/>.

271 Mariana Timler, Elyse Gaitan, and Tessa Cox, "Safe Haven Laws: A Primer," Charlotte Lozier Institute, last modified October 15, 2025, <https://lozierinstitute.org/safe-haven-laws-a-primer/>.

272 Timler, Gaitan, and Cox, "Safe Haven Laws: A Primer."

273 Clare Chapman, "Italy introduces 'baby boxes' to save lives of abandoned newborns," *BMJ* (Clinical research ed.) 332, no. 7537 (2006): 322, <https://doi.org/10.1136/bmj.332.7537.322-b>.

274 Angela Harmon, "Domestic violence shelter," EBSCO, last modified 2020, <https://www.ebsco.com/research-starters/politics-and-government/domestic-violence-shelter>.

275 Angela Harmon, "Domestic violence shelter."

276 Yusra Ribhi Shawar and Jeremy Shiffman, "Global priority for the care of orphans and other vulnerable children: transcending problem definition challenges," *Globalization and health* 19, no. 1 (October 2023), <https://doi.org/10.1186/s12992-023-00975-0>.

277 Shawar and Shiffman, "Global priority for the care of orphans and other vulnerable children: transcending problem definition challenges."

278 "Children in alternative care," United Nations Children's Fund, accessed July 17, 2026, <https://www.unicef.org/protection/children-in-alternative-care>.

279 United Nations Children's Fund, "Children in alternative care."

280 United Nations Inter-Agency Group for Child Mortality Estimation (UN IGME), "Levels and trends in child mortality," United Nations Children's Fund, last modified March 24, 2025, <https://data.unicef.org/resources/levels-and-trends-in-child-mortality-2024/>.

281 United Nations Inter-Agency Group for Child Mortality Estimation, "Levels and trends in child mortality."

282 United Nations Inter-Agency Group for Child Mortality Estimation, "Levels and trends in child mortality."

283 Natalie Sherman, "A year on: Four ways Trump's tariffs have changed the global economy," BBC, last modified April 2, 2026, <https://www.bbc.com/news/articles/c79j1rd92ypo>.

284 World Health Organization, "Accessing Essential Health Services in Fragile, Conflict-Affected and Vulnerable Settings," accessed September 22, 2026, <https://www.who.int/activities/accessing-essential-health-services-in-fragile-conflict-affected-and-vulnerable-settings>.

285 World Health Organization, "Accessing Essential Health Services."

286 World Health Organization, "Accessing Essential Health Services."

287 USA for UNHCR, "Emergencies," accessed September 22, 2026, <https://www.unrefugees.org/emergencies/>.

288 M. Rodwan Abouharb and Sean Watts, "Infant Mortality and the Law of War: Accounting for War's Impact on the Most Vulnerable," Lieber Institute, last modified May 17, 2023, <https://lieber.westpoint.edu/infant-mortality-law-war-accounting-wars-impact-most-vulnerable/>.

289 "The protection of hospitals during armed conflicts: What the law says," The International Committee of the Red Cross, accessed July 17, 2026, <https://www.icrc.org/en/document/protection-hospitals-during-armed-conflicts-what-law-says>.

290 Birke Bogale et al., "Health System Strengthening in Fragile and Conflict-Affected States: A Review of Systematic Reviews," *PLOS ONE* 19, no. 6 (June 2024): e0305234, <https://doi.org/10.1371/journal.pone.0305234>.

291 Hannah Ritchie, "Where in the world are babies at the lowest risk of dying?" Our World in Data, last modified May 12, 2025, <https://ourworldindata.org/where-are-babies-at-lowest-risk-of-dying>.

292 "How three countries lowered their child mortality rates," United Nations Children's Fund, last modified March 23, 2026, <https://www.unicef.org/eca/stories/how-three-countries-lowered-their-child-mortality-rates>.

293 United Nations Children's Fund, "How three countries lowered their child mortality rates."

294 World Health Organization, "WHO Urges Scale Up of Newborn Screening to Improve Early Detection and Care of Birth Defects," news release, June 23, 2026, <https://www.who.int/news/item/23-06-2026-who-urges-scale-up-of-newborn-screening-to-improve-early-detection-and-care-of-birth-defects>.

295 World Health Organization, *Global Strategy on Digital Health 2020–2027* (Geneva: World Health Organization, 2025), <https://iris.who.int/server/api/core/bitstreams/a64d584f-015b-471f-9d86-9ea263cfb516/content>.

296 Daniel Mahadzir and Natasha Tai, "Health Sovereignty Builds Resilience in a Volatile World: Here Are 3 Countries Working towards It," World

-
- Economic Forum, March 21, 2025, <https://www.weforum.org/stories/2025/03/health-sovereignty/>.
- 297 James J. Abbas et al., "Improving Health-Care Delivery in Low-Resource Settings with Nanotechnology: Challenges in Multiple Dimensions," *Nanobiomedicine* 4 (March 2017): article 1849543517701158, doi.org/10.1177/1849543517701158.
- 298 Mahadzir and Tai, "Health Sovereignty Builds Resilience."
- 299 Ariana Wang, "Health Reforms in Uganda," The Borgen Project, July 22, 2025, borgenproject.org/health-reforms-in-uganda/.
- 300 Wang, "Health Reforms in Uganda."
- 301 Kerry Cullinan, "Developing Countries Unite over Need for Binding Contracts with Pharma at Pandemic Talks," *Health Policy Watch*, September 14, 2026, healthpolicy-watch.news/developing-countries-unite-over-need-for-binding-contracts-with-pharma-at-pandemic-talks/
- 302 Doctors Without Borders/Médecins Sans Frontières, "Children's Health," updated March 25, 2026, <https://www.doctorswithoutborders.org/what-we-do/focus/child-health-initiatives>.
- 303 Rural Health Information Hub, "Healthcare Access in Rural Communities," last reviewed November 8, 2024, <https://www.ruralhealthinfo.org/topics/healthcare-access>.
- 304 United Nations Academic Impact, "We Are Indigenous: 'Culture Meets Care' Essential for Indigenous Healthcare and Revitalization," accessed September 22, 2026, <https://www.un.org/en/academic-impact/we-are-indigenous-%E2%80%98culture-meets-care%E2%80%99-essential-indigenous-healthcare-and>.
- 305 "Commission on Population and Development," United Nations, accessed July 25, 2026, <https://www.un.org/development/desa/pd/content/CPD>.
- 306 United Nations, "Commission on Population and Development."
- 307 "International Conference on Population and Development," United Nations Population Fund, accessed July 25, 2026, <https://www.unfpa.org/icpd>.
- 308 Programme of Action - Adopted at the International Conference on Population and Development (ICPD), (Cairo: United Nations Population Fund, September 5-13, 1994), https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf.
- 309 United Nations, "Commission on Population and Development."

The National High School Model United Nations Conference (NHSMUN) is a project of IMUNA, a non-profit organization formally associated with the United Nations Department of Global Communications (UNDGC). IMUNA is dedicated to promoting global issues education through simulation.

© 2026 IMUNA. All Rights Reserved.

