American Mock World Health Organization 2019 Regional Block Name: SEARO/WPRO 5.1 Topic: Reproductive Adolescent Health Sponsors: Indonesia, China, India Signatories: Australia, Malaysia, Japan, Singapore, Republic of Korea, Philippines, Cambodia, Tonga, Vietnam, Thailand, Nepal, New Zealand, Mongolia, Myanmar, Bangladesh Humanitarian Index Score: N/A

*Alarmed by* the lack of access to sexual and reproductive health services in underserved rural and urban areas,

*Deeply concerned with* the continued prevalence of sexually transmitted infections (STIs) and sexually transmitted diseases (STDs) throughout the adolescent population,

*Having* examined past successes and failures in programs dedicated to adolescent sexual and reproductive health,

Fully aware of the lack of proper sexual education of adolescents and medical professionals,

Affirming the need for both proactive and reactive measures to address adolescent health issues,

Emphasizing the relationship between adolescent pregnancy and maternal health,

*Keeping in mind* the social norms and cultural biases of countries surrounding controversial sexual health practices,

The General Assembly Plenary,

<ul> <li>system to provide access to education and treatment for underserved areas</li> <li>a. Creating a board of directors/committee (eMARSH) of government health</li> <li>ministry officials, NGO representatives, and health professionals who will</li> <li>oversee the creation and reevaluation of MARSH</li> <li>i. Defining underserved areas as rural and urban low-income areas that</li> <li>would benefit from access to primary services</li> <li>1. Keeping in mind the current crisis situation, MARSH systems will</li> <li>also serve populations lacking in proper adolescent health</li> <li>resources</li> <li>ii. Routine evaluation of the impact and cost-effectiveness of implementation</li> <li>of MARSH systems by the administrators of tertiary healthcare clinics to</li> <li>target areas of adjustment and guide scale-up approaches</li> </ul>	1	1. Encourages the use of the MARSH (Mobile Access to Reproductive and Sexual Health)
<ul> <li>ministry officials, NGO representatives, and health professionals who will</li> <li>oversee the creation and reevaluation of MARSH</li> <li>i. Defining underserved areas as rural and urban low-income areas that</li> <li>would benefit from access to primary services</li> <li>1. Keeping in mind the current crisis situation, MARSH systems will also serve populations lacking in proper adolescent health</li> <li>resources</li> <li>ii. Routine evaluation of the impact and cost-effectiveness of implementation of MARSH systems by the administrators of tertiary healthcare clinics to</li> </ul>	2	system to provide access to education and treatment for underserved areas
<ul> <li>5 oversee the creation and reevaluation of MARSH</li> <li>6 <ol> <li>Defining underserved areas as rural and urban low-income areas that</li> <li>would benefit from access to primary services</li> </ol> </li> <li>8 <ol> <li>Keeping in mind the current crisis situation, MARSH systems will also serve populations lacking in proper adolescent health resources</li> </ol> </li> <li>11 <ol> <li>Routine evaluation of the impact and cost-effectiveness of implementation of MARSH systems by the administrators of tertiary healthcare clinics to</li> </ol> </li> </ul>	3	a. Creating a board of directors/committee (eMARSH) of government health
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9also serve populations lacking in proper adolescent health10resources11ii. Routine evaluation of the impact and cost-effectiveness of implementation12of MARSH systems by the administrators of tertiary healthcare clinics to	7	would benefit from access to primary services
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	11	ii. Routine evaluation of the impact and cost-effectiveness of implementation
13target areas of adjustment and guide scale-up approaches	12	of MARSH systems by the administrators of tertiary healthcare clinics to
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14		1. Will occur annually for the first five years, and then once every
15		five years after the initial period
16		2. Integrated effort with respective states to collect and process
17		anonymous health information to influence policy making,
18		program actions, and research to further improve adolescent health,
19		including but not limited to:
20		a. STI prevalence
21		b. Maternal/infant mortality
22		c. Average age of first pregnancy
23	b.	Instilling community awareness through educating local leaders that are trusted
24		and respected by native populations
25		i. Offering training to MARSH personnel so they may teach local and
26		religious leaders the proper knowledge needed to address adolescent
27		health issues and mobilizing them to spread that knowledge to the
28		community
29	c.	Providing proactive and reactive treatment for STIs through both national
30		governments and partnerships with helper organizations. Resources could include
31		but are not limited to:
32		i. Short-term contraceptives such as condoms
33		ii. Treatment for preventable STIs such as gonorrhea and chlamydia
34		iii. Pre-exposure Prophylaxis treatment (PrEP) and Post-exposure Prophylaxis
35		treatment (PEP) for Human Immunodeficiency Virus (HIV)/Acquired
36		Immune Deficiency Syndrome (AIDS)
37		iv. Direct-acting antivirals for Hepatitis C
38		v. 9-Valent Human Papilloma Virus (HPV) vaccines
39	d.	Creating a referral network with local clinics to provide further secondary
40		services
41		i. Allowing for the creation of a robust prenatal, neonatal and childbirth
42		network to provide reactive health care to adolescent mothers, which
43		include, but are not limited to:
44		1. Cervical cancer screenings
45		2. Prenatal vitamins and folic acid supplements
46		3. Counseling services
47		ii. Collaborating with local non-governmental organizations to improve or
48		install needed infrastructure for the proper functioning of the MARSH
49		network, such as roads or restocking stations
50		1. Means of mobile transport by MARSH will vary based on the
51		existing infrastructure and geography of the state in question
52		

53	2.	Approv	ves the use of communication technologies such as telemedicine, taking into
54		accoun	t the feasibility of such recommendations on the basis of existing infrastructure
55		and all	owing states discretion over precise implementation
56		a.	Recommending that this board will serve a fixed term of 3 years and regional
57			representatives will be nominated through regional blocks"
58			i. Strongly encourages the use of telemedicine in combination of MARSH
59			systems and the network of local clinics to further augment the reach of clinical
60			and educational efforts in raising community awareness of issues pertaining to
61			adolescent health in areas of maternal health, family planning, and STI
62			transmission and prevention, supported by UNICEF initiatives,
63			
64		b.	Calls upon the empowerment of adolescents through education outside the school
65			setting using various mediums such as digitized cartoons, illustrations, and online
66			platforms,
67			i. Approves celebrity endorsements and social media influencers to garner
68			the attention of adolescents in order to
69			1. Increase engagement with MARSH systems
70			2. Encourage adolescents to participate in preventative healthcare
71			measures
72			3. Suggest a dialogue about sexual and reproductive health
73			ii. Creating a safe space online that allows for peer-to-peer learning and
74			encourages adolescents to seek out available sexual and reproductive
75			services from trained health care professionals
76		с.	Invites urban and rural health centers to collaborate and communicate knowledge
77			and insights through publicly-available scheduled video and phone calls
78		d.	Easing and expediting the transfer of necessary medical knowledge from the
79			urban to rural settings
80		e.	Incorporating technological and mobile applications
81			i. Encourages the development and promotion of mobile applications that
82			provide free, medically-sound advice including, but not limited to chat-
83			based apps which allow patients to communicate online with doctors and
84			other healthcare professionals
85			ii. Designates the creation of text-based subscription services in conjunction
86			with organizations for paternal and maternal education, specifically
87			standardized pre-natal and post-natal practices evidenced to improve the
88			health of adolescent mothers and newborn babies
89			iii. Further requests the use of sexual and reproductive health hotlines staffed
90			by trained health workers to effectively provide tailored information and
91			counselling to young people in a largely private way, discussing topics
92			such as reproductive functions, sexual problems, sex trafficking, and birth
93			spacing

94 95	iv. Recommend that the countries participating will keep patient information confidential
96	3. <i>Emphasizes</i> education for adolescents and health professionals,
97	a. Through the specialized education, inside and outside of MARSH efforts, of local
98	community leaders to increase trust and cultural competence,
99	b. Encouraging local health professionals to encourage adolescents to pursue peer-
100	to-peer education
101	i. Unbiased and evidence-based interventions, such as the Friendship Bench
102	Project, can train local adolescents and trusted leaders in the community to
103	counsel fellow peers in a destigmatized environment
104	c. Inspiring students, especially women, to pursue higher education, thus reducing the
105	likelihood of adolescents partaking in transactional sex work to meet financial needs.
106	d. Providing monetary incentives such as subsidized tuition and student loan forgiveness
107	to prospective healthcare professionals, especially those in underserved areas, to encourage
108	practice in regions lacking resources
109	e. Addressing sex trafficking through the education of healthcare professionals and
110	general public.
111	ii. By teaching healthcare professionals to recognize the signs of sex
112	trafficking victims and treating them in a manner cognisant of their
113	background.
114	iii. Through providing information regarding psychological risks faced by sex
115	trafficking victims.

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