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OFFICIAL HANDBOOK

WHO

Addressing the Long-Term Mental Health Consequences of Armed Conflicts and Forced Displacement

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TABLE OF *contents*

- Committee Overview
- Historical background
- Current Situation
- Key areas of debate
- Different Perspective
- Delegation List
- Sources

COMMITEE

overview

The World Health Organization (WHO) is a specialized agency of the United Nations established on April 7, 1948. As the principal international committee directing authority on global public health, its main purpose is to make sure that all nations are guided to attain the highest possible level of physical, mental, and social well-being. The WHO serves as a forum for international health diplomacy. It establishes global medical standards, coordinates responses to biological emergencies, facilitates scientific research, and offers technical assistance to national healthcare worldwide.

This committee has a structure of three primary bodies. These are the World Health Assembly (WHA), the Executive Board, and the Secretariat. WHA acts as the supreme decision-making authority and meets annually in Geneva, with representatives from all 194 member states. The Assembly is responsible for approving the Organizational Programme Budget, electing the Director-General, and adopting international health regulations or treaties. The Executive Board is composed of 34 health professionals, and the Secretariat is led by the Director-General, with six regional offices and over 150 country offices.It is in times of crisis that the World Health Organization acts as the international center for data exchange, coordination for emergency response, and bringing technical cooperation between states while navigating state sovereignty.

HISTORICAL *background*

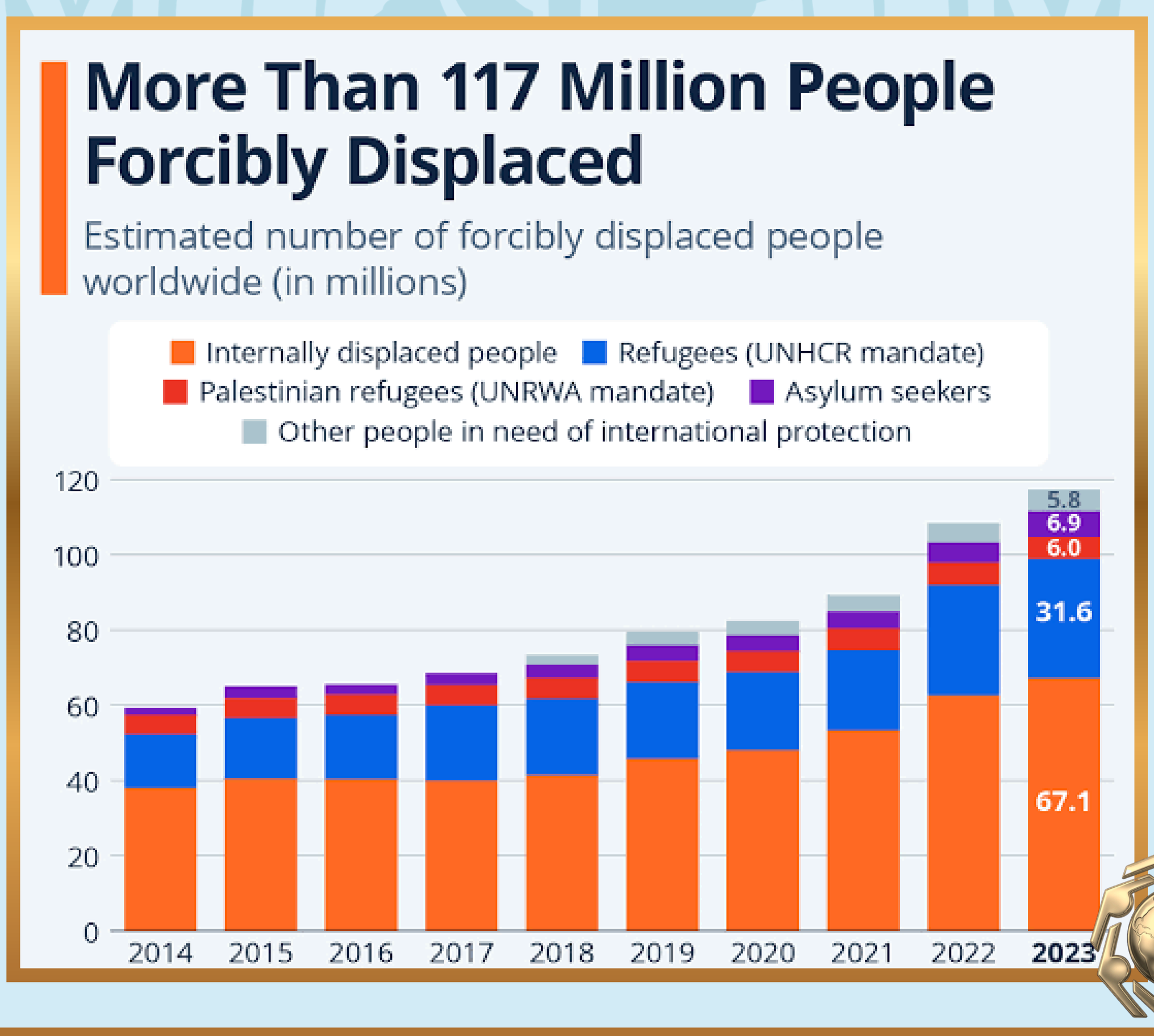
Early humanitarian aid focused almost exclusively on physical survival. Many times, mental health was restricted to pre- existing severe psychiatric disorders such as schizophrenia. It was only after the Vietnam War that PTSD (post-traumatic stress disorder) was formally recognized during 1980s trauma studies, but early international efforts believed in the “one-size-fits-all” Western clinical models that ignored local cultural context and possible generational trauma, which means that for many future years mental health was not only misdiagnosed but mistreated.





It was through constant examples that people were suffering in many other ways that physically when real progress was made in this field. Events such as the Balkans in 1991, where many families lost loved ones and refugees were displaced, and their community was collectively suffering from grief. Or Rwanda in 1994, when a country had just faced genocide, yet the community was expected to act as if nothing had happened.

Regardless of positive developments in the legal arena, the treatment of conflicts and displaced people has focused on physical health and neglected mental health. Displaced persons undergo trauma during all phases of migration, which include violence before leaving home, dangerous travel, and stressful life conditions post-migration (for example, detention, poverty, and legal concerns). The anti-conflict frameworks developed in the past paid little attention to mental health issues, which prevented many people affected by wars and conflicts from receiving timely assistance in solving their problems.



CURRENT *situation*

The number of those being forcibly displaced today is higher than ever before due to long-standing conflicts in places like the Middle East, Eastern Europe, Sub-Saharan Africa, and some regions in Asia. As reported by the United Nations High Commissioner for Refugees, more than 110 million people are displaced around the world today. Furthermore, modern-day warfare increasingly involves urban areas and civilian objects that contribute to the suffering of civilians and aggravate their long-term psychological state.

Despite the effectiveness of Mental Health and Psychosocial Support services, there are significant gaps in their availability. The national health budgets of countries with a large refugee population allocate less than 2% of their entire budget to mental health, while special facilities treating mental health issues do not exist at displacement camps. Also, because funding by humanitarian organizations is usually temporary, it is difficult to create sustainable mental health systems that could be integrated with national health systems.



The World Health Organization (WHO) has launched several initiatives to develop a comprehensive global governance system for mental health. A key component of this effort is the Comprehensive Mental Health Action Plan for 2013-2030, which outlines strategies to improve mental health services and promote mental well-being worldwide. Additionally, the WHO has created specialized toolkits that provide practical guidance for integrating mental health support into humanitarian response efforts. These toolkits are particularly valuable in regions that have been severely affected by crises, as they help ensure that mental health assistance is included alongside other critical health services, addressing the psychological impact of such challenging situations.



KEY AREAS OF *debate*

- Can international donors and member states successfully transition from emergency humanitarian funding to sustainable financing for integrated mental health systems in host countries and post-conflict settings?
- Should resources be focused on integrated community primary health care, or are there situations where dedicated specialized psychiatric care is necessary to deal with severe trauma in refugee populations?
- How can international mental health initiatives find the right balance between respecting cultural diversity and combating stigma while avoiding imposing Western mental health practices onto the local population?
- What can public health authorities do to make progress in monitoring schemes and epidemiological data collection about mental health consequences of refugees, IDPs, and other such groups?
- What should be the degree of obligation of host country governments to help undocumented migrants, refugees, and asylum seekers get access to national mental health care on an equal basis with national citizens?

DIFFERENT *perspectives*

- Countries that host a large number of refugees in the world, including Lebanon, Jordan, Colombia, and Uganda, feel that they have to bear an unfair amount of financial and administrative burden. They argue that the global community's statements on mental health rights mean little until practical help arrives in the form of money, capacity improvements, and shared responsibility among rich donor countries.

- Donor countries emphasize strict accountability and transparency in humanitarian aid delivery. They usually promote the idea of capacity building while preferring individual project financing instead of contributing to general budgetary funding of the receiving governments. One of the pretexts they usually give is the risk of corruption in the aid-giving countries or inefficiency of their bureaucracies.

- International organizations, including the UNHCR, WHO, and NGOs concerned with the provision of medical aid, state that the principle of provision of mental health care applies immediately after the beginning of the emergency. They demand legal obligations and guarantees that such care and support will receive the status of being on par with food, water, and shelter.

DELEGATIONS *list*

- United States of America
- China
- Russia
- Ukraine
- Turkiye
- Lebanon
- Colombia
- Afghanistan
- Japan
- Iran
- Germany
- France
- Ireland
- India
- Brazil
- Médecins Sans Frontières (MSF / Doctors Without Borders)
- International Rescue Committee (IRC)
- International Medical Corps
- Pfizer
- Moderna

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