

2026 Mid-South Model UN Conference



UN Women

Chairs: Max Luo, Hannah Pankey, Nisha Chhetri

Letter from the Chairs

Dear Delegates,

Welcome to the 2026 Mid-South Model United Nations Conference (MSMUN) and to the UN Women Committee. My name is Max Luo, and I will be one of your 2026 UN Women chairs. I am a freshman planning to major in Economics. Hannah Pankey and Nisha Chhetri will also be chairing UN Women with me. Nisha is a freshman planning to major in Data Analytics and International Studies.

We are all very excited to chair the UN Women committee. The 2022-2026 Strategic Plan for UN Women aims to achieve gender equality and empower women and girls worldwide. Therefore, the topic we will be discussing this year is Access to women's healthcare and addressing the issue of violence against women.

We look forward to meeting all of you at the conference and hope that these issues will inspire debate and cooperation. Please do not hesitate to email the chairs if you have any questions.

Regards,

Max

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Introduction to the Committee

The United Nations Women Committee is dedicated to the equality and empowerment of women and girls across the world. Our important work focuses on examining women's rights questions and working to amend them.

UN Women was founded in 2010 by the General Assembly as the UN Entity for Gender Equality and the Empowerment of Women. Our work enforces and promotes the ideal of equal participation, which ought to be enjoyed by the entirety of the international community, regardless of gender. These include women's ability to lead, participate, and benefit equally from governance systems, women's ability to have income security and work and economic autonomy, women and girls' ability to live a life free from violence, and women's ability to have a greater influence in building sustainable peace and resilience and equally benefit from the prevention of natural disasters, conflicts, and humanitarian action. We seek to design equal settlements for these issues in the international community, initiating studies to encourage cooperation and popularize equality for all.

The Committee discusses questions relating to the advancement of women, their fundamental rights, and their right to equality.

Introduction to the Topics

Access to Women's Healthcare:

1. History and past actions

Before the mid-20th century: Women's health was mainly equated with 'maternal and reproductive care,' with the sole goal of reducing maternal mortality. The right to health was not recognized as an independent right.

International consensus in the 1990s: The 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing were key turning points. The concept of 'sexual and reproductive health and rights' was formally proposed, recognizing that women have the right to control their own bodies, access contraception information and services, and enjoy safe pregnancy and childbirth.

Framework established in the 21st century: Through various United Nations resolutions and the emphasis of the Convention on the Elimination of All Forms of Discrimination Against Women, women's health rights were incorporated into mainstream international human rights law. The Millennium Development Goals and Sustainable Development Goals (Goals 3 and 5) set specific and measurable global indicators, such as reducing maternal mortality.

2. Current Situation

Progress: Since 1990, the global maternal mortality rate has decreased by about 38%. More women have access to family planning services and prenatal care.

Ongoing Challenges:

Inequality: Progress is extremely uneven. Maternal mortality rates in the least developed countries are dozens of times higher than in high-income countries.

Narrow scope: Resources are still overly concentrated on maternal health care, with insufficient investment in women's health needs across the life course (such as mental health, non-communicable diseases, menopause care, and cancer screening).

Systemic barriers: Health systems exhibit gender bias, neglecting women's

specific symptoms and experiences; although the proportion of female health workers is high, few hold leadership positions.

3. Problems should be addressed

- 1) How can we go beyond the 'maternal' framework and establish a comprehensive health service system covering the entire lifecycle of women (adolescence, reproductive age, menopause, and old age)?
- 2) How can we persuade governments and donors to provide sustained funding for 'non-emergency' but quality-of-life-impacting women's health issues (such as endometriosis and chronic pain)?
- 3) How can we eliminate gender bias in medical research and clinical practice? How can we increase women's representation in health decision-making roles?
- 4) How can we ensure that women's health services (such as safe childbirth and contraception) are not interrupted during humanitarian crises and conflicts?

Addressing the Issue of Violence Against Women:

1. History and past actions

Long considered a private matter: Historically, violence against women (especially domestic violence) was often regarded by law and society as a 'family private matter,' with no intervention from the state.

Breakthrough in the 1990s: The Beijing Platform for Action was the first to clearly define 'violence against women' as a serious human rights violation, calling on countries to take action. Since then, global advocacy movements such as the '16 Days of Activism against Gender Violence' have emerged.

Legal framework in the 21st century: Many countries have enacted anti-domestic violence laws. The United Nations has passed multiple resolutions addressing gender-based violence and violence in conflict. The International Criminal Court has classified rape as a war crime and a crime against humanity.

2. Current Situation

Prevalence: About one-third of women worldwide experience physical or sexual violence in their lifetime. Most perpetrators are intimate partners.

Varied forms: In addition to domestic and sexual violence, digital violence, human trafficking, and harassment in public spaces are increasingly gaining attention.

Weak response systems:

Gap between law and practice: Many countries have laws, but enforcement is weak, judicial processes are lengthy, and survivor support services are insufficient.

Extremely low reporting rates: Due to stigma, fear of retaliation, and distrust of the justice system, most incidents of violence go unreported.

Lack of prevention: Resources are mainly directed toward post-incident responses rather than addressing the underlying social norms and gender power relations that fuel violence.

3. Problems should be addressed

- 1) How can we intervene at the source and change social norms favoring boys over girls through education, mass media, and community mobilization?
- 2) How can the judicial system be reformed to be more survivor-friendly and efficient (e.g., by establishing specialized courts, and training police and judges)?
- 3) How can barriers between social welfare, police, healthcare, housing, and other sectors be broken down to provide survivors with seamless 'one-stop' services?
- 4) How can laws be created and enforced to tackle online harassment and digital violence? How can human trafficking be more effectively combated in global supply chains?
- 5) How can refugee and displaced women be better protected, and how can post-conflict justice and compensation be ensured?

An Insight into the Topics

Breaking the Cycle: Building an Integrated Framework to End Violence and Promote Women's Comprehensive Health Rights

One in three women worldwide experiences physical or sexual violence. It is not only a health crisis—leading to immediate and long-term physical, sexual, and mental consequences—but also a major barrier preventing women from accessing routine healthcare and maternal services. The chair noticed the traditional separation between 'violence response' and the 'healthcare system,' therefore, looking forward to an integrated strategy that encompasses prevention, response, and empowerment.

An Indivisible Connection: How Violence Becomes the Opposite of Health

Violence against women is far from being an isolated social ailment; in essence, it is an epidemic and a systemic mechanism of health rights deprivation. Its impact manifests in two mutually reinforcing dimensions:

1. Direct health consequences: From trauma and sexually transmitted infections to depression and suicidal tendencies, violence constitutes a complete 'pathological spectrum.'
2. Systemic medical exclusion: Fear, shame, and the control exerted by perpetrators often prevent women from attending routine prenatal check-ups, obtaining contraceptives, or receiving the HPV vaccine. A woman who fears being tracked by her partner at a clinic will never prioritize her own breast health screening. Therefore, the healthcare system must not only serve as a 'repair station' for the consequences of violence but also act as an 'outpost' for preventing violence and a 'safe harbor' that empowers women with autonomy.

At the Fusion of Healthcare and Violence Prevention, What to Consider

1. **Integrated Services:** How can violence investigation and support (such as identifying signs, providing safety plans, and psychological support) be systematically incorporated into all healthcare institutions? Or can we? What are the challenges?
2. **Data and Evidence:** How can a unified data collection system be established to track both incidents of violence and their long-term impact on women's health, in order to inform policy?
3. **Training and Capacity Building:** How can standardized training be provided to healthcare workers to equip them with the skills to identify violence, conduct respectful inquiries, and provide safe referrals?

Topic Guide

1. What are your country's main domestic challenges in addressing "Gender-Based Violence" or "Women's Healthcare"? (e.g., legal barriers, health system capacity, social stigma)?
2. How do you think UN Women should promote the integration of national budgets and data systems for "anti-violence" or "women's health"? Please provide specific indicators.
3. How should an ideal camp clinic for refugee women with integrated violence prevention and health services work? How is it different from a regular community clinic?
4. When driving an integrated framework, will you prioritize seeking alliances with the World Health Organization, UNHCR, or local women's rights organizations? Why?

Resources

https://en.wikipedia.org/wiki/UN_Women

[Welcome | UN Women – Headquarters](#)

[UN Women Strategic Plan 2022–2025 | Digital library: Publications | UN Women – Headquarters](#)

[What we do: Ending violence against women | UN Women – Headquarters](#)

List of Countries

- **Afghanistan:** Women's access to reproductive healthcare has been almost entirely erased, with bans on female health workers dismantling the system. Violence against women is state-sanctioned and systematic, with survivors facing punishment instead of protection. There are no functional legal or support services to address either crisis under the current regime.
- **Brazil:** Has expanded women's healthcare access but struggles with high rates of femicide and domestic violence. Government representation for women remains low.
- **China:** Has improved women's education and workforce participation but contends with a significant wage gap, underrepresentation in leadership, and emerging debates over reproductive rights.
- **Denmark:** Leading in women's rights in healthcare, workplace equality, and political participation. Has well-funded shelters and integrated social services for survivors of violence.
- **Finland:** Strong public healthcare system with a focus on women's holistic health, low adolescent birth rates, and proactive national programs to prevent domestic violence.

- **France:** Excellent healthcare system and strong laws against violence, but lags in economic and property rights equality for women.
- **Indonesia:** Access to maternal healthcare has improved, but comprehensive reproductive rights and contraception access are limited and uneven. Violence against women is widespread, and while a legal framework exists from 2004, enforcement is weak and support services are underfunded.
- **Iran:** Strict laws control women's bodies and dress. Access to reproductive healthcare is politicized, and reporting gender-based violence is difficult due to legal and social barriers.
- **Mexico:** High women's political representation contrasts with high adolescent birth rates and severe issues of femicide and gender-based violence. Access to abortion is limited and varies by region.
- **New Zealand:** Has made significant legislative strides to combat gender-based violence, though wage gaps persist. Provides good access to reproductive healthcare services.
- **Norway:** Known for high women's political representation, comprehensive sexual education, accessible reproductive healthcare, and robust legal frameworks against gender-based violence.
- **Russia:** Has made some progress in reproductive health metrics, but women's political representation is low, and domestic violence was recently decriminalized in its first instance, representing a major setback.
- **Saudi Arabia:** While some reforms have been made, guardianship laws severely restrict women's autonomy, access to healthcare without male permission, and ability to report violence. Reproductive rights are limited.
- **Somalia:** The country has one of the world's highest maternal mortality rates due to a near-total collapse of accessible healthcare infrastructure. Violence against women, including sexual violence used as a weapon of war, is endemic and occurs with almost complete impunity. There are no effective national legal, health, or social systems to protect survivors or provide post-violence care.

- **Sweden:** A global leader in gender equality. Has implemented integrated policies linking healthcare and violence prevention, offers generous parental leave, maintains low maternal mortality, and has strong support systems for survivors.
- **Syria:** Amid conflict, women face extreme violence and shattered healthcare systems. Reproductive care is inconsistent, and support for survivors is virtually nonexistent in many regions.
- **United Kingdom:** Has strong healthcare access and violence prevention frameworks, but struggles with disparities in unpaid domestic labor and recent pressures on reproductive rights in Northern Ireland.
- **United States:** Very high maternal mortality rates (especially for women of color), political polarization over reproductive rights, and uneven access to healthcare. Strong civil society response to violence, but legal enforcement varies widely by state.
- **Zimbabwe:** Has promoted reproductive healthcare initiatives but faces high rates of violence against women and low political representation. Enforcement of laws is weak.