Indore World Summit

Study Guide

AGENDA

Considering the use of ready-to-use therapeutic foo
for children with severe acute malnutrition.

LETTER FROM THE EXECUTIVE BOARD

Greetings Delegates,

As a part of the Executive Board, it is our responsibility to facilitate your educational experience at the simulation of the **UNITED NATIONS INTERNATIONAL CHILDREN'S EMERGENCY FUND** at Indore World Summit, 2022. We would like to thank the organizers of IWS'22 for the constant encouragement that their platform provides. It is by attending such simulations that one understands the thought process that goes into making a decision that has varying effects on every aspect of life of the citizen of a nation.

We hope that by now your research is well on its way and you have formulated an idea about what, how, why, and when you want to discuss something. These questions form the very basis of the flow of debate and argumentation in the committee. This background guide will give you an overview of the topic at hand and the work of the Committee. It contains some basic elements on the topic that will guide your research. However, such mentions do not limit the scope of discussion in the committee at all.

We expect from all delegates an active participation in the proceedings of this committee to have a fruitful discussion on a pertinent global problem. For that purpose, extensive and thorough research is expected of you over and beyond this study guide. Think of this study guide as merely an initiation to your research, defining the broad aspects. A section with the suggested readings has been added at the end of this document and can be utilized to thatregard.

UNAUSA Rules of Procedure shall be adhered to for the due course of this committee simulation. For all those participating in a model UN conference for the first time, and otherwise, kindly refer to this for understanding the procedure-

http://www.unausa.org/global-classrooms-model-un/how-to-participate/model-un-preparation/rules-of-procedure

While representing your country has its own importance, we do hope that you attach importance to finding creative solutions to the complex problems that will be raised

during the course of the two days of this event. There are multiple options that participants are encouraged to explore within the confines of their foreign policies.

Also, an important point here is that while criticism is encouraged, we expect constructive criticism in the committee. This will help you approach a problem differently and understand all perspectives. What needs to be noted here is that opinions are only different, but never wrong. An opinion is a product of multiple factors that an individual is exposed to during the course of life and hence needs to be deconstructed and not discarded.

While forming your arguments, take logical premises and not ludicrous ones as an argument is only as strong as the premise it is based on. Try to communicate your premises, followed by your arguments and then a conclusion keeping in mind the time limit. This will help you convey your messageeffectively.

Finally, and most importantly, I want all participants to focus on their growth and development. While awards are to recognize effort, they should in no manner be your sole point of focus. Instead, aim for something much higher, a change in your thought process, perception, perspective and lastly your personality. An award will get you only so far, but development of a logical and analytical mindset and being able to convey your opinion with utmost clarity will help you flower as an individual.

Regards,

Parth Mangal
(Chairperson, UNICEF)
(Parthmangal1234@gmail.com)

THE NATURE OF PROOF/EVIDENCE IN COMMITTEE

Evidence or proof is acceptable from the following sources

→ **News Sources**:

State operated News Agencies– These reports can be used in the support of or against the State that owns the News Agency. These reports, if credible or substantial enough, can be used in support of or against any Country as such but in that situation, they can be denied by any other country in the council. Some examples are –

1. RIA Novosti (Russia)http://en.rian.ru/,IRNA (Iran)http://www.irna.ir/ENIndex.htm,
2. BBC (United Kingdom)http://www.bbc.co.uk/
3. Xinhua News Agency and CCTV (P.R. Of China)http://cctvnews.cntv.cn/

→ **Government Reports:**

These reports can be used in a similar way as the State Operated News Agencies reports and can, in all circumstances, be denied by another country. However, a nuance is that a report that is being denied by a certain country can still be accepted by the Executive Board as credible information.

Examples are Government Websites like:

1. State Department of the United States of America:http://www.state.gov/index.htm,
2. Ministry of Defense of the Russian Federation:http://www.eng.mil.ru/en/index.htm,
3. Permanent Representatives to the United Nations Reports:http://www.un.org/en/members/(Click on any country to get the website of the Office of its PermanentRepresentative.
4. Multilateral Organizationslike the NATO (http://www.nato.int/cps/en/natolive/index.htm) ASEAN (http://www.aseansec.org/), OPEC (http://www.opec.org/opec_web/en/),etc.

→ UN Reports:

All UN Reports are considered as credible information or evidence for the Executive

Board of the General Assembly.

1. UN Bodies: Like the SC (http://www.un.org/Docs/sc/), GA (http://www.un.org/en/ga/),HRC (http://www.ohchr.org/EN/HRBodies/HRC/Pages/HRCIndex.aspx)etc.
2. UN Affiliated bodieslike the International Atomic Energy Agency (http://www.iaea.org/), WorldBank (http://www.worldbank.org/), International Monetary Fund (http://www.imf.org/external/index.htm), International Committee of the Red Cross (http://www.icrc.org/eng/index.jsp),etc.

Treaty Based Bodieslike the Antarctic Treaty System (http://www.ats.aq/e/ats.htm), the International Criminal Court (http://www.icc-cpi.int/Menus/ICC).

Under no circumstances will sources like Wikipedia (http://www.wikipedia.org/), Amnesty International(http://www.amnesty.org/) or newspapers like the Guardian (http://www.guardian.co.uk/), Times of India(http://timesofindia.indiatimes.com/) etc. be accepted as credible.

ABOUT THE COMMITTEE

UNICEF (United Nations International Children's Emergency Fund)

The United Nations Children's Fund (UNICEF), officially known as the United Nations International Children's Emergency Fund, is an organisation of the UN tasked with delivering humanitarian and developmental aid to children all over the world. It is guided by the Convention on the Rights of the Child and strives to establish children's rights as enduring ethical principles and international standards of behavior towards children. It insists that the survival, protection and development of children are universal development imperatives that are integral to human progress. It mobilizes political will and material resources to help countries, particularly developing countries, ensure a "first call for children" and to build their capacity to form appropriate policies and deliver services for children and their families.

The agency is among the most widespread and recognizable social welfare organizations in the world, with a presence in 192 countries and territories. UNICEF's activities include providing immunizations and disease prevention, administering treatment for children and mothers with HIV, enhancing childhood and maternal nutrition, improving sanitation, promoting education, and providing emergency relief in response to disasters.

UNICEF is the successor of the United Nations International Children's Emergency Fund, created on December 11, 1946, in New York, by the U.N. Relief Rehabilitation Administration to provide immediate relief to children and mothers affected by World War II. The same year, the U.N. General Assembly established UNICEF to further institutionalize post-war relief work.

UNICEF's programs emphasize developing community-level services to promote the health and well-being of children. Most of its work is in the field, with a network that includes 150 country offices, headquarters and other facilities, and 34 "national committees" that carry out its mission through programs developed with host governments.

Committee Mandate

UNICEF has a mandate to safeguard the rights of all children, everywhere. That mandate is rooted in the 1989 Convention on the Rights of the Child (CRC), which sets out universal and indivisible rights that apply to every child, and the Sustainable

Development Goals (SDGs) adopted by world leaders in 2015, which apply to every country.

In the 21 countries and territories in Europe and Central Asia where we have programmes, our focus is on the children who are overlooked and left behind by economic and social progress. Even in the most prosperous nations, there are always children who, because of who and where they are, do not get the childhood they deserve - and to which they are entitled under the Convention. They remind governments in the region of the commitments they have made to all children through the CRC and the SDGs and help them monitor their progress.

Committee History

United Nations Children's Fund (UNICEF) was established in 1946 to provide supplies and assistance to children after World War II. Originally known as the United Nations International Children's Emergency Fund, UNICEF starts as a temporary relief fund of the United Nations. Their mandate was clear: to help children and young people whose lives and futures were at risk – no matter what role their country had played in the war.

What mattered to UNICEF was reaching every child in need, protecting children's rights to survive, thrive, and reach their full potential. This is the DNA of UNICEF. From the ashes of war to the global challenges that affect millions today, their mandate has never wavered. UNICEF has consistently worked to protect the rights and well-being of all children, whoever they are, wherever they live.

In October 1953, the United Nations General Assembly extended UNICEF's mandate indefinitely to assist vulnerable children. As a UN agency with a distinct man-

date, UNICEF develops its own visual identity. UNICEF's first logo features a child drinking a cup of milk, which reflects the organization's main activity at the time: delivering milk to children. This logo retains some elements of the UN logo, on which it is based, such as the olive branches and globe in the background. 'A child drinking milk' becomes the symbol of UNICEF.

UNICEF Innocenti Research Centre

The UNICEF Innocenti Research Centre was established in 1988. It is based at the Ospedale degli Innocenti historic building in Florence, Italy.

The centre was established to promote UNICEF's global advocacy for children and to improve its research capabilities. It is a division of the Office of Research and serves as UNICEF's research division. The Office of Research's main goals are to advance economic policies that benefit children, increase global understanding of issues pertaining to children's rights, and aid in the full implementation of the United Nations Convention on the Rights of the Child in 190 nations and territories.

In collaboration with other UNICEF divisions and outside stakeholders, UNICEF Innocenti develops its research programme. The programme affirms the center's academic freedom as well as the research's emphasis on knowledge gaps, new issues, and delicate subjects that are important to the realization of children's rights in both developing and developed nations.

Read more at about UNICEF at https://www.unicef-irc.org/

ABOUT THE AGENDA

- **Introduction**

Malnutrition is a serious issue for public health in low- and middle-income nations. Around 165 million under-five children are stunted, 52 million are wasted, and 17 million are severely wasted globally. Asia is home to more than two thirds of the wasted children and more than half of the stunted children. Although malnutrition rates have decreased in India over the past ten years, the numbers are still concerning. According to recent data, 21.0% of children in India are squandered, 7.5% are seriously wasted, and 38.4% of children are truncated. Talking about Severe Acute Malnutrition ie.e SAM, according to the WHO it can be defined as – "*Severe acute malnutrition is defined by a very low weight for height (below -3z scores of the median WHO growth standards), by visible severe wasting, or by the presence of nutritional oedema.*" In other words, Severe acute malnutrition (SAM) is caused by asignificant imbalance between nutritional intake and individual needs. It is most often caused by both quantitative (number of kilocalories/day) and qualitative (vitamins and minerals, etc.) deficiencies.

Initially, outpatient therapeutic feeding protocols were developed based on inpatient weight gain data and professional understanding of the physiological needs during recovery for the treatment of simple severe acute malnutrition(SAM) in children. However, weight growth and energy requirements in historical inpatient settings might not be comparable to those in contemporary outpatient settings, making it unwise to use them to inform present therapeutic eating programmes.

Increasing mortality and morbidity rates are a result of malnutrition worldwide. Around 3 million (or 45%) of all under-five child deaths worldwide occur as a result of malnutrition each year. Of them, 11.6% (or 804,000) of the children pass away from inadequate nursing. Strong scientific data demonstrates that inadequate complementary foods (CFs), poor child feeding habits, and a high prevalence of infectious diseases have a negative influence on children's survival, development, and growth.
Increased levels of child malnutrition in developing nations are also attributed to poverty, food instability, ignorance, inadequate hygiene, and sanitation.

In 2013, the UNICEF(United Nations International Children's Emergency Fund) adopted the conceptual framework for pathways to malnutrition that provides a comprehensive understanding of multiple causes of malnutrition that operate at the `immediate', `underlying' and `basic' level.

Do check it once -
https://data.unicef.org/resources/improving-child-nutrition-the-achievable-imperative-for-global-progress/nutritionreport_april2013_final_29/

All of the UNICEF framework's elements interact in concert to create a vicious cycle of insufficient dietary intake, recurrent illnesses, and malnutrition in newborn infants. Caregivers frequently miss malnutrition because they don't frequently seek treatment for it.
"Ready-to-use therapeutic food," also known as RUTF, is a life-saving essential supply item used to treat severe wasting in children under the age of five. Wasting is characterized as low weight-for-height and occurs when a person consumes insufficient quantities of poor-quality food. Children who are squandering at a higher risk of dying if they are not properly handled.

United Nations Children's Fund assists community-based management of acute malnutrition with ready-to-use therapeutic foods (RUTF). The organization is the primary global procurer of RUTF, therapeutic milk and other essential food products for treating severe acute malnutrition, and also provides technical support to governments and non-governmental organizations on their application and use.Other

notable procurers include Mèdicins sans Frontières and the Clinton Foundation. In the past four years, UNICEF has obtained approximately 75 to 80 percent of the RUTF produced worldwide, or 49,000 metric tonnes (MT). UNICEF purchased over two million cartons for South Sudan between 2017 and 2021.

Delivering RUTF to areas where children reside is a challenging endeavor that need great vision and perseverance. The UNICEF warehouse in Juba sends supplies to warehouses in ten field offices spread out over the nation. Once supplies have arrived at these field locations, UNICEF partners transport the last mile of supplies to community health initiatives. Through supply planning, it is made sure that adjacent warehouses have three-month buffer supplies in case there is a spike in demand or a delay in replenishing.

Properly used, RUTF is safe, cost effective, and has saved hundreds of thousands of children's lives in recent years. Severe acute malnutrition is a major killer of children under five, accounting for approximately 1 million deaths . Around 20 million children worldwide are estimated to be suffering annually from this condition, of which only approximately 10 -15 percent currently undergo treatment using RUTF. Although most RUTFs are currently manufactured in and imported from advanced economies, the technology to produce them can be introduced in developing countries with minimal industrial infrastructure and is already in use in several countries.

UNITED NATIONS CHILDREN'S FUND fully adheres to established international norms and guidelines for infant and young child feeding, including exclusive breastfeeding for the first six months of life, followed by continued breastfeeding and the use of appropriate complementary foods for children of 6-24 months; micronutrient supplementation for vulnerable groups; and advocating best practices for child nutrition, health and hygiene.

The organization categorically does not view ready-to-use therapeutic food as a substitute for best nutritional practices or normal household food, but sees it as one part of a medical protocol that should only be used as part of the community-based management of acute malnutrition in children, in accordance with international standards for such care and in conjunction with essential primary health care.

- **<u>Discussion upon the reliability on 'RUTF'</u>**

No specific research has been conducted on the inclusion of RUTFs in national essential medicines lists, or on their potential inclusion in the WHO Model List of Essential Medicines (EML), but existing literature suggests it could facilitate access to treatment. Using PubMed, Embase, Google, and Google Scholar, a review of the literature on RUTFs and essential medicine lists was carried out between January and March 2015 and updated in August 2018. The following terms were entered into each database: "RUTF," "ready-to-use food," "essential medicines list," "essential drug list," "commodities," and "WHO." A desk-based evaluation of national medicines and commodities lists was conducted between January and March 2015 and updated in August 2018 in order to map the status of RUTFs in national essential medicines lists and local regulatory frameworks.

The majority of search results discussed how well RUTFs and community-based management of acute undernutrition work. The use of RUTFs through community-based management of acute malnutrition is advised, and local production of RUTFs is encouraged, according to a 2007 joint statement from WHO, the World Food Programme, the United Nations System Standing Committee on Nutrition, and the United Nations Children's Fund (UNICEF).

Nutritional commodities are less likely to be included in national distribution networks when they are not on national essential medicines lists, according to a 2016 UNICEF study in eastern and western Africa. Inclusion by the Government of Cambodia is advised in a 2015 research by Prak and colleagues to make purchase easier and to reduce reliance on donors for the items needed to treat severe acute malnutrition.

The World Health Organization (WHO) and United Nations Children's Fund (UNICEF) diagnostic criteria for severe acute malnutrition (SAM) in children aged 6 to 59 months include any of the following:

(1) weight-for-height Z scores below −3 standard deviation (SD) of WHO child growth standards,
(2) the presence of bilateral pedal edema, and
(3) mid-upper arm circumference (MUAC) below 115mm.

With any of these criteria, globally close to 2.4% (16 million) of all children younger than 5 years are affected by this serious nutritional disorder and who have a 9.4-fold increased risk of death compared to healthy peers.2 Bangladesh has an estimated 450 000 children (3.1%) with SAM. In most cases, children with wasting can be treated with RUTF, allowing them to recover in their own homes and communities rather than in a health facility. UNICEF procures and distributes an estimated 75-80 per cent of the world's RUTF supply.

Delivering RUTF to communities where children live is a complex exercise. Supplies

of RUTF are typically transported to warehouses in field offices. Once commodities reach these field locations, UNICEF partners take supplies across the last mile – to community health programmes. Careful supply planning ensures that buffer stocks are available in nearby warehouses in case there is a surge in demand or a delay in replenishment.

Many countries don't include RUTF in their essential medicines and commodities lists – unlike vaccines – and so don't routinely procure it. Treatment for severe wasting is also often poorly integrated into routine services. This leaves the vast majority of severely wasted children who live in non-emergency contexts without access to RUTF treatment. Meanwhile, the COVID-19 pandemic and armed conflicts, including the war in Ukraine, are driving up the price of RUTF.

According to a 2012 UNICEF case study on Ethiopia, RUTFs must be registered in the national system and included on the national essential medicines or commodities list in order to be a consistent source of supply (16). The paper lists difficulties include community-based management of supplies for acute malnutrition and aid being returned to the source nation because it couldn't pass customs. To circumvent supply problems and import restrictions, the study suggests including RUTFs on the essential medications list.

RUTFs were added to national essential medicines lists for a variety of reasons, including reducing stockouts of nutrition-related products by addressing parallel supply chains (Zimbabwe); removing obstacles to RUTF production and import, which eventually reduced costs (Nigeria); and enlisting political and financial support (Haiti). Budgets are routinely distributed among nations based on priorities and the crit-

ical medicines included on those lists. Treatments that are officially recognised as essential medications on the national list typically receive priority in terms of funding and programme assistance. The inclusion of RUTFs in Haiti's list of necessary medications was done to garner more political support and funding for the treatment of undernutrition.

Statement of Issue

- The majority of ready-to-use therapeutic food (RUTF) is utilized during an emergency. Averaging 49,000 metric tonnes (MT) per year over the last four years, UNICEF meets an estimated 75–80% of the world's need for RUTF, enough to treat 3.5 million children. Despite the substantial funding provided by UNICEF, only 25% of the estimated total number of children who suffer from severe wasting are still covered. An additional five to ten percent of RUTF is obtained by governments, non-governmental organizations (NGOs), and other United Nations (UN) agencies. Because of this, 65 to 70 percent of children who suffer from severe wasting do not have access to therapy and the majority of them reside in less-noticed non-humanitarian settings.
- The number of RUTF suppliers has grown significantly over the past ten years. Currently, UNICEF procures RUTF from 22 different vendors, 18 of which are situated in nations with high rates ofmalnutrition.
- Most of the ready-to-use therapeutic food (RUTF) is used in emergency response. UNICEF procures an estimated 75-80 per cent of the global demand for RUTF, averaging 49,000 metric tons (MT) per year over the last four years, suitable to treat 3.5 million children.1 Despite the high volumes through UNICEF, it still only covers 25 per cent of the global estimated number of children suffering from severe wasting. RUTF procured by governments, non-governmental organizations (NGOs) and other United Nations (UN) agencies cover an additional five to ten per cent. As such, approximately 65-70 per cent of children suffering from severe wasting, globally, do not have access to treatment, and most live in non-humanitarian contexts, which get less attention.
- The RUTF supplier base has expanded substantially over the last ten years. UNICEF now procures RUTF from22differentsuppliers,ofwhich18arelocated-incountrieswithhighlevelsofmalnutrition.The global

  RUTF production capacity currently exceeds the global funded demand and is sufficient to respond to increasing the treatment coverage of children with severe wasting.
- The interest in non-peanut based RUTF is increasing, particularly from coun-

tries where peanuts are not a staple food in local diets. To increase the treatment of severely wasted children that have not had access to treatment, UNICEF encourages the validation and access to alternative RUTF formulations. capacity currently exceeds the global funded demand and is sufficient to respond to increasing the treatment coverage of children with severe wasting.

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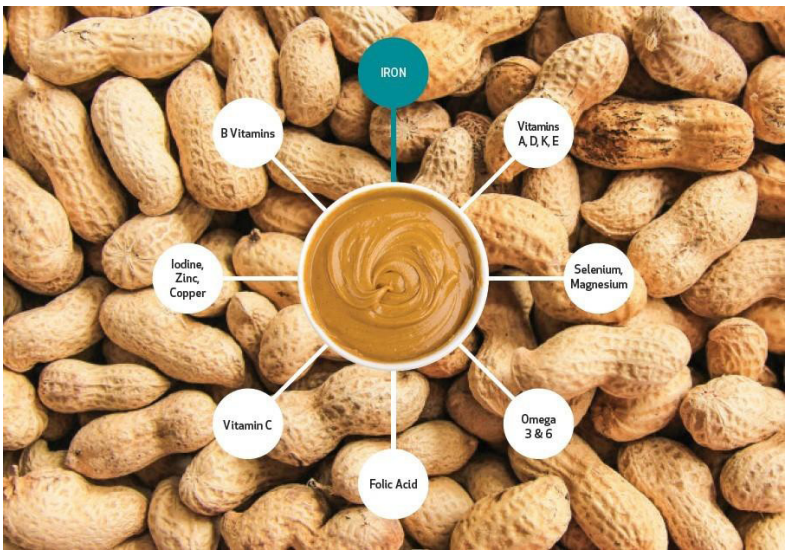


History

- During the hunger emergencies of the 1980s and 1990s, children with severe acute malnutrition required around-the-clock care at therapeutic feeding centers (TFCs). The nutrients were delivered through therapeutic milk, which required on-site preparation and clean water. Because of the need for 24-hour medical staffing, TFCs were few and far between. They were also often too far from the communities they were meant to serve. Mothers would often need to leave their homes for weeks at a time, which meant lost work and wages (and other children to take care of).
- Recovery rates were low because moms would withdraw their children before they received full treatment so they could return home to work. Infection was also a risk in the crowded patient wards. Millions of children unnecessarily died because they were too far away, relapsed after an incomplete course of treatment, or were exposed to other illnesses.

- UNICEF concluded its 2014 tender in December 2013. 18 manufacturers were awarded supply arrangements for 2014 from 25 submitted offers. Additional potential new suppliers in the Republic of Korea and Pakistan were identified through the tender. Their manufacturing sites were inspected in 1Q 2014, and they are implementing suggested corrective actions. UNICEF will continue to facilitate and promote increased locally produced and procured RUTF market share.
- UNICEF anticipates procuring 34,000 MT of peanut based RUTF during 2014. Demand for non-peanut based RUTF is also expected from Asian countries where peanuts are not part of the naturaldiet.
- In 2013, UNICEF received 3,200 MT of RUTF as in-kind donations from US-AID, contributing to the therapeutic feeding needs identified in Afghanistan, Burundi, Pakistan, Somalia and Yemen. It accountedfor ~10% of the annual volume.

- **Analysis of theAgenda**

Due to rising procurement volumes, competition, and supplier diversity, the weighted average price (WAP) for RUTF keeps dropping. From USD 57.00 per carton in 2008 to USD 41.01 per carton in 2020, the WAP for RUTF purchased for export and usage in programme nations declined by 28% over that time period, making it more cheap. Even though locally manufactured RUTF continues to be more expensive than imported RUTF, the WAP for locally produced goods fell by 22% during the same time period.

Having developed local sources of supply close to the need has substantially aided UNICEF's response to RUTF demand during the COVID-19 pandemic. The ability of the RUTF sector to meet demand has not been significantly impacted by the epidemic since RUTF producers are frequently spared from lockdowns and closures because they are viewed as critical businesses. However, they have still had to deal with logistical problems and delays in the raw material supply. According to UNICEF, the pandemic's economic effects and the burden it places on routine health and nutrition services will cause levels of malnutrition to rise sharply.

UNICEF concluded its last tender in 2018 to cover its April 2019-April 2021 tender period, seeking to maintain a healthy supplier base in programme countries close to beneficiaries, as well as to increase programme coverage by trying to make RUTF more affordable, and more acceptable, with alternative formulations.

Good progress has been made in reaching the target of reducing the global WAP by

10 per cent, compared to the 2018 baseline.

However, the disruptions caused by the pandemic have hampered new product development, trialing, and introduction of innovative RUTF products made with alternative ingredients. In addition, they delayed the construction and start-up activities of new manufacturers in strategic regions. This required UNICEF to extend the tender duration by two years until April2023.

Here a question arises then, What missing ingredient in the fight against malnutrition? Community-based care seemed to be the solution, but there was one more problem: At the time, there wasn't a suitable food that could be used at home by mothers versus in a clinic by a healthcare professional. Everything required water. If the family used contaminated water, they risked further harming their child.

This is why most therapeutic foods are made with peanuts: First, the crop is generally accessible in the countries that have the highest severe malnutrition rates. What's more, by creating an oil-based product with the nut, there is no room for bacteria to breed. This also meant a long shelf-life and no cooking required. The oil base also helps Plumpy'nut to clock in at 500 much-needed calories per packet.

But developing the food was not enough: We also needed a program that adapted to this new feeding model. Enter Dr. Steve Collins, whom Briend describes as "the key person to change the approach."

"RUTFs have revolutionized the treatment of uncomplicated forms of severe

acute malnutrition among children."

Ready-to-use therapeutic food(RUTF) are energy dense, micronutrient enhanced pastes used in therapeutic feeding. These soft foods are a homogenous mix of lipid rich foods, with a nutritional profile similar to the World Health Organization-recommended therapeutic milk formula used for inpatient therapeutic feeding programmes.

Typical primary ingredients for RUTF include peanuts, oil, sugar, milk powder and vitamin and mineral supplements. For several reasons, RUTF is essential for the community-based management of children who are suffering from uncomplicated severe acute malnutrition and who retain an appetite.

First, it provides all the nutrients required for recovery. Second, it has an excellent shelf life, and does not spoil even after opening. Third, since RUTF is not water based, bacteria cannot grow, and consequently it is safe to use without refrigeration and in areas with poor hygiene conditions. Fourth, it is liked by children, safe and easy to use without close medical supervision. Finally, it can be used in combination with breastfeeding and other best practices for infant and young child feeding.

"Use of RUTF is undertaken through community-based management of acute malnutrition."

RUTF was first introduced in situations of humanitarian emergencies during the early 2000s when access was a considerable barrier to expanding coverage of inpatient treatment. Its application within community management of acute malnutrition

(CMAM) – an inter-agency strategy supported by WHO, the World Food Programme, the UN Standing Committee on Nutrition and UNICEF has resulted in a sharp rise in programme coverage and children treated successfully. In Ethiopia alone, there has been a twelve-fold increase in the number of children treated in the past nine years. Currently, 61 countries have some form of treatment for severe acute malnutrition with a community component available, compared to just 9 in 2005.

"Although not a cure-all for all types of childhood malnutrition, RUTF is a medical treatment for severe acute malnutrition."

For all types of severe acute malnutrition in children, RUTF is not a cure-all. Medical issues such severe oedema, anorexia, high fevers, or severe dehydration necessitate inpatient treatment with specialist therapeutic milks and round-the-clock medical attention for those who experience them. All affected infants younger than six months old should be referred to a stabilization centre, which is frequently housed in a hospital, and supported in their efforts to breastfeed. In extreme circumstances, such as for maternal orphan infants under six months suffering from severe acute malnutrition, infants whose mothers cannot breastfeed, or infants whose mothers are HIV positive and choose not to breastfeed, diluted therapeutic milk or special ready-to-use infant formula (RUIF) may be considered appropriate. Although RUTF is generally an appropriate treatment for uncomplicated forms of severe acute malnutrition in HIV-positive children, their recovery rates are lower and case fatality rates higher than those who are HIV negative. Given the overlap in the presentation of severe acute malnutrition and HIV infection in children, particularly in poor areas, it is essential to maintain strong links between the case management of the former and the latter.

"Treatment recovery"

Gilbert Dachi, Manager of UNICEF's Nutrition Programme in South Sudan responsible for the care and treatment of children with acute malnutrition, explains. "In South Sudan, UNICEF and partners treat close to a quarter of a million children every year with RUTF – averting potential deaths. Nutrition programmes for children with severe wasting in South Sudan achieve a treatment recovery rate of 95 per cent."

Malnutrition is a leading contributor to South Sudan's high mortality rate of 96.2 deaths for every 1,000 live births among children under five years old. Compare this devastating number with Denmark, Japan, Switzerland, and the UK, where the under-five mortality is between two to four deaths per 1,000 births. Each year South Sudan distributes about 2,600 metric tons (MT) or 190,000 cartons -185 truckloads

of RUTF, procured by UNICEF or donated as contributions-in-kind .

For the last four years, UNICEF has been procuring an estimated 75 to 80 per cent of the world's RUTF – equivalent to 49,000 metric tons (MT). Between 2017 and 2021, UNICEF procured some two million cartons for South Sudan.

- **<u>Major Impacts</u>**

1.**Maternal and child undernutrition: global and regional exposures and health consequences**

Maternal and child undernutrition is highly prevalent in low-income and middle-income countries, resulting in substantial increases in mortality and overall disease burden. In this paper, we present new analysis to estimate the effects of the risks related to measures of undernutrition, as well as to sub optimum breastfeeding practices on mortality and disease. We estimated that stunting, severe wasting, and intrauterine growth restriction together were responsible for 2·2 million deaths and 21% of disability-adjusted life-years (DALYs) for children younger than 5 years. Deficiencies of vitamin A and zinc were estimated to be responsible for 0·6 million and 0·4 million deaths, respectively, and a combined 9% of global childhood DALYs. Iron and iodine deficiencies resulted in few child deaths, and combined were responsible for about 0·2% of global childhood DALYs. Iron deficiency as a risk factor for maternal mortality added 115 000 deaths and 0·4% of global totalDALYs.

Sub optimum breastfeeding was estimated to be responsible for 1·4 million child deaths and 44 million DALYs (10% of DALYs in children younger than 5 years). In

an analysis that accounted for co-exposure of these nutrition-related factors, they were together responsible for about 35% of child deaths and 11% of the total global disease burden.The high mortality and disease burden resulting from these nutrition-related factors make a compelling case for the urgent implementation of interventions to reduce their occurrence or ameliorate their consequences.

2. **A Violation of children'srights**

Malnutrition is a violation of children's right to nutrition. Gilbert and other UNICEF colleagues are deeply moved by the relief and appreciation that mothers express when their children are saved by RUTF treatment. RUTF's irrefutable success in saving millions of children from dying has had the power to shock donors and partners to do whatever it takes to ensure RUTF is adequately pre-positioned wherever children are vulnerable to hunger crises.

Integrating nutrition supply chains into national supply systems to improve care for vulnerable children and support for the cost-effective and sustainable production of RUTF is a significant contribution of the supply function towards saving lives.

However, UNICEF's Nutrition Programmes are based on evidence-informed protocols for the early detection and treatment of children with severe wasting. A holistic, preventive approach is at the heart of UNICEF's nutrition strategy.

3. **Child malnutrition fueled by impacts of COVID-19, climate change and war in Ukraine**

The socio-economic impacts of the COVID-19 pandemic have made an existing child malnutrition crisis worse by increasing household poverty and food insecurity and disrupting essential nutrition services in already vulnerable communities. The ripple effects of the war in Ukraine on global supply chains have further contributed to rising food and fuel prices. Years of severe drought in the Horn of Africa — the region's worst climate-induced emergency in 40 years — is endangering millions of young lives.

UNICEF estimates that 8 million children under age 5 in 15 countries are at risk of death from severe wasting unless they receive immediate therapeutic food and care, and has issued an urgent appeal for support to accelerate its response. UNICEF has long worked with manufacturers of RUTF to increase the product's ready availability and to keep prices down. In May 2022, however, UNICEF flagged that the price of Ready-to-Use Therapeutic Food was projected to increase by up to 16 percent over the next six months due to a sharp rise in the cost of raw ingredients
– potentially leaving up to 600,000 additional children without access to lifesaving treatment at current spending levels. Shipping and delivery costs were also expected to remain high.

"For millions of children every year, these sachets of therapeutic paste are the difference between life and death," UNICEF Executive Director Catherine Russell said. "A 16 percent increase may sound manageable in the context of global food markets, but at the end of that supply chain is a desperately malnourished child, for whom the stakes are not manageable at all."

- **Government & Non-government Efforts in SAM Treatment Remains Key Driver to RUTF demand**

As RUTF tends to deliver rapid weight gain while the children are still recovering, it has been the top nutrition alternative recommended by the WHO, UNICEF, WFP, and UNSSCN for malnourished kids worldwide, over the years.
A few emerging economies in the Asia Pacific region and some of the African countries register a significant rate of malnutrition and thus constantly fuel the demand for RUTF. Several organizations, teaming up with a variety of initiatives funded by governments, are increasingly taking efforts in raising funds for buying and distributing RUTF products in underprivileged Asian and African countries.

UNICEF is encouraging R&D of innovative raw materials and domestic production of ready-to-use food products, which is identified to be a major driver to the market growth.

Surging awareness about combating malnutrition and strong support from government as well as non-government entities from across the world will stand to be the most impactful factors improving the performance of the global ready-to-use therapeutic food products in near future.

However, expensive prices of RUTF products may continue to impose financial pressure on individuals, governments, and non-government bodies across developing economies

- **Case Studies**

CASE STUDY - 1

The day Prosper rushed his 3-year-old son, Pierre, to the nearest health center, he wondered if he would survive. Pierre weighed just under 20 pounds and he had severe diarrhea. During the 7-mile walk from their village to the capital of the Central African Republic, Prosper prayed: “I wondered if God’s plan was to take him back.”

Pierre’s mother had died shortly after he was born. With no job in a country ripped apart by conflict, Prosper was struggling to provide for his family, collecting corn from the dwindling supplies at a nearby farm. As Pierre’s weight steadily dropped and he grew sicker, refusing to eat, Prosper looked to traditional medicine to help his son, thinking he couldn’t afford hospital care. The situation is all too common in

CAR and in many other countries and across regions where UNICEF works. Severe drought, armed conflict, the effects of the COVID-19 pandemic and other crises has resulted in soaring rates of child malnutrition around the world. Over the past nine years, fortified ready-to-use foods have made a remarkable impact on the treatment of malnutrition in children in sub Saharan Africa. These lipid paste foods resist bacterial contamination because they contain very little water, do not require cooking and are very energy dense (5.5 kcal/g) (Manary 2006).

These characteristics make them ideally suited for use in places in which food insecurity is common and hygiene is poor. Ready-to-use therapeutic food (RUTF) refers to a lipid paste with a formulation that meets the compositional requirements for the treatment of severe malnutrition (composition is equivalent to F-100) as set forth by the World Health Organization (WHO). The only efficacy trial conducted with RUTF was in Senegal in 2001, in which 70 children were fed either F-100, a standard milk-based food, or RUTF. In this trial, there were no adverse events, and the rate of weight gain among those children taking RUTF was 1.5 fold greater than children receiving F-100 (Diop et al. 2003). The first effectiveness trial with RUTF, conducted in 2001, used home-based therapy with RUTF to treat severely malnourished children. This trial compared thee home diets: RUTF, corn/soy blend, and a peanut fortified spread.

This trial demonstrated that the complete RUTF diet was associated with the best outcome; 95 percent of children recovered (Manary 2004). RUTF allows for treatment in the home, a reversal of former practices in which children were treated as inpatients and only 25 percent of children recovered (Brewster 1997). Home-based therapy offers the

advantages of being more hygienic because the alternative, inpatient care, is often delivered in overcrowded facilities where communicable disease is common. Hospitalization requires that an adult stay with the child for the duration, and consequently pulls mothers, mostly subsistence farmers, away from families and fields, often with deleterious results to the family's food production. RUTF made with local ingredients has been shown to achieve the same recovery rate as imported RUTF (Sandige 2004).

In 2003, a large, controlled clinical trial was conducted in which home-based therapy with RUTF was compared to standard inpatient therapy (Ciliberto 2005). In this trial, RUTF achieved 79 percent recovery, while standard therapy was effective in only 46 percent of children. Since that time, RUTF has been used operationally in Malawi;

one documentation of its operational use showed that recovery rate was 89 percent for severe childhood malnutrition (Linneman 2007). RUTF has been endorsed by the UN agencies, including the WHO, World Food Programme and UNICEF, as the most effective method to restore the health of severe/acute malnourished children (WHO 2007). Malawi instituted a national program for the treatment of severe malnutrition in 2007 that encompasses all districts; this program includes home-based therapy with RUTF as trialed through the College of Medicine.

RUTF contains 25 percent milk, an expensive ingredient that is not readily available worldwide. At current market prices, milk constitutes 67 percent of the ingredient cost of RUTF. While the inclusion of some source of animal protein such as milk is thought to be prudent (Schack-Nielsen 2007), such a large amount of milk seems unnecessary when standard human nutrient requirements are considered. Soy has been successfully substituted for animal products in a variety of other foods, including infant formula. Substituting soy for a portion of the milk in RUTF would reduce costs and increase availability. The purpose of this clinical trial was to determine conclusively whether soy might be substituted for a portion of the milk without a reduction in clinical efficacy. The hypothesis tested was that 25 percent milk RUTF would result in a superior recovery rate when compared to 10 percent milk RUTF.

CASE STUDY - 2

At six months, Adifa was diagnosed with severe wasting. Her mother agreed to participate in a groundbreaking study on the acceptability and efficacy of locally produced Ready-to-Use Therapeutic Food. Eight weeks later, Adifa had made a full recovery. Lisnawati smiles as she watches her younger daughter, Adifa, cheerfully play at home in Bogor, West Java Province, Indonesia.

“Nothing makes a mother’s heart happier than seeing her child grow up healthy — and I’m proud to say that I am now a happy mother,” says the mother of two.

For the first six months of her life, Adifa was breastfed by her mother. When Lisnawati tried to introduce solid complementary food to her daughter’s diet, Adifa refused. As a result, she did not gain enough weight and fell below the standard for a healthy child her age, evidenced by her slight frame and weak muscles.

When Lisnawati brought Adifa to a posyandu (integrated community health post) for growth monitoring in July 2021, a health worker diagnosed her with severe wasting, a life-threatening form of malnutrition. Based on Adifa’s condition, the health worker offered the family the opportunity to participate in a groundbreaking study on the acceptability and efficacy of locally produced Ready-to-Use Therapeutic Food (RUTF), a shelf-stable, nutrient-packed paste used to treat severely wasted children. Having already tried several ways to improve her daughter’s condition to no avail, Lisnawati agreed to take part in the study.
Severe wasting — the most dangerous form of malnutrition – continues to be a major public health issue in Indonesia, affecting more than 2 million children under age 5. The condition increases the risk of childhood mortality by approximately 12 times and requires urgent treatment.

While RUTF allows severely wasted children to be successfully treated at home, it has never been produced locally in Indonesia despite strong government commitment. As a result, RUTF products are not widely available in the country due to higher costs and import difficulties.

- **Case Study from different Nations**

1. **Niger, WestAfrica**

Researchers have shown a correlation between the inclusion of vitamin A supplementation into semi-annual or yearly national immunization days in Niger, one of the first countries in Africa, and lower death rates (5, 6). Numerous other countries in the region have successfully included this programme to their programmes. The Ministry of Public Health oversees the organization of nutrition services in the public sector. The Nutrition Division of this ministry oversees all national nutrition promotion initiatives. The Direction of the Health of the Mother and Child, the Direction of Programs and Studies, and the National Program to Fight Malaria are further pertinent divisions and directions within the Ministry of Public Health. The Ministry of Economy and Finances' Direction of Studies and Census and the Ministry of Agricultural Development's Information System for Agricultural Markets are two other governmental organizations involved in IYCN-related operations. The majority of these organizations deal with various facets of managing malnutrition and ensuring foodsecurity.

Additionally, there are numerous national and international non-governmental organizations that concentrate on different nutrition-related activities. National and international organizations have formed a nutrition coordination group that meets frequently in Niamey to coordinate nutrition initiatives throughout Niger. Although reports weren't formally organized for our examination, this group also strives to compile information on supply chain management, coverage, and programme training.

According to reports from UNICEF personnel, how many nutrition rehabilitation facilities there are, a significant increase was made in reaction to the 2005 crisis and are now easier to access in Niger than anywhere else in the

area. However, these facilities offer instead of preventing acute malnutrition, treat it. In this situation, severe malnutrition exists with young children. A diet high in lipids Niger is producing a supplement for usage in Malnutrition prevention and treatment (personal touch with UNICEF officials). This performance reduces the time needed to supply malnourished programmes fortherapy.

These included the fact that links between inpatient and outpatient care were ill-established, the supply chain was primarily supported by external organizations (NGOs and UNICEF), and pre- and in-service training for healthcare workers at all levels was insufficient to support programme operations. Even though the purpose of this paper was to address nutrition crises among CMAM facilities, the conclusions can be used to guide the management of otherlevels of malnutrition care. For use in enhancing results in other malnutrition programmes, the state of these programme activities should be assessed.

2. **Kwale, Kenya**

The Sustainable Development Goal (SDG) 2 (zero hunger and enhanced nutrition), set by the UN in 2015, recognises the need for better nutrition. This SDG gives national and international motivation to tackle malnutrition and advance quickly. Malnutrition is still one of the most serious health problems affecting children under the age of five in Kenya. In Kenya, 4% of children under 5 have acute malnutrition, 26% of children under 5 have chronic malnutrition, and 11% are underweight. According to the Kenya Demographic and Health Survey, the infant mortality rate is 39 deaths for every 1,000 live births, and the mortality rate for children under the age of five is 52 deaths for every 1,000 live births.

According to the 2009 Kenya Demographic and Health Survey (KDHS), Kwale County, one of Kenya's 47 counties, had the second-highest percentage of malnutrition amongst young children under the age of five (39%) compared to the national average.
(Official Report -https://dhsprogram.com/pubs/pdf/fr229/fr229.pdf)
This has decreased over time, according to the 2014 Kenya Demographic and Health Survey (KDHS), and was reported as 29.7%, but it was still the second highest in the nation. Due to the highest rate of malnutrition among children under the age of 5, Trnava University from the Slovak Republic established 3 nutrition centers in chosen areas within Kwale County. The logistical location of the centers was also a deciding factor in the field being considered a subset as it allowed for easy access from the local communities.

In 2012, nutrition centers were built in the Matuga Sub-County of Kwale County and were situated in the Mkongani Health Center, the Tiwi Rural Health Training Center, and the Kwale Sub-County Hospital. Through the diagnosis and treatment of malnutrition, the provision of adequate complementary food (porridge, vitamin supplements, beans), as well as the education of caregivers on child care and their health, these offer medical, cultural, and counseling

services for undernourished children and their caregivers. This helps to improve the quality of life for the households and communities in their entirety.
Malnourished children were also given medical attention in collaboration with neighbourhood hospitals. Treatment of malnutrition-related ailments, deworming, and vaccinations were all included in medical care.

The three feeding centers offered two nutrition programmes:

- Children in the SFP (Supplemental Feeding Program) who were moderately-

underweight;

- Outpatient Therapeutic Feeding Programs (OTP) for the severely malnourishedchildren.

Children with severe malnutrition who were registered in the OTP were given Ready to Use Therapeutic Food (RUTF). Once these children were discharged from the OTP, they were immediately accepted into the SFP. Malnourished children below 5 years showed significant improvement in their nutritional status when they are admitted into therapeutic feeding programs for a period of at least four months. This improvement corresponds with a proven approach of integrated management of malnutrition where there are interventions at the national/regional level (available health center and nutrition center with educated and skilled experts); interventions at community level (for caretakers, family members and communities to provide health and nutrition education, promotion of optimal infant-feeding practices and better childcare); systematic organization of work in a nutrition center (accurate anthropometric measurements, adequate supplementary food for malnourished children under 5as RUTF, porridge, vitamins but also support food for families during child's treatment); home visiting and monitoring of children in their home environment; regular assessment of child nutrition status and creation of the networking among professionals working with malnourished children to share knowledge and experiences and to collaborate if needed.

- **Future Outlook**

RUTF has saved thousands of lives in recent years and a Codex guideline could help to:
Facilitate trade disputes and provide guidance on importation requirements, provide a framework for sustainable procurement of quality products and provide an official global reference for manufactures on the minimum requirements for RUTF. This will help to ensure products are safe, efficacious and of a good quality.

Provide an advocacy opportunity for children's rights to good nutrition, provide an opportunity to clarify certain aspects, e.g contaminants so that the formulation can be improved and assist in the development of a regulatory framework at national levels.

As per the regional analysis, Europe and MEA are and will remain the key markets, whereas North America is slated to thrive at a healthy double digit growth rate over the assessment period. Regional players in the European market are the key suppliers of RUTF to UNICEF and other leading organizations. Maximum manufacturing facilities are sophisticated enough and are now under the process of expansion. Attributed to this, Europe is estimated to exhibit robust production and revenue generation, and in turn healthy growth. Local governments in MEA are increasing the budget for malnutrition treatment, whereas regional governments are taking efforts to establish manufacturing facilities.

As a result, the revenue contribution from MEA will however be relatively higher during the forecast period. In APAC, the implementation of CAMAM in Asian countries is propelling demand. APAC and MEA expected to expand vigorously, owing to the highest number of opportunities through to 2024.

Possible Solutions

Locally produced energy reaches food or manufactured by local people and groups using local food ingredients should be used for community management of severe forms of malnutrition.

- Strategies to manage all forms of malnutrition, including severe acute malnutrition, should be food-based, not single supplement product-based.
- Reduction in the prevalence of severe malnutrition, particularly in chil-

dren, over a specified period of time, should be the first indicator of the success of strategies to manage malnutrition.

- Reduction in RUTF cost using different alternatives sources of nutrition or by reducing process parameters.

UNICEF's Nutrition Strategy 2020-2030

\UNICEF's Nutrition Strategy 2020–2030 calls for multi-sector programmes to strengthen the capacity and accountability of the food, health, water and sanitation, education, and social protection systems to deliver nourishing diets, essential nutrition services, and positive nutrition practises for children, adolescents, and women in order to achieve the Sustainable Development Goal (SDG) of ending child malnutrition.
(Nutrition Strategy – *https://www.unicef.org/media/92031/file/UNICEF%20Nutrition%20Strategy%202020-2030.pdf*) (SDG's – *https://sdgs.un.org/goals*)

The major duty for upholding children's right to nourishment lies with national governments. However, achieving nutrient-dense diets, necessary nutrition services, and beneficial nutrition practices for all children, adolescents, and women requires collaboration across a number of public, corporate, societal, and governmental stakeholders.

Conclusion

Acute malnutrition puts 52 million children at high risk of not reaching their physical and cognitive potential, and the regions shouldering the highest burdens of this life-threatening condition, southern Asia and Africa, represent some of the most under-resourced and underdeveloped countries in the world. The call to end hunger in Sustainable Development Goal 2 will require more than just advancing the treatment of acute malnutrition using effective, locally produced RUTF. RUTF saves lives as a proven and high-quality nutrition treatment needed for a child to recover, but ensuring that all children can reach their full development potential requires us to go further.

RUTF contains all nutrients needed for the recovery of such SAM children. This can be a practical solution to at least 2 million children outside the hospitals and medical facilities. Ready to use therapeutic food within the person's own home for the treatment of severe acute malnutrition in children under five years of age may be effective at improving weight gain and recovery when compared to alternative

dietary approaches. The effectiveness of ready to use therapeutic food on potential relapses or on overall mortality is not clear. Henceforth the benefits of the RUTF need more intensive research. This can also bring in the development of guidelines and toolkit to counsel families on nutrition and feeding practices. In turn, it works as a soft power to educate the community on preventive measures against malnutrition and also about food culture, sanitation and gender disparity.

By looking at both the sides of the coins i.e. RUTF is a Practical solution but right on the other hand, its effectiveness is not very clear, the committee as its conclusive outcome would be willing to give a final answer to the question that, “Can Ready-to-use therapeutic food be considered as a permanent solution; and with the help of countries having rich resources, asking them for production and procuring RUTF and then distributing it to the needful; is it an efficient solution?

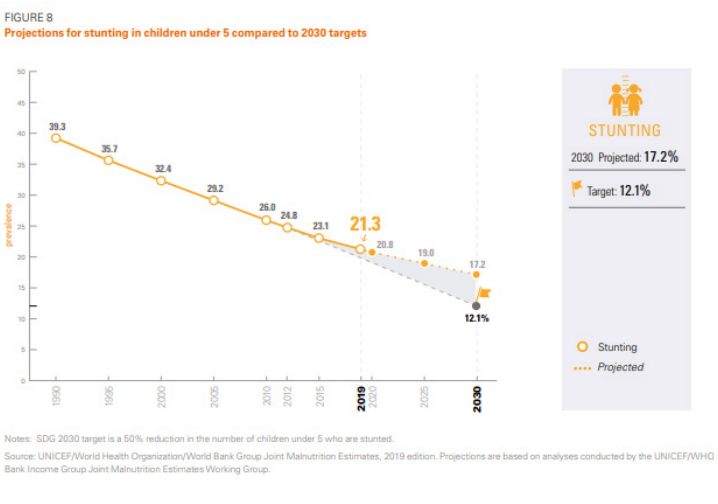
Questions to Ponder

Q1. What is a benefit of RUTF to treat malnutrition?

Q2. How do you manage a child with severe acute malnutrition? Q3.Whataresomenursinginterventionstopromotegood-nutrition? Q4. Why is RUTF often seen as a threat tobreast-feeding?

Q5. Why is it recommended that RUTF formulations comply with section 3 of the standards for the labeling of and claims for foods for special medical purposes?

Q6. How has RUTF resulted in surge in demand in low income countries that are frequently food nsecure?



Suggested Readings

1. https://www.unicef.org/nutrition/RUTF
2. https://www.unicef.org/supply/stories/saving-lives-rutf-ready-use-therapeutic-food
3. https://www.unicef.org/nutrition/RUTF#:~:text=RUTF%20is%20ready%2D-to%2Duse,most%20dangerous%20form%20of%20malnutrition
4. https://www.actioncontrelafaim.org/wp-content/uploads/2018/02/rutf_on_the_eml_cf_version.pdf
5. https://www.unicef-irc.org/files/documents/d-3838-Position-Paper--Ready-to-.pdf
6. https://www.raps.org/news-and-articles/news-articles/2022/8/the-value-of-a-ready-to-use -therapeutic-food-guide
7. https://research.un.org/en/un-resources
8. https://www.un.org/development/desa/disabilities/resources.htm

- **Rules of Procedure**

Roll Call

A committee meeting begins with a roll call, without which quorum cannot be established. A debate cannot begin without a quorum being established. A delegate may change his/her roll call in the next session. For example, if Delegate answers the Present in the First session, he can answer Present and vote in the next session when the roll call occurs.

During the roll call, the country names are recalled out of alphabetical order, and delegates can answer either by saying Present or Present and voting. Following are the ways a roll call can be responded in -

- Present - Delegates can vote Yes, no, or abstain for a Draft Resolution when they answer the Roll Call with Present;

- Present and voting - An delegate is required to vote decisively, i.e., Yes/No only if they have answered the Roll Call with a Present and voting. A Delegate cannot abstain in this case.

- Abstention - The Delegate may abstain from voting if they are in doubt, or if their country supports some points but opposes others. Abstention can also be used if a delegate believes that the passage of the resolution will harm the world, even though it is unlikely to be highly specific. A delegate who responded with present and voting is not allowed to abstain during a substantive vote. An abstention counts as neither “yes” nor “no vote”,and his or her vote is not included in the total vote tally.

Quorum

In order for the proceedings of a committee to proceed, quorum (also known as a minimum number of members) must be set which is one-third of the members of the committee must be present. Quorum will be assumed to be established unless a delegate’s presence is specifically challenged and shown to be absent during the roll call. The Executive Board may suspend committee sessions if a quorum is not reached.

General Speakers List

After the agenda for the session has been established, a motion israised to open the General Speaker's List or GSL. The GSL is where all types of debates take place throughout the conference, and the list remains open throughout the duration of the agenda's discussion. If a delegate wishes to speak in the GSL, he or she must notify the Executive Board by raising his or her placard when the Executive asks for Delegates desiring to speak in the GSL. Each country's name will be listed in the order in which it will deliver its speech. A GSL can have an individual speaker time of anywhere from 60-120 seconds. Following their GSL speech, a Delegate has the option of yielding his/her time to a specific Delegate, Information Points (questions) or to the Executive Board.

Speakers List will be followed for all debate on the Topic Area, except when superseded by procedural motions, amendments, or the introduction of a draft resolution. Speakers may speak generally on the Topic Area being considered and may address any draft resolution currently on the floor. Debate automatically closes when the Speakers List is exhausted.

Yield

A delegate granted the right to speak on a substantive issue may yield in one of three ways at the conclusion of his/her speech: to another delegate, to questions, or to the Director. Please note that only one yield is allowed. A delegate must declare any yield at the conclusion of his or her speech.

• Yield to another delegate. When a delegate has some time left to speak, and he/she doesn't wish to utili#e it, that delegate may elect to yield the remaining speaking time to another delegate. This can only be done with the prior consent of another delegate (taken either verbally or through chits).The delegate who has been granted the other's time may use it to make a substantive speech, but cannot further yield it.

• Yield to questions. Questioners will be selected by the Executive Board. Follow-up questions will be allowed only at the discretion of the Director. The Director will have the right to call to order any delegate whose question is, in the opinion of the Director, rhetorical and leading and not designed to elicit information. Only the speaker's answers to questions will be deducted from the speaker's remaining time.

• Yield to the EB. Such a yield should be made if the delegate does not wish his/her speech to be subject to questions. The moderator will then move to the next speaker.

Motions

Motions are the formal term used for when one initiates an action. Motions cover a wide variety of things.

- Once the floor is open, the Chairs will ask for any points or motions. If you wish to bring one to the Floor, this is what you should do:
- Raise your placard in a way that the chair can read it
- Wait until the Chair recognizes you
- Stand up and after properly addressing the Chair(":hank you, honourable Chair" or something along these lines), state what motion you wish to propose
- Chairs will generally repeat the motions and may also ask for clarification. Chairs may do this if they do not understand and may also ask for or suggest modifications to the motion that they feel might benefit the debate.

Every motion is subject to seconds, if not otherwise stated. To pass a motion at least one other nation has to second the motion brought forward. A nation cannot second its own motion. If there are no seconds, the motion automatically fails.

If a motion has a second, the Chair will ask for objections. If no objections are raised, the motion will pass without discussion or a procedural vote. In case of objections, a procedural vote will be held. The vote on a motion requires a simple majority, if not otherwise stated.

While voting upon motions, there are no abstentions. If a vote is required, everyone must vote either "Yes" or "No". If there is a draw on any vote, the vote will be retaken once. In case there are multiple motions on the Floor, the vote will be casted by their Order of Precedence. If one motion passes, the others will not be voted upon anymore. However, they may be reintroduced once the Floor is open again.

During a moderated caucus, there will be no speakers' list. The moderator will call upon speakers in the order in which the signal their desire to speak. If you want to bring in a motion for a moderated caucus, you will have to specify the duration, a speakers' time, a moderator, and the purpose of the caucus. This motion is subject to seconds and objections but is not debatable.

In an unmoderated caucus, proceedings are not bound by the Rules of Procedure. Delegates may move around the room freely and converse with other delegates. This is also the time to create blocks, develop ideas, and formulate working papers, draft resolutions, and amendments. Remember that you are required to stay in your room unless given permission to leave by a Chair.

During the course of debate, the following **points** are in order:

Point of Personal Privilege: Whenever a delegate experiences personal discomfort which impairs his or her ability to participate in the proceedings, he or she may rise to a Point of Personal Privilege to request that the discomfort be corrected. While a Point of Personal Privilege in extreme case may interrupt a speaker, delegates should use this power with the utmost discretion.

Point of Order: During the discussion of any matter, a delegate may rise to a Point of Order to indicate an instance of improper parliamentary procedure. The Point of Order will be immediately decided by the Director in accordance with these rules of procedure. The Director may rule out of order those points that are improper. A representative rising to a Point of Order may not speak on the substance of the matter under discussion. A Point of Order may only interrupt a speaker if the speech is not following proper parliamentary procedure.

Point of Parliamentary Enquiry: When the floor is open, a delegate may rise to a Point of Parliamentary Inquiry to ask the EB a question regarding the rules of procedure. A Point of Parliamentary Inquiry may never interrupt a speaker. Delegates with substantive questions should not rise to this Point, but should rather approach the committee staff during caucus or send a note to the dais.

Point of information: After a delegate gives a speech, and if the delegate yields their time to Points of Information, one Point of Information (a question) can be raised by delegates from the floor. The speaker will be allotted the remainder of his or her

speaking time to address Points of Information. Points of Information are directed to the speaker and allow other delegations to ask questions in relation to speeches and resolutions.

Right to Reply: A delegate whose personal or national integrity has been impugned by another delegate may submit a Right of Reply only in writing to the committee staff. The Director will grant the Right of Reply and his or her discretion and a delegate granted a Right of Reply will not address the committee except at the request of the Director.

Draft Resolution

Once a draft resolution has been approved as stipulated above and has been copied and distributed, a delegate(s) may motion to introduce the draft resolution. The Director, time permitting, shall read the operative clauses of the draft resolution. A procedural vote is then taken to determine whether the resolution shall be introduced. Should the motion received the simple majority required to pass, the draft resolution will be considered introduced and on the floor. The Director, at his or her discretion, may answer any clarificatory points on the draft resolution. Any substantive points will be ruled out of order during this period, and the Director may end this clarificatory question-answer period' for any reason, including time constraints. More than one draft resolution may be on the floor at any one time, but at most one draft resolution may be passed per Topic Area. A draft resolution will remain on the floor until debate on that specific draft resolution is postponed or closed or a draft resolution on that Topic Area has been passed. Debate on draft resolutions proceeds according to the general Speakers List for that topic area and delegates may then refer to the draft resolution by its designated number. No delegate may refer to a draft resolution until it is formally introduced.

Amendments

All amendments need to be written and submitted to the executive board. The format for this is authors, signatories and the clause with mentioning the add, delete and replace. There are two forms of amendment, which can be raised by raising a motion for amendment and approval of the chair:

- Friendly Amendments: Amendment,which is agreed upon by all the author's does not require any kind of voting

- Unfriendly Amendments: Amendments that are introduced by any other need not be voted upon by the council and are directly incorporated in the resolution. You need a simple majority in order to introduce a normal amendment.

BODY of Draft Resolution

The draft resolution is written in the format of a long sentence, with the following rules:

- Draft resolution consists of clauses with the first word of each clause underlined.

- The next section, consisting of Preambulatory Clauses, describes the problem being addressed, recalls past actions taken, explains the purpose of the draft resolution, and offers support for the operative clauses that follow. Each clause in the preamble begins with an underlined word and ends with a comma.

- Operative Clauses are numbered and state the action to be taken by the body. These clauses are all with the present tense active verbs and are generally stronger words than those used in the Preamble. Each operative clause is followed by a semi-colon except the last, which ends with a period.

SAMPLE POSITION PAPER

Committee : UNDP

Country : Chad

Topic : Women in Development

Chad is concern with gender equality issues and quite glad with the attention tChad is concerned about gender equality concerns and is pleased that people are paying attention to this subject. We promote human rights and believe that all humans, including men and women, are created equal. We see that violence and gender discrimination would be a violation of human rights. We also think that women, like men, should be allowed a larger role in practically every facet of life.

This crisis has been resolved in practically every country, and we now need to create a safer and more secure environment.

improved environment for women and their activities As many as 70% to 80% of women are responsible for their home. However, they are in an unpleasant condition due to a lack of education, financial management, and even awareness of their rights. Which led to bigger problems such as unpaid overtime work, low education owing to forced young marriage, and other culturally based constraints that make people unhappy.

Our country may have joined and ratified human rights accords that acknowledged the Gender equality is a concept. And our government enthusiastically passed the domestic violence statute, which is yet another step toward recognising this issue. Nonetheless, we think that there is a problem in law enforcement, which is why Chad will participate in UNDP programmes regarding gender equality, women empowerment, and advocating our position to our own people.

The government of Chad presented various remedies to this problem.

1. Creating an environment in which women are accepted and treated equally. in which case

As an example, UNDP should engage in social and cultural activities to create a “model community.” to different villages Education is one of the projects. The majority of the time, young girls are stolen.away from school and compelled to work or marry owing to financial difficulties Developing an option may be night school or another flexible-in-time and free school.

2. A basic financial education. Women should seek out services or products that are effective. capable of handling them We would aid them in obtaining credit and a better and safer loan. And they should be functioning as entrepreneurs in their town or group. Which in this case In this situation, they create a new, independent employment.