UCIMUN 2025

UNIFEM

Background Guide

By: Sydney Nguyen

Greetings Delegate,

Welcome to the 33rd annual UCIMUN Conference! My name is Sydney Nguyen, and I am so excited to be the Director of the UNIFEM Committee, otherwise known as the United Nations Development Fund for Women. I served 4 times as Director of MUN committees during my junior and senior years of high school. This will be my second year a part of MUN at UCI as I previously served as an Assistant Director for a crisis committee. Throughout the 6 years of my MUN journey, I have been in your shoes as a high school delegate at 12 conferences across Orange County, UC Berkeley, Brown University, and Rutgers University. Being in your position before, I know things may be a little nerve-wracking, but I can assure you that I will be here to support you along the way as we create a dynamic and collaborative environment for debate!

I am a second second-year student at UCI in the honors program, and my major is Biological Sciences. On campus, I am involved in a variety of culture clubs, as well as clubs focused on community service and volunteering. Outside of school, I've been playing the piano for 13 years. More recently, I have really enjoyed finding and trying cute local cafes, especially those that have strawberry matcha drinks. I live in Huntington Beach and especially love going to the beach, riding bikes at the beach, watching sunsets, and PCH drives.

Our first committee topic (*Measures for Protecting Maternal Health in Crisis Settings*) opens the floor to discussions on prioritizing women's prenatal care during all pregnancy stages and ensuring safe delivery during emergencies such as armed conflicts and natural disasters. Our second topic (*Addressing the Burden of Unpaid Care and Domestic Work on Women and Girls*) The theme at our conference is "Advancing upon the global issues of our community," and considering half our world is women, these topics are of particular significance in our world today. It is essential to break down these systemic barriers so that women can fully advance and thrive within their communities.

Remember, this topic synopsis is just a starting point for you to reference as you embark on your research journey. I encourage you to conduct further research in order to really gain a comprehensive understanding of the two topics, your country's policy, and possible solutions!

I look forward to hearing about your innovative solutions, seeing your different research perspectives, and watching you learn and grow as a researcher, debater, and writer throughout the conference. Please do not hesitate to email me if you have any questions. I cannot wait to meet you all in April!

Best,

Sydney Nguyen

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Topic A: Measures for Protecting Maternal Health in Crisis Settings

Introduction

Pregnancy and childbirth do not stop in times of crisis, and neither should access to timely, quality maternal care. Protecting maternal health is one thing, but protecting maternal health specifically in crisis settings is another. The topic is particularly relevant as there are numerous urgent crises in our world today. For instance, Palestine faces forced displacement and famine risks due to ongoing conflict and occupation, while Ukraine faces danger and destroyed infrastructure due to the war with Russia and military aggression. In addition, disasters such as the recent earthquake in Haiti or forced displacements such as the refugee crisis after the conflict in Myanmar continue, posing challenges for humanitarian aid. Furthermore, the earthquakes of February 2023 in Syria brought destruction to a country that has already been hit by displacement, epidemics, and a pandemic on top of the refugee crisis (*8 Crises*, 2024). Even extreme weather events such as wildfires and floods are getting more extreme and frequent in all areas of the world. In such crisis settings, pregnant women receive suboptimal nutrition and have limited access to quality maternal care. Conflict and crises weaken health systems as essential health resources are depleted, leading to alarmingly high rates of maternal and newborn mortality (*Maternal and Newborn Health*, 2023).

Countries affected by a humanitarian crisis or fragile conditions account for almost 2 in 3 (61%) cases of maternal deaths (*Maternal Mortality*, 2015). More historically, 50% of all maternal deaths in 2008 were in only six countries. These countries were India, Nigeria, Pakistan, Afghanistan, Ethiopia, and the Democratic Republic of the Congo, and they were all largely conflict or post-conflict states (Hogan, 2010). In 2015, the number of maternal deaths in

the 35 countries affected by a humanitarian crisis or fragile conditions was estimated at 185,000, which was 61% of the global estimate of maternal deaths. This translates to an estimated ratio of 417 maternal deaths per 100,000 live births in crisis settings, compared to the global estimate of 216 maternal deaths per 100,000 live births (*Maternal Mortality*, 2015).

Description of the Topic

Defining Maternal Health and Crisis Settings

According to the World Health Organization (WHO), the concept of maternal health is more centered around the health of women during pregnancy, childbirth, and the postpartum period. Maternal health is promoted through access to services such as antenatal care, skilled birth attendance, emergency obstetric care, postnatal care, and comprehensive maternal and newborn immunization services. All together, these services reduce the risk of maternal and neonatal morbidity and mortality (Vogel, 2014). Maternal injuries and deaths are often directly linked to excessive blood loss, infection, high blood pressure, unsafe abortion, and obstructed labor, as well as indirectly linked to anemia, malaria, and heart disease (*Maternal Health*). The main focus of this topic is to ensure the well-being of women and their babies, as well as guarantee that they reach their full potential of health during a crisis. Successful maternal health care should not be defined by simply surviving pregnancy and childbirth. Instead, it should be focused on reducing maternal injury, promoting health and well-being, and making the process an overall positive experience. The International Conference on Population and Development defines reproductive health as a state of complete physical, mental, and social well-being, not limited to only the absence of disease or weakness (Chi, 2015).

In crisis settings, public health, infrastructure, and delivery of maternal care are often greatly reduced and in danger. A humanitarian crisis can be understood as "a situation in which there is an exceptional and generalized threat to human life, health or subsistence. These crises usually appear within the context of … a series of pre-existent factors (poverty, inequality, lack of access to basic services) exacerbated by a natural disaster or armed conflict, multiply[ing] the destructive effects." There are also complex political emergencies, which are man-made crises in situations of violence. Humanitarian crises often include armed conflicts and even natural disasters that cause human fatalities, forced displacement, epidemics, and famine (Francesch, 2010, p. 111).

One of the first models to assess causes of maternal deaths is the Three Delays Model, which highlights three major delays that contribute to maternal mortality. Phase 1 shows a delay in deciding when to seek care. This is followed by Phase 2 with a delay in identifying and reaching a health facility. Lastly, Phase 3 includes a delay in receiving appropriate care and treatment once in a facility. Socioeconomic and cultural factors, accessibility of facilities, and quality of care are all factors that affect the outcome of these phases and delays. These main causes and delays of maternal morbidity and mortality are severely worsened during a crisis, leading to increased mortality rates. For example, it is well known that in emergency settings, access to basic health care services such as obstetric care – management of both normal and complicated pregnancies as well as the delivery and postpartum periods – is extremely limited and difficult to obtain. In crisis settings, hygiene and sanitation is severely disrupted and coupled with poor access to nutritious foods. These inadequacies are directly or indirectly translated into increased obstetric risk, diseases, and poor dietary intake – both dangerous for the mother and child (Chi 2015).

Key Restrictions to Maternal Health During Emergency Situations

According to the United Nations Population Fund, humanitarian crises increase womens' risk of poor health due to a sudden loss of medical support, reduced access to information and essential services, massive population displacement, trauma, malnutrition, disease, and exposure to violence. During emergency situations, women have limited or no access to reproductive health services such as prenatal care, assisted delivery, and emergency childbirth care. As a result, more pregnancies are left unsupported with proper care, leaving women in unbearable and life-threatening conditions. Humanitarian emergencies disrupt the effectiveness of health systems, often being associated with poor leadership and governance (Chi, 2015). By 2017, conflict-affected and fragile countries had the highest maternal mortality rates, specifically in South Sudan, Chad, Afghanistan, Central African Republic, and Somalia. The COVID-19 pandemic and Ebola virus disease outbreaks added on top of these crisis zones (Amsalu, 2022).

During crises, there is typically a lack of infrastructure for delivering health services, including facilities, workers, equipment, supplies, medicine, vaccines, and technology. In some cases, health facilities even get destroyed from bombings, and senior health personnel might flee the area or get killed. In 2011, the International Committee of the Red Cross reported that violent, lethal attacks on patients, healthcare workers, facilities, and medical vehicles are common in conflict settings, threatening women's access to maternal health care during crises.

Hygiene and sanitation are also severely disrupted, and people have poor access to nutritious foods for a healthy intake during a crisis. In areas of conflict or emergency disasters, there is constant destruction, devastating hygiene and sanitation. Water and sanitation systems are often vulnerable to attack during conflict. With a shortage of potable water or adequate

sanitation and hygiene facilities, women already suffering from malnutrition and weakened immune systems become even more susceptible to water-borne diseases. Crisis settings experience supply chain disruptions and delays in deliveries due to the danger and difficulty of transportation to these areas.

Regions experiencing a crisis see catastrophic increases in physical and sexual violence, leading to unintended and unwanted pregnancies. This increases unsafe abortions that jeopardize the health of women who are already in dangerous situations during crises. Out of the five leading causes of maternal mortality (severe bleeding, infections, high blood pressure during pregnancy, complications from delivery, and unsafe abortions), unsafe abortions is the only one that can be entirely prevented – with adequate maternal health services. Coercion and exploitation tend to thrive in humanitarian crisis settings; desperation can lead people to engage in sex work for survival or fall victim to traffickers. While a 2022 UNFPA report estimated that half of all pregnancies are unintended, this rate increases catastrophically during a humanitarian crisis. Contraceptive services and sexual and reproductive health care are much harder to come across in crisis settings, so women and girls are less able to control their fertility. In 2015, UNFPA estimated that more than 60% of all maternal deaths occur in conditions of scarce access to life-saving health services, which is particularly prominent in fragile crisis settings (*Risk of Sexual*, 2022). Furthermore, the stresses of conflict heighten women's vulnerability to gender-based violence, including sexual violence and intimate partner violence. Survivors of intimate partner violence are twice as likely to report experiencing an unintended pregnancy. In general, unintended pregnancies are correlated with greater health risks to women – higher maternal death rates and worse health and economic situations for families. Pregnancies that result from sexual violence also have social and psychological effects on women. Dr. Wato

Chuol, who works with the International Medical Corps, a UNFPA partner, recalls, "We delivered a lady who refused to touch her newborn at our health facility…she seemed unhappy about seeing the newborn. Later on, we discovered that her pregnancy resulted from sexual assault" (*Risk of Sexual*, 2022).

United Nations Involvement

Over the past decade, in partnership with the WHO, UNICEF, and UNFPA, UN Women has carried out joint programs in West and Central Africa (Chad, Guinea, Mali, Niger, Togo, and more). The program promotes funding in addition to training midwives and community health workers. Each country office worked in partnership with local NGOs, civil society, UN agencies, and government departments to promote sexual reproductive health and family planning. For instance, the Women and Reproductive Health Unit and UNFPA Global Midwifery Strategic Plan (2017-2020) trained 120 new coach midwives in Burkina Faso. In theory, a midwife's work is from conception to childbirth, but in reality, they often continue working with new mothers after the baby is born. They encourage mothers to breastfeed exclusively up to 6 months and recommend at least a 2 year break between pregnancies. In West and Central Africa, UNFPA supported more than 3,000 obstetric fistula repair surgeries and trained nearly 10,000 health care providers. As of 2015, UNFPA's efforts in West and Central Africa were estimated to have saved almost 9,000 women from dying in or from childbirth, 600,000 unsafe abortions, and prevented more than 2 million unintended pregnancies (Adeniyi, 2016). With more community nurses and access to family planning commodities, women and girls in remote areas are better prepared and supported. This greatly improved the access to and quality of maternal care for women. UNICEF

even developed a conditional cash transfer program in India in order to attract women to safely deliver in health facilities, reducing maternal deaths.

On December 10, 2021, the UN General Assembly immediately adopted five humanitarian aid draft resolutions in response to the crises of COVID-19, conflicts, and climate change, aiding women and children in these contexts (*General Assembly*, 2021). Resolution 75/127, adopted by the General Assembly on December 11, 2020, focuses on strengthening the coordination of emergency humanitarian assistance, which ensures that women and children are protected. This resolution encourages countries to guarantee that women have access to basic healthcare services, mental health and psychosocial support, and all necessary assistance to prevent mortality and morbidity from occurring in humanitarian crises. Resolution 75/125 was also adopted by the General Assembly the same day, discussing the safety and security of humanitarian personnel. When the transportation of these personnel, along with their supplies and equipment, are safe and unhindered, women's maternal health can be protected. In other words, when humanitarian personnel and their supplies are readily available, they are able to provide women with the necessary maternal health services. On July 14, 2021, the Human Rights Council adopted Resolution 47/25, urging all countries to eliminate preventable maternal mortality and morbidity by ensuring the availability, accessibility, and quality of healthcare services, even during crises.

Case Study

In March 2022, a Russian missile struck a maternity and children's hospital in Mariupol, Ukraine, leaving staff and patients (including children), trapped under the rubble. At that time, there were around 120,000 "displaced pregnant women in and around Ukraine" and around 18,000 "in need of emergency obstetric interventions" (Schroeder, 2022). During the conflict,

women are at risk of being cut off from quality maternal health. Some have even given birth in bomb shelters, where there may be no basic supplies for safe births or skilled medical personnel (Schroeder, 2022). The Russia-Ukraine War has left a devastating impact on Ukraine's hospital system. Researchers from Rutgers University and international collaborators have tracked the healthcare systems in these crisis zones, specifically regions impacted by combat. Since Russia's invasion in February of 2022, hundreds of hospitals in Ukraine have been forced to close or operate at reduced capacity due to the destruction and supply shortages. Before Russia's invasion, about 720 hospitals were operating in Ukraine, but by April 2023, this number dropped to 450 hospitals (Hoyt, 2024). Ubydul Haque, lead author of this study, states, "The war has devastated Ukraine's hospital system, leaving it ill-equipped to meet the needs of a population in crisis."

Maternal and newborn health in Ukraine was negatively affected due to the decrease in availability of essential services including ambulances, defibrillators, ventilators, hospital beds, and intensive care unit beds. The disruptions in supply chains took a toll on essential equipment and pharmaceuticals. Hospitals experience shortages of laboratory test kits, delays in delivery of crucial medications, medication storage problems caused by power outages, reductions in staff numbers, and increased hours that hospital staff have to work. The Rutgers researchers found that there was a 13% reduction in the number of hospitals offering laboratory testing, a 26% reduction in gynecological services, and 25% reduction in pharmacy services, which are all important for maternal health care. The study reported the war reducing access to vaccines. This can lead to higher incidences of infectious diseases, putting pregnant women and their babies at risk (Hoyt, 2024).

Bloc Positions

No-Crisis Bloc

In this bloc, people of these countries are overall able to meet basic needs such as food, health, shelter, and cleanliness. Although there may be some needs, shortages, or accessibility issues, they are not life-threatening (*Inform*, 2019). For the most part, these countries are not actively experiencing crises such as natural disaster emergencies or armed conflicts. These nations typically have stable governance, functioning economies, and infrastructure that supports the general well-being of their populations. Social safety nets and public systems often play a role in mitigating risks and addressing minor disruptions efficiently.

Acute Emergencies/Stressed Humanitarian Conditions Bloc

In this bloc, countries might have localized or targeted incidents of violence or human rights violations. Basic needs may be higher but are still not life-threatening. In other cases, people might face some shortages, availability, or accessibility problems in regard to basic services on a level that causes discomfort or on a high level of suffering, but the conditions might not be life-threatening. There may be significant service gaps and populations facing malnutrition or physical and mental harm. In these areas, there might be a call for humanitarian assistance (*Inform*, 2019).

Emergency/Severe Crisis Bloc

Large populations of countries in this bloc may face life-threatening conditions and significant shortages, availability, or accessibility problems, leading to high levels of suffering and irreversible damage. Severe food consumption gaps are present, and people face extreme losses of assets. In these countries, individuals often rely on desperate measures to survive, such

as selling remaining possessions, engaging in unsafe labor, or resorting to migration, further exacerbating their vulnerabilities.

Under more extreme humanitarian conditions, people in these countries may face extreme shortages, availability, and accessibility problems regarding basic services. There is widespread mortality, a complete lack of food, and starvation may be likely. Basic needs are not being met. There may be high levels of acute malnutrition and the presence of irreversible harm, including widespread grave violations of human rights and excess mortality. Humanitarian assistance is absolutely needed (*Inform*, 2019). Such dire circumstances may lead to the collapse of social structures, as well as the breakdown of healthcare, education, and legal systems, leaving communities in a state of prolonged instability and crisis.

Recovery or Post-Crisis Bloc

This bloc consists of countries that have a history of crises, and some may still be in a crisis but on the road to recovering from recent crises. They may be coming out from armed conflicts or natural disaster emergencies. Others might have already recovered from a crisis and can lend a helping hand with previously being in similar situations. These nations often share a deep understanding of resilience and the challenges of rebuilding societies and economies. Their experiences enable them to offer unique perspectives and strategies for recovery and growth. Additionally, their collective efforts can foster stronger regional cooperation, ensuring that future crises are met with coordinated and effective responses.

Committee Goals

The goal of this UNIFEM committee is to bring forth original, innovative solutions that

can be key to protecting maternal health in crisis settings. Solutions, both short-term and long-term solutions, should be well thought out with details on implementation. Delegates are highly encouraged to research and learn from one another. The directors hope to see active participation, well-researched speeches, active debate and compromise, participation in both moderated and unmoderated caucuses, and contribution to the writing of resolutions in order to best understand the issue at hand and come up with possible solutions. Be sure to read the research questions below and keep them in mind when creating well-rounded solutions. The committee hopes to create a dynamic and collaborative environment where each person can thrive, express their ideas, develop their skills, and improve as a delegate.

Research Questions

1. Have there been any humanitarian crises, conflicts, or emergencies in your country or neighboring countries? How have these events impacted women's maternal health?
2. What is being done to provide and protect maternal health in your country? What programs and plans are set in place to help? What has been successful or not successful, and what needs to be improved?
3. Can similar maternal healthcare programs seen in your country be implemented in crisis zones? Has your country helped other countries in crisis settings with maternal healthcare?
4. How can maternal healthcare systems prepare and reinforce their systems in order to prevent sudden disruptions and crises from inhibiting efficiency and quality?
5. During a crisis, how can it be guaranteed that there will be enough personnel to help provide maternal health care? When people are fleeing a country, especially well

educated and experienced people, who will be left to care for pregnant women who still remain?

6. In conflict areas, what emergency plans can be made in the case that health facilities get destroyed? Where will pregnant women have to turn to for assistance? If those facilities get destroyed, how can the medical supplies and equipment get replaced in a timely manner?
7. During crises when women often have other priorities, such as doing physical labor to save their homes or even traveling long hours in unbearable conditions to flee their country, what can be done to shift their mindsets to prioritize their maternal health and seek help instead of ignoring it and waiting until it might be too late?

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Topic B: Addressing the Burden of Unpaid Care and Domestic Work on Women and Girls

Introduction

The topic is particularly relevant as the vast majority of unpaid care and domestic work – nearly 80% of all unpaid care work – is performed by women. By 2050, women globally will be spending 9.5%more time, or 2.3 more hours per day, on unpaid care than men (Hanna, 2023). The work is often undervalued and disproportionately falls on women and girls. The International Labour Organization defines unpaid care work as "non-remunerated work carried out to sustain the well-being, health, and maintenance of other individuals in a household or the community" (ILO, 2018, p. 40). Care work is essential for sustainable economic development and social well-being, and it involves the activities and social relations needed to satisfy the needs of all human beings. The work includes care for children, the elderly, people living with disabilities, and people facing illnesses. Adding to the list is indirect care or domestic work, such as prepping meals, routine housework, and other necessities for a household. When adding up women's time spent on caring responsibilities and time in the labor market, women have much longer workdays. To put it into perspective, before and after women even go to work, they often have other forms of work to do. This makes their workdays longer, with these responsibilities being unpaid. On average, women tend to work (or rather, work for pay), fewer hours a week than men. This unequal distribution of unpaid care and domestic work hinders women's empowerment, perpetuates gender stereotypes, and further adds to economic and social inequalities (Kolovich, 2024).

UN Women estimates that, globally, adult individuals in 2023 spent 12 percent of their

day, or 2.9 hours, on unpaid care and domestic work. At a closer look, the time is not evenly distributed: on average, men spend 6.5%of their day, or 1.6 hours, on unpaid care work, while the average for women is 18%, or 4.3 hours. In other words, women spend nearly 3 times (2.8) as much of their day on unpaid care and domestic work as men. Advancements in care policies, services, jobs, and infrastructure are necessary to recognize, reduce, and redistribute unpaid care and domestic work (Hanna, 2023).

Description of the Topic

Social Norms Tied to Reinforced / Invisible Gender Roles

One factor in the lagging progress in women achieving equal status in society is the expectation for them to shoulder a disproportionate share of unpaid care and domestic work responsibilities, reinforcing gender roles. Meal preparation, cooking, collecting water, caring for children, household chores, and caring for others are often deemed women's and girls' responsibilities in many societies. These responsibilities are disproportionately assigned to women and girls, deeply ingrained within cultural norms as their expected duties. Marginalized groups, including those facing poverty, racial or ethnic discrimination, or displacement, often bear an even heavier burden due to systemic inequalities and a lack of access to resources. Women who engage primarily in unpaid work face limited access to financial independence, social security benefits, or retirement savings. Their unpaid care and domestic work go unrecognized and undervalued, becoming invisible labor and perpetuating domestic care as women's and girls' responsibility. These cultural norms and expectations across all generations reinforce the division of labor along gender lines and make it difficult to break the stereotypes.

While unpaid work is essential for households and economies, the male counterparts are not doing an equal share of the work, leaving the heavy load to fall to women's duties.

Social norms greatly contribute to expectations of women and girls, factoring into the gender gap in care and domestic work. Countries with egalitarian social norms and policies can reduce the gender gap since they are based on the principle that all people deserve equal rights and opportunities. These egalitarian norms encourage the redistribution of unpaid care work between men and women, supported by measures such as parental leave policies for both genders and affordable childcare services. On the other hand, countries deeply rooted in traditional norms and cultural contexts (countries with strong religious beliefs and discrimination against women in social institutions), such as culturally Catholic countries, can widen the gender gap (Ferrant, 2014). In such societies, women are often expected to prioritize domestic responsibilities, while men are encouraged to focus on paid work, perpetuating an unequal division of labor at home.

Implications in Developed vs. Developing Countries

The gender gap and total time spent on unpaid care and domestic work varies in different regions, with the burden of unpaid care and domestic work placed on women and girls being particularly higher in rural areas. While people in urban areas have access to time-saving and labor-saving devices, basic infrastructure, and processed food, women and girls in rural regions spend more time on own-use good production (collecting water and gathering firewood), in addition to indirect care work such as cooking and cleaning (Hanna, 2023). Unpaid care and domestic work affect marginalized households in developing countries the most. Marginalized households lack essential infrastructure, such as clean water and fuel, so women and girls are left spending more time on indirect care work. Low-income households struggle to afford quality

childcare services or domestic care services. As a result, women and girls are more likely left to deal with these tasks, instead of working more hours in paid jobs (Kolovich, 2024). Due to these domestic responsibilities, girls may have less time for education, leading to lower educational attainment. It is important to note that in many developing countries, some areas are seeing increases in education, correlated with less time being spent in unpaid care work for both men and women. However, while women's educations are matching those of men, the gender gap in unpaid care and domestic work has not closed (Hanna, 2023).

Social and Economic Impacts

The ILO estimates that women and girls spend 3 to 3.4 times more on unpaid care work, hindering their economic, social, learning, and leadership opportunities. Additionally, women in households with dependents, such as children or elderly people, work fewer hours in paid employment than women with no dependents. Time poverty among employed women can lead to income poverty when women and households cannot afford to outsource care services (Kolovich, 2024). All around the world, men spend more time in paid market work, while women spend more time on unpaid care and domestic work. Studies find that women often work more hours of "total work" when combining market and non-market work (ILO, 2018). The disproportionate share of unpaid care and domestic work gives way to inefficiency and women's occupational downgrading. Occupational downgrading is seen when these women take jobs below their level of education and qualifications so that they can still do forms of unpaid care in their own homes (*Global Gender Gap*, 2021). This burden hinders women's social and economic opportunities, as they have less leisure time and opportunities for personal development. Women are being kept in vulnerable jobs, part-time jobs, and jobs below their skill levels, contributing to the gender gap in wages.

Considerable research has named unequal gender distribution of care work as a key problem to women's social, economic, and political empowerment. In fact, Kolovich writes that "socially prescribing women and girls and caregivers undermines their basic human rights and limits their opportunities and capabilities" (2024). The burden of unpaid care and domestic work translates to women's very limited improvements in economic opportunities and agency over their lives (Ferrant, 2014). The unequal division of domestic work and childcare keeps women, especially those who have dependent children at home, out of paid work. Even if there are improvements in women's education around the world, this problem still hinders women's participation rates in the workforce. In other cases, while more women are joining the labor force, they are still tasked with devoting the same amount of time to domestic and care work. Putting it into perspective, women who are working full-time jobs often come home to a "second shift" of care and domestic work (Hochschild and Machung, 2012). Either way, there is an unequal gender gap as women and girls are working longer hours and have less economic agency.

Recent United Nations Involvement

Earlier in 2024, the UN Women Multi-Country Office - Caribbean partnered up with the Barbados Statistical Service to collect local data for the first time, measuring unpaid care and domestic work locally. This initiative is aimed at determining the contribution of unpaid domestic care work to the economy. The data will provide insight into the distribution of household responsibilities that men and women share within their home and family networks. Getting hold of this region-specific data can help inform policies on access to services that can support equal distribution of unpaid care work (*UN Women*, 2024).

On July 24, 2023, The United Nations General Assembly adopted resolution 77/317, proclaiming October 29 as the International Day of Care and Support. It calls on all Member States and organizations of the UN to observe the day on an annual basis to raise awareness of the importance of care and support. It emphasizes its key contribution to achieving gender equality and the sustainability of societies and economies, as well as investing in a resilient and inclusive care economy and support systems (*International Day*, 2023). The General Assembly adopted another resolution on December 19, 2023, focused on achieving gender equality and empowering all women and girls to realize all Sustainable Development Goals. The resolution urges Member States to promote a gender-equitable division of unpaid care and domestic work, specifically through the sharing of responsibilities between women and men within a household and by prioritizing social protection policies and infrastructure development (*Achieving Gender Equality*, 2023).

Bloc Positions

Europe, North America, Eastern Asia, and South-Eastern Asia

In Eastern and South-Eastern Asia, Europe, and North America, women and girls spend the lowest percentage of their day on unpaid care and domestic work. In Eastern and South-East Asia, this percentage is 15.2%, which is 3.6 hours per day. In Europe and Northern America, it is 16%, or 3.8 hours per day, doing unpaid care and domestic work (Hanna, 2023). In this bloc, while women and girls in these regions spend less time on unpaid work than in other parts of the world, there still remains a gender gap. Though on a smaller scale, they continue to shoulder a disproportionate part of their days on this burden.

Central Asia, Southern Asia, Western Asia, and Northern Africa

The highest unpaid work burden is in Central and Southern Asia and Northern Africa and Western Asia (21.4% and 21.1%, or 5 hours every day). The greatest gender gaps are also in Northern Africa and Western Asia (4 more hours of unpaid care work than men) and Central and Southern Asia (3.7 more hours). In this bloc, women and girls in these regions shoulder the heaviest burden of disproportionate unpaid care and domestic work (Hanna, 2023). Many countries in this bloc are centered around cultural beliefs and traditional norms, where women and girls face discrimination and reinforced, invisible gender roles.

Sub-Saharan Africa, Latin America, the Caribbean

In Latin America and the Caribbean, women and girls spend 4.2 hours on unpaid care and domestic work, as opposed to men's 1.8 hours. In sub-Saharan Africa, women spend 4.0 hours to men's 1.4 hours (Hanna, 2023). Women in sub-Saharan Africa name unpaid care work duties as the top reason for not participating in the labor force. Countries in this bloc are often vulnerable to crises, including but not limited to internal and external conflicts, environmental degradation, and climate change. Crises often lead to higher demands in care needs (Kolovich, 2024).

Committee Goals

The goal of this UNIFEM committee is to bring forth original, innovative solutions that can be key to closing the gender gap and reducing the burden of unpaid care and domestic women that women and girls are faced with. Delegates are encouraged to research their country policy, and when creating solutions, keep in mind the unique issues that women and girls in their

areas may be faced with. For example, be mindful of the traditional norms and cultural or religious beliefs that many women and girls are confined to.

The directors hope to see active participation, well-researched speeches, active debate and compromise, participation in both moderated and unmoderated caucuses, and contribution to the writing of resolutions in order to best understand the issue at hand and come up with possible solutions. There should be variety in the solutions, both short term and long term solutions, as well as region-specific solutions and those that could be expanded to broader areas. The committee hopes to create a dynamic and collaborative environment where each person can thrive, express their ideas, develop their skills, and improve as a delegate.

Research Questions

1. What is your country's history in prioritizing care policies and infrastructure to achieve gender equality, inclusive development, and resilience in the face of these burdens?
2. How disproportionate is the gender gap and distribution of unpaid care and domestic work among men and women in your specific country? What are the social and economic impacts of unpaid care and domestic work for girls and women in your country?
3. What specific short term solutions and long term solutions can be implemented to close the gender gap in unpaid care and domestic work? How will the burden be recognized, reduced, and redistributed?
4. What resources can be offered and plans can be carried out for women and girls in areas that are deeply rooted in traditional norms and cultural or religious beliefs that discriminate against women?
5. What are the key factors that contribute to this burden, and what can be done in your

country and around the world to minimize this problem?

6. How can it be ensured that women and girls can be empowered and will be able to make social and economic advancements when this burden still exists?

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