



NHSMUN

National High School Model United Nations

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A Note on the NHSMUN Difference

Esteemed Faculty and Delegates,

Welcome to NHSMUN 2027! We are Armen Bagdassarian and Sabeeh Mirza, and we are elated to serve as this year's Secretaries-General. Thank you for choosing to attend NHSMUN, the world's largest and most diverse high school Model United Nations conference. As a space for collaboration, consensus, and compromise, NHSMUN strives to transform today's brightest thinkers, speakers, and collaborators into tomorrow's leaders. We believe that an emphasis on education through simulation is paramount to the Model UN experience.

Realism and Accuracy: Although a perfect simulation of the UN is never possible, we believe that one of the core educational responsibilities of MUN conferences is to educate students about how the UN System works. We strive to invite real UN, NGO, and field experts into each committee through our committee speakers program. Moreover, we arrange meetings between students and the actual UN Permanent Mission of the country they are representing. These exclusive resources are only available due to IMUNA's formal association with the United Nations Department of Global Communications and consultative status with the Economic and Social Council. No other conference goes so far to deeply immerse students into the UN System.

Educational Emphasis: At the heart of NHSMUN lies education and compromise. Part of what makes NHSMUN special is its diverse delegate base. As such, when NHSMUN distributes awards, we strongly de-emphasize their importance in comparison to the educational value of Model UN. In particular, our daises look for and promote constructive leadership and diplomacy that strive toward consensus, as real ambassadors do in the United Nations.

Research and a Dedicated Staff: Our staffers care deeply about delegates' experiences and what they take away from their time at NHSMUN. Our Directors spend over six months preparing Background Guides, in addition to Update Briefs written to reflect the rapidly changing nature of the topics to be discussed. Our staffers are trained rigorously to provide the best conference experience possible. Our daises provide thoughtful comments on submitted position papers. Our staff aims to tailor the committee experience to delegates' reflections and research, but also to facilitate an environment where all delegates' thoughts can be heard.

Empowering Participation: The UN relies on the voices of all of its member states to create resolutions. This is our philosophy at NHSMUN too. Our Rules of Procedure and our staff focus on making every voice in the committee heard, regardless of country assignment or skill level. Additionally, unlike many other conferences, we also emphasize delegate participation after the conference. Delegates spend countless hours researching topics critical to the UN and broader international sphere.

Delegates, it is our sincerest hope that your time at NHSMUN will be thought-provoking and stimulating. NHSMUN is an incredible time to learn, grow, and embrace new opportunities. We look forward to seeing you work both as students and global citizens at the conference.

Best,

Armen Bagdassarian
Secretary-General

Sabeeh Mirza
Secretary-General

Position Paper Requirements

Delegate research and preparation is a critical element of attending NHSMUN and enjoying the debate experience. We have provided this Background Guide to introduce the topics that will be discussed in your committee. We encourage and expect each of you to critically explore the selected topics and be able to identify and analyze their intricacies upon arrival to the conference.

The task of preparing for the conference can be challenging. To assist delegates, we have updated our [Beginner Delegate Guide](#) and [Advanced Delegate Guide](#). These guides contain more detailed instructions on how to prepare a position paper and excellent sources that delegates can use for research. Use these resources to your advantage. They can help transform a sometimes overwhelming task into what it should be: an engaging, interesting, and rewarding experience.

To accurately represent a country, delegates must be able to articulate its policies. Accordingly, NHSMUN requires each delegation (the one or two delegates representing a country in a committee) to write a position paper for each topic on the committee's agenda. More information about how to write and format position papers can be found in the [Research Guide](#). To summarize, position papers should be structured into three sections.

I: Topic Background – This section should describe the history of the topic as it would be described by the delegate's country. Delegates do not need to give an exhaustive account of the topic, but rather focus on the details that are most important to the delegation's policy and proposed solutions.

II: Country Policy – This section should discuss the delegation's policy regarding the topic. Each paper should state the policy in plain terms and include the relevant statements, statistics, and research that support the effectiveness of the policy. Comparisons with other global issues are also appropriate here.

III. Proposed Solutions – This section should detail the delegation's proposed solutions to address the topic. Descriptions of each solution should be thorough. Each idea should clearly connect to the specific problem it aims to solve and identify potential obstacles to implementation and how they can be avoided. The solution should be a natural extension of the country's policy.

Each topic's position paper should be **no more than 10 pages long** double-spaced with standard margins and 12 point font size. This is a maximum; **3–5 pages per topic is often a suitable length**. The paper must be written from the perspective of your assigned country and should articulate the policies you will espouse at the conference.

Each delegation is responsible for submitting position papers on or before **February 26, 2027**. If a delegate wishes to receive detailed feedback from the committee's dais, their position paper must be submitted on or before **February 5, 2027**. The papers received by this earlier deadline will be reviewed by the committee dais and returned before February 26. Instructions on how to submit position papers will be shared directly with faculty advisors.

Submission instructions for position papers will be sent to faculty advisers via email. If delegations are unable to submit their position papers on time, please contact us at nhsmun@imuna.org.

Delegations that do not submit position papers will be ineligible for awards.

Committee History

The World Health Organization (WHO) was established on April 7, 1948, with the initial aim of serving as an international health organization.¹ To achieve this goal, the WHO Constitution divides the organization into three organs: The World Health Assembly (WHA), the Executive Board, and the Secretariat.² WHA serves as the main legislative body, consisting of not more than three delegates representing each member state in the UN.³ Its main functions are to “determine the policies of the Organization, appoint the Director-General, supervise financial policies, and review and approve the proposed programme budget,” alongside other financial, legislative, and public health duties.⁴ Some of the legislation that the WHA has the power to discuss how to enact include sanitary and quarantine procedures, disease nomenclatures, and standards for diagnostic procedures and biological goods.⁵

Most WHA resolutions contain recommendations rather than requirements that Member States must follow.⁶ However, the WHO Constitution also allows the WHA to adopt conventions and regulations in specified areas. One example is the International Health Regulations, which were adopted in 2005 and entered into force in 2007.⁷ Under the IHR, the WHO Director-General, acting with advice from an Emergency Committee, determines whether an event constitutes a public health emergency of international concern. This designation was applied to the West African Ebola outbreak in 2014 and COVID-19 in January 2020.⁸

It has been observed that since the foundation of the WHO, public health challenges have been reduced and even eradicated as a result of the efforts of such organizations. Some of the WHO's most important achievements include developing the International Health Regulations, coordinating the successful eradication of smallpox, and supporting international efforts against diseases such as polio, tuberculosis, malaria, and HIV. Despite WHA's infrastructural capabilities, logistical or bureaucratic challenges can sometimes arise. For instance, during the COVID-19 pandemic, many critics emerged concerning the slow decision-making. Despite its limitations, the organization has proven the importance of its existence and the relevance of international cooperation.

A more recent challenge arose in January 2026, when the WHO acknowledged the United States' notification of withdrawal from the organization.⁹ The United States was a founding member and had contributed to major WHO efforts involving smallpox, polio, HIV, Ebola, tuberculosis, malaria, and other health threats. The WHO warned that the decision could make both the United States and the wider world less safe. The withdrawal raised broader concerns about how the loss of a major financial and technical partner could affect international coordination and the WHO's ability to respond to global health challenges.¹⁰

¹ “History,” WHO, accessed September 23, 2023, <https://www.who.int/about/history>.

² WHO, “History.”

³ “World Health Assembly,” WHO, accessed September 23, 2023, <https://www.who.int/about/governance/world-health-assembly>.

⁴ “World Health Assembly,” WHO, accessed September 23, 2023, <https://www.who.int/about/governance/world-health-assembly>.

⁵ WHO, “History.”

⁶ “Basic Documents,” World Health Organization, accessed September 23, 2023, apps.who.int/gb/bd/pdf_files/BD_49th-en.pdf.

⁷ “Hosted Partnerships,” WHO, accessed September 23, 2023, www.who.int/about/collaboration/partnerships/hosted-partnerships.

⁸ WHO, “Constitution of The World Health Organization,” apps.who.int/gb/bd/PDF/bd47/EN/constitution-x.pdf?ua=1.

⁹ World Health Organization, “WHO Statement on Notification of Withdrawal of the United States,” *statement*, January 24, 2026, www.who.int/news/item/24-01-2026-who-statement-on-notification-of-withdrawal-of-the-united-states.

¹⁰ World Health Organization, “WHO Statement on U.S. Withdrawal.”

TOPIC A

WHA | NHSMUN 2027

Global Rise of Non-Communicable Diseases



Introduction

Non-communicable diseases (NCDs) are diseases that are not spread from one person to another.¹ Instead, they usually develop slowly and can last for many years or even for a person's entire life. NCDs can be caused by a mix of genetic, environmental, social, and lifestyle factors.² These causes are known as risk factors and include smoking, alcohol use, unhealthy diets, lack of exercise, obesity and air pollution. Common types of NCDs include heart disease, cancer, chronic respiratory diseases, and diabetes. Worldwide, these four groups cause 80 percent of NCD deaths before the age of 70.³

Currently, NCDs are the leading cause of death globally and affect people in every region of the world.⁴ Low- and middle-income countries are affected the most, because many people do not have stable access to doctors, medicine, or long-term treatment. This problem has only worsened during the last few decades. People are living longer, cities are growing, and daily habits have changed. Many people now consume more processed foods, sugary drinks, and meals that are high in salt and unhealthy fats. People are often less active because of changes in work, transportation, urban development, and daily life.

Smoking, alcohol use, pollution, and unhealthy foods all increase the risk of non-communicable diseases. However, NCDs are not only caused by personal choices. A person's health is also shaped by their location, including access to healthy food and healthcare. In some communities, healthy food is too expensive, but processed food is cheap and easy to find. Some areas do not have safe parks, sidewalks, or sports spaces. Companies also affect one's health through the products they sell and the ways they advertise them. Therefore, preventing NCDs is not only the responsibility of individuals. Governments, businesses, schools, health systems, and communities also play an important role. This shared burden has led to an important debate: whether governments should place greater responsibility on individuals to live healthier lives, or if they should focus on regulating the environments that shape people's

choices.

NCDs do not affect everyone in the same way. People living in rural or impoverished areas face many more challenges to access care. Some may not have a clinic nearby, may be forced to travel for hours to receive care, or may be unable to afford treatment. Refugees and people living in conflict zones may lose access to doctors, pharmacies, and medical records. Children can also develop health risks early in life due to poor nutrition, stress, pollution, and lack of exercise.⁵ These problems can increase their chance of developing NCDs later in life.⁶ Another challenge is that NCDs require both prevention efforts and long-term care. Governments must try to stop new cases, while also helping people who are already sick. Prevention may involve government policies such as better nutrition labels, exercise programs, vaccination against infections that can cause certain cancers, and regular health checks. Meanwhile, accessible treatment requires trained health workers, local clinics, and affordable care. For example, a person with diabetes may need insulin, blood tests, doctor visits, and other supplies for the rest of their life. Without regulation, this can be very expensive, so people may not be able to afford the essential care they need to survive.

Countries must also decide how to best use their limited health resources. Wealthier countries may be able to invest in both prevention and treatment. However, greater national wealth does not guarantee that everyone can access

care. Low-income households, racial and ethnic minorities, migrants, Indigenous communities, people with disabilities, and people living in rural areas may still face high costs, discrimination, long travel distances, language barriers, or shortages of specialized providers. Emerging economies may face rapid growth in NCDs while their healthcare systems are still developing. Low-income countries may face a double burden of disease. This means they must fight both infectious diseases and NCDs with limited funding, infrastructure, medicines, and healthcare workers. Therefore, no single solution will work for every country. Even within the same country, different populations may face very different barriers to prevention and treatment. High-income countries, emerging economies, and low-income countries face unique challenges and have different resources available. Therefore, governments must adjust their priorities to make sure all populations can receive appropriate and affordable care.

NCDs are an urgent issue for the World Health Assembly (WHA) because they affect health, education, jobs, families, and national economies. They increase healthcare costs, limit people's ability to work or attend school, and worsen poverty and inequality. They also threaten progress toward the Sustainable Development Goals (SDGs). SDG 3.4 calls for countries to reduce early deaths from NCDs by one-third by 2030.⁷ Addressing these challenges requires the international community to work together to prevent and reduce the effects of NCDs.

History and Description of the Issue

THE “BIG FOUR” NON-COMMUNICABLE DISEASES AND THEIR GROWING GLOBAL BURDEN

The impact of NCDs extends far beyond health outcomes. These diseases place significant

pressure on healthcare systems, reduce workforce productivity, increase healthcare expenses, and contribute to cycles of poverty and inequality.⁸ Although NCDs affect populations in all regions of the world, low- and middle-income countries experience the greatest disease burden.⁹ More than 75 percent of premature NCD-related deaths occur in countries where access to healthcare, prevention programs, and treatments remain limited. Deaths are considered premature when they happen between the ages of 30 and 70 and are caused by one of the main NCDs.¹⁰ Four main diseases account for the majority of NCD-related deaths and disabilities worldwide: cardiovascular diseases, cancer, respiratory diseases and diabetes. These conditions are commonly referred to as the “Big Four” NCDs because of their overwhelming contribution to global illness and mortality.

CARDIOVASCULAR DISEASES

Cardiovascular diseases (CVDs) are the most prevalent non-communicable disease and are the leading cause of death worldwide. According to the World Health Organization (WHO), nearly 20 million people die from CVDs each year. This accounts for approximately one-third of all global deaths, which is more than any other NCD category.¹¹ In 2021, cardiovascular diseases accounted for at least 38 percent of all deaths from NCDs among people under the age of 70.¹² While many cardiovascular conditions are preventable, millions of people continue to die each year due to limited access to early diagnosis, treatment, and preventive healthcare. This is often caused by weak healthcare systems, the high cost of care and medicines, a shortage of healthcare workers, and limited access to regular health screenings. As a result, many people are diagnosed only after the disease has become more serious and harder to treat.

The growing burden of cardiovascular disease is related to changes in population health. High blood pressure has become one of the most

important risk factors for CVDs. A risk factor is a condition or behavior that increases a person's likelihood of developing a disease. Factors such as obesity, the consumption of processed foods, an inactive lifestyle, and the consumption of alcohol and tobacco all lead to a higher risk of disease.¹³ These trends have been observed in both developed and developing countries, although their effects are often more severe in regions with weaker healthcare systems. This is because people are less likely to receive regular health check-ups, early treatment, and medicines to control these risk factors before they lead to serious disease.

Another big factor in the increase in cardiovascular diseases is population aging.¹⁴ This happens because the heart and blood vessels naturally change with age, and risk factors such as high blood pressure, high cholesterol, and diabetes have more time to damage the body over many years. As a result, researchers project that annual cardiovascular deaths could increase from approximately 20.5 million in 2025 to 35.6 million by 2050.¹⁵

Obesity rates have increased because many people now consume more energy-dense and ultra-processed foods and sugary drinks while living increasingly sedentary lives and receiving too little physical activity.¹⁶ Obesity can, in turn, increase the risk of hypertension and other cardiovascular conditions. High blood pressure, also known as hypertension, is influenced by high-sodium diets, physical inactivity, obesity, tobacco use, harmful alcohol use, and population aging.

These risk factors are found around the world, but are rising especially quickly in many low- and middle-income countries. Because cardiovascular diseases are responsible for more deaths than any other NCD, reducing their impact remains a priority for governments and international organizations. Improving prevention, expanding access to treatments and addressing the major risk factors like hypertension and obesity will be essential if countries hope to reduce mortality.

CANCER

Cancer is one of the most significant non-communicable diseases worldwide and is responsible for nearly 10 million deaths each year.¹⁷ Cancer includes more than one hundred different conditions that can affect almost any part of the body. Combating cancer is particularly challenging, due to the growing number of people who require long-term treatment and care.

The burden of cancer varies considerably across regions. In many high-income countries, breast, colorectal, prostate, and lung cancer are most common.¹⁸ These patterns are correlated with large aging populations, as well as lifestyle-related risk factors such as smoking, obesity, physical inactivity, and alcohol consumption.¹⁹ Many high-income countries have invested in screening and early-detection programs. This can help patients receive earlier diagnoses and improve their chances of survival, though access remains unequal within these countries.²⁰ Many lower-income countries face additional barriers, including limited funding, diagnostic equipment,

As life expectancy rises, a larger share of the global population is reaching the ages at which heart disease and strokes become more common.

healthcare facilities, and trained personnel.

Cancers linked to infectious diseases, such as cervical cancer and liver cancer, remain more common because many people do not have access to vaccines, regular screening, or early treatment for infections such as human papillomavirus (HPV) and hepatitis B, which can increase the risk of developing cancer over time. Access to screening, diagnosis, and treatment is limited, meaning that many cases are only discovered once the disease has reached an advanced stage.²¹ As a result, countries with fewer resources often experience higher cancer mortality rates even when the total number of cases might be lower.

Cancer is not only a medical issue, but also a development challenge closely linked to healthcare inequality. For many families, a cancer diagnosis can lead to significant financial debt due to treatment costs and lost income. This burden is especially severe in low- and middle-income countries, where health insurance is limited and many people must pay for treatment themselves. Families may also lose income when patients or caregivers are unable to work, making it even harder to afford medicines, transportation, and other daily needs.

Rising cancer rates place increasing pressure on healthcare budgets and can reduce economic productivity as more people require long-term care or leave the workforce because of illness.²² These challenges are expected to grow as populations continue to age and life expectancy increases globally.

Addressing cancer requires more than improving treatment alone. Governments must also focus on prevention by reducing tobacco use, promoting healthier lifestyles, expanding vaccination programs like for human papillomavirus (HPV) and hepatitis B, and ensuring that early detection services are available to all populations.²³ Without stronger action in these areas, cancer is likely to remain one of the fastest growing non-communicable diseases in the coming decades.

CHRONIC RESPIRATORY DISEASES

Chronic respiratory diseases (CRDs) are long-term diseases that affect the lungs and airway, making it difficult for people to breathe. Common examples include asthma and chronic obstructive pulmonary disease, which includes chronic bronchitis and emphysema. CRDs affected an



Cancer patient

Credit: Rhoda Baer

estimated 545 million people in 2017, an increase of nearly 40 percent since 1990.²⁴ Despite affecting hundreds of millions of people, these diseases often receive less attention and funding than other major NCDs. This is partly because they are often underdiagnosed, receive less public attention than diseases such as cancer and cardiovascular disease, and are given lower priority in many national health programs. This is despite the fact that they caused approximately 4.2 million deaths globally in 2023 and continue to have a major impact on people's daily lives.²⁵ Suffering from a CRD often makes it difficult to work, attend school, or carry out everyday activities, because symptoms such as shortness of breath, chronic coughing, wheezing, and fatigue can make even simple physical activities more difficult. Severe cases may also require frequent medical visits or hospital stays, leading to missed work and school.²⁶

One of the most important features of chronic respiratory diseases is their strong connection to the environment. While smoking remains a major risk factor worldwide, the causes of respiratory disease differ from region to region. In many rural and underserved communities, smoke from burning wood, coal and other solid fuels remains a serious health risk, especially for women and children.²⁷ This smoke contains tiny particles and harmful gases that can damage the lungs over time, leading to inflammation, reduced lung function, and diseases such as chronic obstructive pulmonary disease (COPD). Women and children are often the most affected because they spend more time near indoor cooking fires. Many of these households do not have access to clean cooking fuels, electricity, or good ventilation, forcing families to rely on solid fuels for cooking and heating.

Alongside household air pollution, outdoor pollution from motor vehicles, industrial facilities, power generation, and other sources also poses a serious health risk.²⁸ It affects both urban and rural areas and contributes to acute and chronic respiratory diseases, lung cancer, and other health conditions.

Reducing the burden of respiratory diseases will therefore require not only better healthcare, but also better efforts to improve air quality and reduce pollution.²⁹ Many countries are already taking action by introducing stricter vehicle emission standards, expanding public transportation, creating smoke-free public spaces, and supporting the use of cleaner cooking fuels. The WHO has also developed global air quality guidelines to help countries reduce pollution and protect public health. Together, these strategies can lower exposure to harmful air pollutants and reduce the number of people who develop chronic respiratory diseases.

DIABETES

Diabetes is described as a global epidemic and is one of the fastest growing non-communicable diseases in the world. Today, approximately 589 million people are living with diabetes. This number is projected to increase to 853 million by 2050 if current trends continue.³⁰ More than 90 percent of cases are Type 2 diabetes, a form of the disease that is largely preventable.³¹ Unlike Type 1 diabetes, which is caused by the immune system attacking the cells that produce insulin, Type 2 diabetes develops when the body does not use insulin properly. Type 2 diabetes is strongly linked to risk factors such as obesity, unhealthy diets, physical inactivity, and population aging, although genetics also play a role.

Diabetes rates are rising rapidly in parts of Africa, Southeast Asia, the Middle East, and North Africa. This growth is associated with rapid urbanization, changing diets, lower levels of physical activity, rising obesity rates, population growth, and longer life expectancy.³² Pakistan illustrates the scale of this challenge. According to International Diabetes Federation data cited by Health Policy Watch, approximately 33 million Pakistanis, 26 percent of the adult population, were living with diabetes in 2021, giving the country the world's highest adult prevalence rate.³³ More than one-third of these cases were undiagnosed, and the number of people living

with diabetes was projected to reach 62 million by 2045 without stronger preventive action. Between 2009 and 2019, death and disability caused by diabetes in Pakistan increased by 87 percent.³⁴

These trends are especially concerning because healthcare systems may already face shortages of funding, trained workers, screening services, and essential medicines. In Pakistan, some primary-care facilities established to address NCDs have lacked staff, insulin, and other medicines, limiting their ability to provide the full range of promised services.³⁵ As the number of cases grows, governments will face increasing pressure to expand prevention and early detection while also providing affordable, long-term care to people already living with diabetes. Access to insulin, medicines and regular monitoring remains unequal across countries, leaving many people unable to properly control their condition.³⁶ As a result, diabetes continues to take millions of lives each year and places a growing strain on healthcare systems worldwide. For many policymakers, addressing diabetes is not only a health priority, but also a development challenge that will become increasingly important in the coming decades.³⁷

Together, cardiovascular diseases, cancer, chronic respiratory diseases and diabetes account for the majority of deaths and disabilities caused by NCDs worldwide. Although each presents a unique challenge, all four place increasing pressure on healthcare systems, particularly in low and middle income countries. Their shared risk factors and long-term treatment needs create important questions about how governments should divide resources between prevention, early detection, and continuing care.

NCDs AMONG VULNERABLE AND AT-RISK POPULATIONS

Non-communicable diseases (NCDs) do not affect everyone the same way. A person's health is often shaped by where they live, how much money they have, and whether they can get medical care. These differences create health gaps, meaning that some groups face greater disease risks, worse health outcomes, and less access to care. These include people living in poverty, refugees, migrants, Indigenous communities, older adults, people with disabilities, and people living in rural or conflict-affected areas.³⁸ People living in poverty are also more likely to rely on inexpensive



A child with diabetes wearing an insulin pump

Credit: Guus Herbschleb

processed foods that are high in sugar, salt, and unhealthy fats. They may have fewer safe places to exercise, face greater exposure to air pollution, and experience chronic stress caused by financial insecurity. Together, these factors increase the risk of developing NCDs such as diabetes, cardiovascular disease, and obesity.

One of the main reasons for these differences is that many people lack access to healthcare. In some rural areas, the nearest clinic may be several hours away.³⁹ Families may not have enough money to travel or pay for treatment.⁴⁰ In many low- and middle-income countries, there are also too few doctors, nurses, and medicines. This problem affects both urban and rural areas, although it is often more severe in rural communities. It is mainly caused by limited healthcare funding, shortages of trained health workers, and unequal distribution of medical resources. Health services are often focused in large cities, leaving small towns and villages with very limited care.⁴¹ Because of this, many diseases are diagnosed too late, making them harder to treat. Long travel distances and high costs may cause people to delay check-ups or discontinue treatment, allowing conditions such as hypertension, diabetes, and cancer to become

more difficult and expensive to manage.

War makes these problems even worse. In countries such as Sudan, Ukraine, and Yemen, hospitals have been damaged or destroyed, and many healthcare workers have had to leave due to ongoing conflict.⁴² Millions of people have been forced to leave their homes and become refugees. Refugees often lose access to their doctors, medicines, and medical records. Many live in camps or temporary shelters where healthcare is limited. Poor living conditions, stress, and not having enough healthy food can also make long-term diseases harder to manage.⁴³ Many refugees also experience interrupted treatments for chronic diseases while moving between countries. Medicines may not always be available, and language barriers can make it more difficult to communicate with healthcare providers. Even after a conflict ends, it can take many years to rebuild hospitals and return healthcare services to normal.⁴⁴

Children and older adults often face extra challenges. Children depend on adults to recognize symptoms and obtain care. Also, conditions during childhood, including poor nutrition, pollution, and chronic stress, can shape their risk of NCDs throughout life. Older

Oral health care

Credit: Brendan John



adults often need ongoing care and medicine to manage long-term diseases, but many struggle to pay for treatment or travel to a clinic.⁴⁵ They are especially affected by conditions such as cardiovascular diseases, diabetes, and cancer, which become more common with age and often require regular monitoring and lifelong treatment. People with disabilities may also face barriers if healthcare buildings, transportation, or health information are not easy to access. These barriers can further delay diagnosis and treatment, increasing the risk of complications. Those with disabilities may also have higher healthcare costs and require specialized equipment or trained professionals who are not always available. In many rural and low-income areas, limited healthcare services and long travel distances make these challenges even greater.

Oral health is a good example of these health gaps. Tooth decay is the most common health condition in the world. It affects about 2.5 billion people, even though it can usually be prevented with good oral hygiene, less sugar, fluoride toothpaste, and regular dental care.⁴⁶ Children, low-income families, refugees, migrants, and people living in rural areas are more likely to have untreated cavities because they often cannot visit a dentist or afford fluoride toothpaste.⁴⁷ Tooth decay can cause pain, infections, trouble eating, and missed days of school or work. This reduces quality of life and increases healthcare costs. It also shares important risk factors with many other NCDs, especially diets that are high in sugar. Because oral diseases and other NCDs share many of the same risk factors, policies that promote healthy diets and improve access to preventive healthcare can reduce the burden of both. Including oral healthcare in primary-care and NCD strategies may therefore allow governments to address several shared risk factors through the same programs.

Many of these problems can be reduced with simple actions. Mobile clinics can bring healthcare to remote communities. Community health workers can teach healthy habits and help people receive basic care close to home.⁴⁸

Schools can provide health education, healthy meals, and support oral health programs. Digital health programs can also provide health education, reminders, and continuing support through mobile phones.⁴⁹ For example, the WHO–ITU Be He@lthy, Be Mobile initiative supports mobile health programs in countries including India, Senegal, Egypt, and Zambia.⁵⁰ These programs send information about diabetes management, healthy lifestyles, tobacco cessation, and cancer screening directly to participants. In Senegal, diabetes-related text messages were associated with improved blood-sugar control; in Zambia, a mobile cervical-cancer program reached more than 500,000 people and contributed to a six-percent increase in screening at participating sites.⁵¹ Governments can also make sure that refugees and migrants are included in national healthcare systems instead of being left behind, by allowing them to enroll in public health insurance programs, providing affordable or free healthcare services, and offering language interpretation and culturally appropriate healthcare when needed.

Reducing health gaps should be a goal for every country. Better access to healthcare, healthy food, education, clean water, and medicines can prevent many NCDs before they become serious. Countries should focus on prevention, while also making sure that treatment is available for everyone, no matter where they live or their income. By helping the people who face the greatest barriers, governments can improve health, reduce healthcare costs, and give millions of people a better quality of life.

CHILDHOOD RISK FACTORS AS THE EARLY DEVELOPMENT OF NCDs

Non-communicable diseases (NCDs) do not only affect adults. Research shows that the risk of developing these diseases often begins much earlier. Health during pregnancy, infancy, childhood, and adolescence can affect a person's health for the rest of their life.⁵² This idea is known as the life-course approach. It indicates

that NCD prevention should start early, instead of waiting until people become sick later in life.⁵³ Delegates must therefore consider how international NCD strategies should support early-life prevention and how states with limited resources can fund these programs while continuing to treat people already living with NCDs.⁵⁴

The first stage begins before birth. During pregnancy, a baby's body and organs develop very quickly. A mother's nutrition, health, and environment all play an important role in keeping babies healthy.⁵⁵ Poor nutrition, smoking, alcohol use, air pollution, and health problems during pregnancy can affect how a baby grows.⁵⁶ Babies born either too small or much larger than expected have an increased risk of developing different NCDs later in life, including obesity, type 2 diabetes, heart disease, and other chronic conditions.⁵⁷ As a result, many countries are increasing support for prenatal care, healthy pregnancies, and maternal nutrition. For example, countries such as Nepal, Rwanda, and Tanzania have expanded prenatal care programs by providing free prenatal check-ups, iron and folic acid supplements, nutrition counseling, and regular screening for conditions such as gestational diabetes and high blood pressure. Protecting a mother's health also helps protect the health of the next generation.

The first 1,000 days of life, from birth until a child's second birthday, is another key period of development.⁵⁸ During this time, the body and immune system continue to grow and develop. Appropriate nutrition, vaccines, and regular health check-ups, as well as a safe home, all

support healthy development. Problems during these early years can affect growth and long-term health. For example, poor nutrition during this period can weaken the immune system, slow brain development, and affect healthy growth. Children who do not receive proper nutrition or health care early in life are more likely to develop obesity, type 2 diabetes, cardiovascular disease, and hypertension as adults.

Exposure to air pollution, repeated infections, and diets high in added sugar can also increase the risk of chronic diseases later in life. The WHO and UNICEF recommend exclusive breastfeeding during the first six months of life, followed by nutritious complementary foods while continuing breastfeeding until at least two years old. Regular vaccinations, growth monitoring, vitamin and mineral supplementation when needed, and reducing children's exposure to tobacco smoke are also important ways to protect long-term health. Studies have shown that children who receive proper nutrition and healthcare during the first 1,000 days are more likely to grow, learn, and stay healthy throughout their lives.⁵⁹ Even small improvements during this stage can have lifelong benefits for children and lower the future burden of NCDs.⁶⁰

Diets high in sugar, salt, and unhealthy fats can increase the risk of obesity.⁶¹ At the same time, many children spend more time sitting and using screens while spending less time being physically active. Spending more time on screens is often linked to unhealthy eating habits, shorter sleep, and less time spent outdoors, which further increase the risk of non-communicable diseases. Sleep is also important. Children who do not

As children grow older, their daily habits become one of the biggest factors that affect their future health.

get enough sleep are more likely to develop unhealthy eating habits and weight problems. Lack of sleep can affect the hormones that control hunger and fullness, making children feel hungrier and more likely to choose foods that are high in sugar and fat. Children who are tired may also be less physically active and spend more time using screens.⁶² Because these behaviors often continue into adulthood, building healthy habits early is one of the best ways to prevent future disease.

However, children are shaped by the world around them. Children are more likely to eat healthy foods when schools provide healthy meals and when fresh food is affordable and easy to find. They are also more likely to stay active when schools offer physical education or when communities have safe parks, playgrounds, and sports programs. At the same time, advertising for foods and drinks high in sugar, salt, and unhealthy fats can encourage unhealthy habits from an early age.⁶³ For example, ads for sugary breakfast cereals, soft drinks, fast food, and candies are commonly shown on television, social media and mobile apps. Companies also use cartoon characters, toys included in children's meals, and social media influencers to make these products more attractive to young audiences, encouraging children to choose unhealthy foods more often. Creating healthy environments makes healthy choices easier for children and their families.

However, opportunities to be physically active are not distributed equally. Children in lower-income households may be less able to afford sports fees, equipment, or transportation; they may also attend schools or live in communities with fewer safe and accessible places for exercise.⁶⁴ Studies have also reported differences in average physical activity levels among children from different racial and ethnic backgrounds. These differences are not necessarily caused by race or ethnicity itself; they may partly reflect inequalities in income, education, available time, transportation, and neighborhood resources.⁶⁵ These findings suggest that governments should

examine whether all children have equal access to safe spaces, school programs, transportation, free time, and affordable opportunities for physical activity.

Mental and emotional health are another important part of early NCD prevention. Children who grow up with long periods of stress, family conflict, violence, neglect, or other difficult experiences may face health problems later in life.⁶⁶ Long-term stress can affect how the body responds to illness and may increase the risk of both physical and mental health conditions.⁶⁷ Over time, chronic stress can increase blood pressure, affect the immune system, and change the way the body controls blood sugar and stores fat. It can also make children more likely to develop unhealthy coping behaviors later in life, such as smoking, drinking alcohol, physical inactivity, or unhealthy eating, all of which increase the risk of NCDs. Safe homes, supportive schools, and strong communities help children develop healthy habits and build resilience as they grow. Programs that provide mental health support, positive parenting education, school counselors, and protection from violence can reduce the effects of early-life stress. Helping children build strong relationships with parents, teachers and other adults also improves emotional well-being and lowers the risk of long-term health problems.

Many NCDs are no longer seen only in adults. Around the world, more children and teenagers are being diagnosed with obesity, type 2 diabetes, high blood pressure, and other long-term health conditions.⁶⁸ Unhealthy environments and behaviors are affecting people at very young ages. Without early action, many children may live with these diseases for most of their lives, increasing pressure on families and healthcare systems.

As a result, many countries are now focusing more on prevention than treatment. Governments are expanding programs that support healthy pregnancies, breastfeeding, healthy school meals, regular physical activity, tobacco

control, and nutrition education.⁶⁹ For example, Finland has provided free, nutritious school meals to all students for decades and includes nutrition education as part of its national curriculum. Brazil's "Amamenta e Alimenta Brasil" program promotes breastfeeding and healthy complementary feeding through primary healthcare services. Their National School Feeding Program provides healthy meals planned by nutritionists and limits sugary and highly processed foods in schools.⁷⁰ Some countries have also limited the marketing of unhealthy foods to children or introduced taxes on sugary drinks to encourage healthier diets. For example, Norway has strict regulations that prohibit television advertising directed at children under the age of 18. The government also promotes healthy eating through national guidelines, limits the marketing of unhealthy foods to children, and provides free fruits and vegetable programs in many schools to encourage healthier eating habits. While these efforts have shown positive results, many countries still need stronger policies and better funding to reach every child.

Investing in children is one of the most effective ways to reduce the future burden of NCDs. Healthy habits formed early in life often last into adulthood, making prevention one of the best long-term public health strategies. By supporting families, improving school environments, and helping children make healthy choices from the start, countries can reduce disease, improve quality of life, and build healthier generations for the future.

CASE STUDY: THE AMERICAN TOBACCO INDUSTRY AND ADVERTISING

Corporations have played a major role in the spread of NCDs. Some businesses have a positive impact on global health. For example, pharmaceutical companies develop medicines and vaccines that save millions of lives. On the other hand, other industries profit from products that contribute to serious health risks. One example is the tobacco industry. Tobacco

causes significant harm to its users, as well as the people around them. It is highly addictive and damages almost every organ in the body with direct inhalation or second-hand smoke. It can lead to major NCDs, such as heart disease, lung disease, weakened immunity, and many forms of cancer. Currently, one sixth of deaths by NCDs are caused by tobacco.⁷¹ Around the world, over 1.2 billion people use tobacco products, causing over 7 million deaths every year.⁷² The World Health Organization states that "All forms of tobacco use are harmful, and there is no safe level of exposure."⁷³ Despite this, it is projected that the tobacco industry will generate roughly USD 1 trillion by the end of 2026.⁷⁴

Advertising has played a major role in the growth of the tobacco industry. One corporation that revolutionized the role of advertising is the R. J. Reynolds Tobacco Company (RJR). Throughout the 1800s, tobacco became very popular throughout the United States. RJR was founded during this time and in 1913, they introduced Camel cigarettes. Before this, pre-packaged cigarettes were relatively unpopular in the United States. However, RJR used creative advertising methods to build publicity for their product. They published joke ads claiming that "The Camels are coming," as well as bringing real camels from circuses into towns and giving out free cigarettes.⁷⁵ As a result of these methods, Camel quickly became one of the most popular brands in the United States.⁷⁶

However, RJR has also faced major challenges and backlash due to its advertising methods. From 1936 to 1939, the company advertised Camel cigarettes as beneficial for digestion. The Federal Trade Commission did not prohibit these claims until 1951, more than a decade after the campaign ended.⁷⁷ This delay illustrates how misleading advertising can cause harm before regulators respond and why rules are only effective when they are enforced promptly.⁷⁸

By the time the FTC got involved, the ads had been out of circulation for more than a decade, so the ruling had very little direct impact on

RJR's operations. This example shows that corporations may use misleading health claims to generate profits, particularly when advertising rules are weak or poorly enforced. RJR was able to run a campaign of false and misleading ads for four years and faced virtually no consequences. While regulations are important and can be effective, they can only be successful when they are enforced well. Although this case study focuses on the United States, tobacco companies operate across borders and may shift marketing toward countries with weaker advertising rules. It therefore raises a broader question for WHA delegates: how can countries coordinate business regulations while respecting national authority and different markets?

RJR continued to use misleading advertising. By 1946, some medical specialists had begun to speak out about the dangers of smoking.⁷⁹ As tobacco sales increased, so did rates of lung cancer. Some doctors began to wonder if there was a connection.⁸⁰ In response, RJR launched the "More Doctors Smoke Camels" campaign.⁸¹ This campaign claimed that Camel was the most used cigarette brand among doctors. It was supposedly based on an independent survey of over 100,000 doctors around the United

States.⁸² However, the study that RJR cited was conducted by the William Esty Company, an advertising agency that directly worked for RJR. Since this study was not independent, it is difficult to determine if it is fully accurate and free from bias. Additionally, there are some claims that participants were asked about their cigarette preferences after they were given a free pack of Camel cigarettes. This would mean that the data may have been influenced in favor of Camel and was not fully accurate.

Another major issue with this campaign was credibility. Many of the supposed doctors portrayed in their ads were often actors, not medical professionals.⁸³ At the time, doctors were viewed as highly trusted figures in society. Even though it didn't explicitly say this, the "More Doctors" campaign implied that if doctors used Camels, it meant that they were healthier or safer than other brands. This message was not backed by real scientific evidence. Instead, it misrepresented data to help RJR increase its sales.⁸⁴

Similar advertising strategies continue today. Corporations use suggestive, but often inaccurate, messages to market unhealthy products as healthier than the competition.

More people are smoking **CAMELS** than ever before!

According to a Nationwide survey:

DOCTORS SMOKE CAMELS THAN ANY OTHER CIGARETTE

When 113
by three i
ganization
they smok
Camel tha

"More Doctors Smoke Camels" campaign

Credit: Internet Archive Book Images

However, that does not mean that they are healthy in the first place. In industries like tobacco and alcohol, this can have major consequences on public health. Today, similar risks can appear when social-media influencers promote alcohol, tobacco, and vaping products to young people, sometimes in content that may escape existing advertising regulations.⁸⁵ WHA delegates should consider how governments can require companies to disclose financial relationships and scientific conflicts of interest, verify health claims, and protect children from misleading digital advertising.

Finally, one of the biggest dangers of the tobacco industry is its history of advertising to the youth. In 1987, RJR introduced Old Joe (also called Joe Camel), a cartoon camel mascot as part of a new ad campaign.⁸⁶ This campaign was extremely controversial. Cartoons and animal mascots are commonly used to advertise to younger age groups, mainly children. In May 1997, the FTC issued a complaint that the Old Joe campaign violated federal law. It claimed that the campaign encouraged children to smoke and directly led to an increase in smoking among minors.⁸⁷

Officially, RJR claimed this campaign was not meant to target any specific age groups. However, internal documents later revealed that RJR intended for Old Joe to appeal to children under 18.⁸⁸ One study tested this by showing famous logos and brands to children aged 3-6. It found that over 50 percent of children in this age range recognized the Camel brand through Old Joe, including 90 percent of children aged six.⁸⁹ In July 1997, after ten years of use, RJR relented and discontinued the Old Joe campaign in the United States.⁹⁰ The Old Joe campaign remains relevant because it shows how advertising can build familiarity with an unhealthy product before children are old enough to understand its risks. Similarly, advertising can make unhealthy food products more familiar and appealing to children, influencing their perceptions and preferences.⁹¹ Early brand recognition can make tobacco use appear normal, harmless, or socially appealing and may influence later decisions to begin

smoking. WHA delegates should therefore consider how advertising rules can protect children from both traditional campaigns and newer forms of digital marketing.

In the 21st century, traditional cigarettes have become less popular. However, the tobacco industry and its use of advertising are still relevant. This is especially evident through the use of electronic cigarettes (e-cigarettes). E-cigarettes have also been promoted as tools to help adults quit smoking. Some studies indicate that nicotine e-cigarettes can help certain smokers quit traditional cigarettes.⁹² However, WHO does not consider their effectiveness as consumer cessation products established at the population level, and their appeal to young people creates separate public-health risks. Current advertising has shifted to promoting vaping as a healthier alternative to smoking. E-cigarette aerosol generally contains fewer harmful chemicals than smoke from traditional cigarettes, but most contain nicotine, which is highly addictive.⁹³ Their aerosol may also contain cancer-causing chemicals, heavy metals, and tiny particles that can travel deep into the lungs.⁹⁴

E-cigarettes also have new risks not present in other cigarettes, such as ingestion of the liquid itself.⁹⁵ However, many companies continue to use the “healthier than cigarettes” premise in advertising their products. Many companies also target younger demographics, including teens and preteens. Advertising is done by including new flavors, bright packaging, and targeted social media collaborations and ads. As a result, vaping has become strongly linked to pop culture. This has led to new forms of social pressure to try and continue vaping.⁹⁶ Even students who want to quit may struggle because of nicotine addiction and social pressure, both of which can be reinforced by corporate marketing.

The tobacco industry is a prominent example of the role corporations have in the spread of NCDs. The industry has continued to employ misleading advertising to expand and reap profits at the expense of consumers. Regulations

exist to prevent this type of misinformation, but enforcement can be inefficient and often takes a long time to carry out. The connection between tobacco and many NCDs has been well-established for decades. More proof is available than ever before, yet it is easier than ever for corporations to target vulnerable groups. This is also the case for other related industries, including alcohol, fast foods, and unhealthy drinks. It is essential for countries to consider their own policies regarding harmful industries and advertising when attempting to solve this issue.

Current Status

OBESITY AND LIFESTYLE RISK FACTORS

The World Health Organization (WHO) defines obesity as being overweight and having enough excess body fat to increase the risk of disease and poor health.⁹⁷ According to the Organization for Economic Co-operation and Development (OECD), high obesity rates are one of the main contributors to NCD development worldwide.⁹⁸ Obesity raises the risk of type 2 diabetes, heart disease, stroke, and certain cancers. Because of this, many experts consider obesity one of the most important health crises of the 21st century. Today, obesity is recognized as a chronic and relapsing disease. It develops due to many different factors working together beyond lifestyle. This includes biological factors, such as genetics and brain function, as well as external factors including mental health and access to healthy foods.⁹⁹ Instead, it is a complex disease influenced by many conditions that are often outside a person's control.

The obesity epidemic has rapidly worsened over the last three decades. In 2022, about one in every eight people in the world was living with obesity.¹⁰⁰ Currently, around 2.5 billion adults are considered overweight, and more than 890 million are obese.¹⁰¹ This is about 16 percent of

adults worldwide.¹⁰² Since 1990, the number of adults living with obesity has more than doubled. The increase has been even greater among children and adolescents. In this age group, obesity increased from about 2 percent in 1990 to 8 percent in 2022. The number of adolescents living with obesity has roughly quadrupled.¹⁰³ Obesity was once a problem seen mainly in high-income countries, because wealthy states were the first to experience abundance of mass food, cheap processed foods, and widespread desk jobs. Today, obesity rates are increasing in almost every region of the world, especially in low- and middle-income countries.¹⁰⁴

Many lower income countries now face what the WHO calls the “double burden of malnutrition.”¹⁰⁵ This burden is when undernutrition and obesity exist at the same time, even affecting the same family or the same person at different times.¹⁰⁶ For example, someone may consume enough calories to gain excess weight, but still lack important vitamins, minerals, and other nutrients because their diet is poor in quality. This showcases that obesity is not only about eating too much food. It is also about eating foods that provide many calories but very little nutrition.

In many countries, people are eating more processed foods and drinks than ever before. This is called the “industrialization of foods” partly because these products are often cheaper and last longer than healthier food options.¹⁰⁷ This is especially relevant for many lower-income families. In some communities, fast food and processed products are cheaper and easier to buy. These products are often high in sugar, salt, and unhealthy fats, while containing little fiber and relatively few essential nutrients.¹⁰⁸ Healthy foods can be expensive or difficult to find, so many people do not eat enough fruits and vegetables.¹⁰⁹ Due to factors such as the COVID-19 pandemic, armed conflicts, inflation, climate change, and problems in global food supply chains, healthy foods have become more expensive.¹¹⁰ Armed conflicts, such as the war in Ukraine, have disrupted the global supply of grains, vegetable oils, fertilizers, and fuel. These

factors significantly increased the costs of food production and transportation. Climate change has also reduced crop yields through more frequent droughts and other extreme weather events, making healthy foods less available and more expensive.

A lack of physical activity is another major risk factor. Many people spend much of their day sitting at school, work, or home. This is partly due to more time spent using technology, especially with the rise of remote work and online learning. This shift has continued beyond the COVID-19 pandemic. In the European Union, the share of internet users participating in some form of online learning increased from 21.4 percent in 2019 to 34.8 percent in 2025.¹¹¹ In the United States, the share of college students taking at least one online course remained about 18 percentage points above its pre-pandemic level in 2023.¹¹² Additionally, as cities expand, people have to travel further to reach their jobs and homes. As a result, cars and public transportation have replaced walking and cycling for many daily trips. Many cities also lack safe sidewalks, parks, bicycle lanes, and affordable places to exercise, making it more difficult for people to be active every day.¹¹³ Children are spending more time

using phones, tablets, computers, streaming services, and video games, leaving less time for outdoor play. Together, these changes mean that people often consume more calories while burning fewer calories than previous generations. Over time, this can lead to obesity.

The World Health Organization reports that not getting enough exercise increases the risk of heart disease, diabetes, and some cancers.¹¹⁴ To encourage more active lifestyles, many countries have invested in infrastructure to make activity more convenient, such as parks, walking paths, bicycle lanes, and sports programs. Some governments also run awareness campaigns and events to encourage people to be active. For example, Colombia's "Ciclovía" program closes many city streets to cars on Sundays so people can walk, run, and ride bicycles.¹¹⁵ While these programs do help, many people still do not get enough exercise.

Today, some of the highest obesity rates in the world are found in Pacific Island countries, such as Nauru, Tonga, Samoa, and the Cook Islands. In these places, changes from traditional diets to imported processed foods and lower levels of physical activity have greatly increased obesity.¹¹⁶ Many high-income countries, including the United

Bogotá's Ciclovía

Credit: Lombana



States, also have higher obesity rates because unhealthy foods are widely available and many people have sedentary lifestyles. To address this issue, some governments have introduced taxes on sugary drinks, required nutrition labels on food packages, and improved school meal programs. For example, Finland introduced warning labels on foods high in salt and worked with the food industry to reduce salt in many products. These efforts helped lower salt intake and improved heart health.¹¹⁷ Furthermore, Mexico implemented a tax on many sugary drinks, which was followed by a decline in purchases of taxed beverages.¹¹⁸ Although these policies have made progress, obesity rates continue to rise in many parts of the world. This shows that no single solution is enough and countries must combine prevention, education, healthier food environments, and stronger healthcare systems to reduce obesity and prevent non-communicable diseases.

Personal behavior, commercial practices, and the environments in which people live all shape NCD risk. Delegates must therefore consider how far governments should regulate unhealthy products and environments while respecting national circumstances and individual choice.

STRENGTHENING PREVENTION VERSUS EXPANDING TREATMENT IN THE AGE OF GLP-1 MEDICINES

As the rate of non-communicable diseases continues to increase around the world, governments must decide how to distribute resources between preventing these diseases and treating people who are already sick. This is one of the biggest debates in global health today. Health systems must balance caring for sick patients while also trying to prevent new cases from appearing. Every country has limited money, healthcare workers, medicine, and medical equipment, so governments must decide how to use these resources wisely.¹¹⁹ The growing use of new medicines to treat obesity has made this debate even more urgent.

Some experts believe prevention is the best long-term investment, because it can stop NCDs before they even start. This method may reduce healthcare costs in the long run. The WHO recommends several proven policies called the “Best Buys” to help reduce the dangerous NCD risk factors.¹²⁰ These include higher taxes on tobacco, reducing salt and trans fats, building parks, sidewalks, and bicycle lanes, creating public sports facilities, supporting physical education in schools, and organizing community exercise programs to encourage physical activity. Governments can also improve food labels and limit ads for unhealthy foods and drinks aimed at children. However, prevention cannot meet the needs of people already living with obesity, diabetes, cardiovascular disease, and other NCDs.

Adequate prevention also includes routine screening for NCDs. Simple tests for high blood pressure, diabetes, and some cancers help doctors find disease early in their development. Early diagnosis allows treatment to begin sooner and helps prevent serious complications. But even with strong prevention, millions of people already live with NCDs. These patients need treatment now. Without appropriate treatment, diseases may grow worse over time. This can lead to serious disabilities or even early death. Treating diseases early on costs less than treating severe complications later. Expanding treatment saves lives, but can require governments to make expensive, long-term commitments.¹²¹

GLP-1 medicines provide a recent example of this challenge. These treatments include liraglutide and semaglutide, as well as tirzepatide, a related medicine that acts on both GLP-1 and GIP receptors.¹²² These treatments can lower blood sugar and support weight loss. In September 2025, the WHO added GLP-1 medicines to its Model List of Essential Medicines for adults with type 2 diabetes who also have cardiovascular disease, chronic kidney disease, or obesity.¹²³ In December 2025, it issued the first global guideline on using these medicines to treat

obesity in adults.¹²⁴ This guideline reflects the WHO's recognition of obesity as a chronic, relapsing disease that may require long-term care, rather than a condition caused only by individual lifestyle choices.

However, the WHO's recommendation was conditional.¹²⁵ This is because questions remain about GLP-1's long-term safety and effectiveness, treatment after discontinuation, cost, health-system readiness, and unequal access. Although current evidence suggests that GLP-1 medicines generally have a favorable balance of benefits and risks, continued monitoring is necessary as their novel use expands.¹²⁶ GLP-1 medicines also require continuing medical care. Healthcare providers must determine whether a patient is eligible, gradually adjust the dose, monitor side effects, and provide support if treatment ends. After patients stop taking these medicines, their appetite, blood sugar, and weight may also increase again.¹²⁷ Further, in the United States, semaglutide and tirzepatide can cost approximately USD 900-1,300 per month, although actual costs vary according to the medicine and insurance coverage.¹²⁸

Overall, strong primary healthcare is one of the best ways to improve NCD treatment.¹²⁹ This effectiveness is shown across 28 countries in the Americas, where the Pan-American Health Organization (PAHO) reported in 2025 that more than six million people received standardized hypertension care through primary healthcare centers participating in its HEARTS initiative, and 58 percent had their blood pressure under control.¹³⁰ This directly demonstrates that local clinics can manage a major NCD risk factor.

Other PAHO programs such as the Better Care for NCDs Initiative help countries improve primary healthcare.¹³¹ The initiative supports countries by strengthening primary healthcare services, improving the early detection and treatment of diseases such as hypertension, diabetes, and cervical cancer, and expanding access to essential medicines and diagnostics. Primary healthcare also connects prevention and treatment.¹³² During one visit, patients can receive health education, screenings, diagnosis, treatment, and long-term care. It could also play an important role in providing and monitoring GLP-1 medicines, although many health systems lack the workers and resources needed to do so.

Prioritizing treatment is especially difficult for low- and middle-income countries, since many face a double burden of disease.¹³³ This means they must fight infectious diseases, such as malaria, tuberculosis, and HIV/AIDS, while also dealing with rising rates of diabetes, cancer, heart disease, and other NCDs. Governments must respond to both problems with limited resources and fewer healthcare workers.¹³⁴

Kenya is one example of a lower-middle-income country facing a double burden of disease. Kenya has an estimated adult diabetes prevalence of 3.1 percent to 4.5 percent.¹³⁵ Many patients are not diagnosed until they have already developed serious complications. Further, diabetes-related complications are associated with 60-70 percent of hospital admissions in Kenya, while 80 percent of dialysis patients have diabetes-related kidney failure.¹³⁶ These data demonstrate how failures in early screening and routine care can place additional pressure on hospitals and require more

The WHO emphasizes that GLP-1 medicines should accompany, not replace, healthy diets, physical activity, and broader prevention policies.

expensive forms of treatment, such as dialysis. Thus, it is important that governments focus on treatment and prevention simultaneously.

GLP-1 medicines could deepen some NCD-related inequalities. The WHO estimates that, even if production expands rapidly, GLP-1 medicines may reach fewer than 10 percent of the people who could benefit from them by 2030.¹³⁷ Adding to the resource strain are those who take GLP-1s for cosmetic or non-medical purposes. Social media promotion in particular has encouraged some healthy individuals to seek Ozempic for rapid or cosmetic weight loss. This off-label demand may contribute to shortages and make the medicine harder to obtain for patients with diabetes or obesity who have a clinical need for treatment.¹³⁸ Governments must therefore decide how to regulate these medicines, which patients should receive priority, and whether funding them would leave less money for basic healthcare, infectious-disease programs, or prevention. To address some financing concerns, the WHO has identified pooled procurement, tiered pricing, and voluntary licensing as possible ways to lower prices and expand access.¹³⁹ Still, every country has different resources and health challenges.

Combating NCDs is not simply a choice between prevention and treatment. Delegates must consider how states should balance immediate care for existing patients with long-term investments that reduce future diseases, particularly when funding, health workers, and medical supplies are limited. They must also decide how countries can expand fair access to new treatments such as GLP-1 medicines without allowing their cost to weaken primary healthcare or long-term prevention programs.

ACCESS TO ESSENTIAL MEDICINES, DIAGNOSTICS, AND LONG-TERM CARE

Access to healthcare means more than having medicine available. People living with noncommunicable diseases need to receive a diagnosis, begin treatment and continue receiving

care for many years. If one part of this process is missing, then patients do not receive the full care they need. A person may be diagnosed but unable to obtain medicine or may begin treatment and later stop because it becomes too expensive or unavailable.

Diabetes is one of the clearest examples of the importance of access to treatment. Before insulin was discovered in the early 1920s, type 1 diabetes was almost always fatal.¹⁴⁰ The discovery of insulin transformed diabetes and allowed millions of people to survive the once deadly disease. However, more than 100 years later many people still cannot obtain even basic insulin.¹⁴¹ Insulin is often too expensive, health facilities may not have a reliable supply, and many rural communities have limited access to clinics, trained healthcare workers, and proper diagnosis. As a result, patients may go without treatment or receive it too late, increasing the risk of serious complications and early death.

Insulin affordability is a global issue because it may be unavailable or unaffordable in both lower- and higher-income countries. The global market is also dominated by only three multinational companies that control more than 95 percent of the global insulin market, while taxes, transportation costs, pharmacy charges, and other supply-chain markups can further increase the price paid by patients.¹⁴² Globally, only about one in two people with type 2 diabetes who need insulin can access it, whereas in sub-Saharan Africa, only about one in seven people with type 2 diabetes who need insulin can access it.¹⁴³

Hungary shows that government subsidies alone cannot guarantee continuous access to insulin. Insulin and diabetes supplies are heavily subsidized through Hungary's public healthcare system, but the country imports all of its insulin.¹⁴⁴ In November 2025, Novo Nordisk announced that it would withdraw six insulin products from markets across the European Union, including products used in Hungary. Patients using Fiasp were required to change treatments and adjust when they ate, exercised, and administered

insulin because alternative products did not work in exactly the same way.¹⁴⁵ This case demonstrates how countries can remain vulnerable when a small number of companies control production and decide which medicines remain available. Delegates should therefore consider whether governments should diversify suppliers, maintain emergency reserves, require advance notice before essential medicines are withdrawn, or support regional and public production.

Access to diagnostic services is equally important. Doctors need reliable tests to diagnose diseases, select appropriate treatments, and monitor patients over time. For example, people with diabetes need blood glucose and HbA1c testing, while cancer patients require imaging tests or biopsies before treatment can begin.¹⁴⁶ Without these services, patients may be diagnosed too late or treated incorrectly.

Treating diabetes with insulin alone is not enough. Patients also need syringes or insulin pens, glucose meters, test strips, regular blood tests and medical visits.¹⁴⁷ They must also learn how to safely manage their disease. In many places, unreliable electricity makes it difficult to keep insulin refrigerated. Without the supplies and services needed, treatment becomes much less effective and may become unsafe. This can lead to blindness, kidney disease, heart disease, nerve damage, or even amputation.¹⁴⁸ Therefore, medicine donations can provide temporary relief, but long-term access also requires affordable supplies, trained healthcare workers, reliable electricity, and continuous financing.

A cervical cancer program led by the non-profit organizations Maya Health Alliance and Friendship Bridge in rural Guatemala showcases how every step of care matters.¹⁴⁹ Nearly 9,000 women were offered free cervical cancer screening throughout community health services.¹⁵⁰ About two-thirds accepted screening, but many women with abnormal results never returned for further testing or treatments.¹⁵¹ Researchers found that fear of the healthcare system, language barriers, travel costs, and limited family support prevented many patients from continuing care. To address these challenges, patient navigators helped women understand their diagnosis, arrange appointments, travel to hospitals and remain connected to their treatment plans. Programs like this are vital to ensure that patients stay in care, which is just as important as providing the first diagnosis.

Chronic respiratory diseases present similar access problems. Asthma can often be controlled with inhaled medicines, but these treatments are not consistently available. In 2023, potentially lifesaving inhalers were available in healthcare facilities within fewer than two-thirds of low- and lower-middle-income countries, while preventive steroid inhalers were available in fewer than half.¹⁵² Brazil's national Farmácia Popular program distributes subsidized medicines through participating pharmacies. Medicines for hypertension and diabetes became free in 2011, and free asthma medicines were added in 2012. The expansion of participating pharmacies substantially increased geographic access to these essential medicines.¹⁵³ In 2024, the

Without preventive treatment, patients may instead depend on emergency inhalers or seek hospital care when a severe asthma attack occurs.

program operated through 31,170 accredited pharmacies in 4,758 municipalities and benefited 24.07 million people. At that time, 95 percent of the medicines and health supplies covered by the program were available free of charge, including medicines for asthma, diabetes, hypertension, and several other conditions.¹⁵⁴

Conflict demonstrates why care continuity is especially important for NCD care. Chronic diseases may not appear immediately life-threatening, but patients can quickly deteriorate when insulin, dialysis, cancer treatment, or blood-pressure medicines are interrupted. Gaza provides a recent example. In May 2025, WHO reported that 64 percent of medical equipment and more than 40 percent of essential medicines and vaccines in Gaza were completely out of stock.¹⁵⁵ Damaged health facilities and restrictions on supplies have also disrupted care delivery.

These crisis conditions force healthcare providers to divide limited medicines, equipment, fuel, and hospital space between emergency trauma care and patients who require continuing treatment. This environment can also produce new medical emergencies among people whose conditions were previously controlled. Across the Eastern Mediterranean region, WHO estimates that heart attacks, strokes, and asthma attacks may occur two to three times more frequently during emergencies than in stable settings.¹⁵⁶ However, NCD care has not yet been fully incorporated into most national emergency-preparedness and response plans.

Access to healthcare requires more than the development of new medicines. Patients need affordable medicines, diagnostic tests, trained healthcare workers, reliable supply chains, and health systems that can continue operating during emergencies. Without these elements, people living with NCDs may be diagnosed too late, discontinue treatment, or never receive care. For the World Health Assembly, the challenge is to help Member States provide continuous and affordable care from diagnosis through long-

term treatment.¹⁵⁷ Delegates must also consider how prices should be regulated, how emergency supplies should be distributed, and who should be responsible for maintaining care when national health systems are disrupted.

Bloc Analysis

POINTS OF DIVISION

Although Member States generally agree that NCDs require action, they disagree over which policies should receive priority and how those policies should be financed. The first point of division is the balance between prevention and treatment. Some states support stronger regulations of tobacco, alcohol, unhealthy foods, and commercial advertising because prevention can reduce future disease and healthcare costs. Other states argue that limited resources must first be used to strengthen clinics, train healthcare workers, and treat people already living with NCDs.

A second point of division concerns international support. Lower-income states may seek greater financing, technical assistance, and access to affordable medicines and diagnostics. Donor states may support assistance but disagree over whether it should be voluntary, coordinated through the WHO, or connected to national reporting and measurable results.¹⁵⁸

A third division concerns national flexibility. Some states support common international targets and stronger regulations based on the WHO “Best Buys.” Others emphasize that diets, health systems, economic resources, and commercial regulations differ between countries. These states may resist uniform policies and support nationally determined approaches instead.¹⁵⁹

Finally, states disagree over how to improve access to medicines and medical technology. Possible approaches include pooled procurement, voluntary licensing, technology

transfer, regional manufacturing, donated supplies, and reforms to pricing or intellectual-property rules. These disagreements will shape how each bloc balances public-health goals, national sovereignty, and international cooperation.

BLOC 1: STATES PRIORITIZING PREVENTION AND STRONG PUBLIC-HEALTH REGULATION

Countries in this bloc believe the best way to fight non-communicable diseases is to prevent them before they start. They believe governments should help people stay healthy by regulating smoking, unhealthy diets, harmful alcohol use, and physical inactivity. They argue that preventing diseases not only improves people's health but also lowers healthcare costs and reduces pressure on hospitals.¹⁶⁰ For this reason, they support the WHO "Best Buys" which are simple, low-cost actions that have been proven to reduce NCDs.¹⁶¹

These countries also believe it is important to find diseases early. They support regular check-ups, health screenings, and appropriate vaccinations. They also support investments in primary healthcare, screening programs, and workforce training so that diseases can be identified and treated before they become more serious. They also believe that governments should use research and reliable health data to decide which programs work best and where to invest public resources.¹⁶²

Specifically, Norway combines high tobacco taxes, strict tobacco control laws, and universal healthcare to help prevent and treat noncommunicable diseases.¹⁶³ Denmark has expanded national cancer screenings while continuing to invest in prevention.¹⁶⁴ Regular pre-booked mammography screening for women aged 50-69 achieves participation rates exceeding 80 percent, ranking among the highest in Europe.¹⁶⁵ These examples show a commitment to prevention and early intervention.

In committee, this bloc will likely support more funding for prevention programs, stronger health education, and better access to screening and primary healthcare. They also support working closely with the WHO and sharing successful public health policies with other countries. Representative countries include Canada, Norway, Finland, Sweden, Denmark, Australia, New Zealand, Chile and the United Kingdom where disease prevention is a central part of national health policy. These countries have introduced measures such as tobacco taxes, smoke-free public places, front-of-package nutrition labels, national cancer screening programs, and strong primary healthcare systems to help prevent NCDs and detect diseases early. These states may also support shared international targets and reporting, although they may disagree over how much funding they should provide to other countries.

BLOC 2: STATES SUPPORTING HEALTH-SYSTEM EXPANSION AND NATIONAL FLEXIBILITY

Countries in this bloc are seeing a fast rise in noncommunicable diseases. As more people move to cities, change their diets, become less active, and live longer, diseases such as diabetes, cancer, heart disease, and chronic respiratory diseases have become much more common.¹⁶⁶ Many states in this bloc have established national NCD programs but need to expand them as demand grows. At the same time, many of these countries are still dealing with infectious diseases and do not have enough money or healthcare resources to meet all of these health needs.

These countries believe that preventing NCDs is important, but they also believe they must first improve their healthcare systems to care for the growing number of existing patients. They support stronger primary healthcare initiatives by investing in local clinics, training healthcare workers, expanding access to essential medicines and diagnostic services, and more support from the international community

through increased funding, technical assistance, and partnerships with organizations such as the WHO and other international donors. Many also support prevention policies for regulating NCDs but believe that each country should be able to choose the solution that best fits their own needs and capabilities. They may therefore resist uniform taxes, advertising restrictions, or other regulations that do not account for national economic and social conditions.

In committee, this bloc is likely to support more international funding, technical support, strong healthcare systems, and better access to affordable medicines and medical technology. Representative countries include Brazil, India, China, South Africa, Indonesia, Vietnam, Egypt, and Mexico, where NCDs are increasing quickly while healthcare systems continue to face many other challenges.¹⁶⁷ Many of these countries are also working to control infectious diseases such as tuberculosis, HIV/AIDS, and malaria, which continue to place pressure on healthcare systems. For example, India has expanded free diabetes and hypertension screening through its national NCD program, while Brazil has strengthened primary healthcare through its Family Health Strategy, improving access to preventive and long-term care in local communities.¹⁶⁸

BLOC 3: STATES PRIORITIZING INTERNATIONAL ASSISTANCE AND BASIC ACCESS

Countries in this bloc face a double burden of disease. They are still fighting infectious diseases, such as malaria, tuberculosis, HIV/AIDS and illnesses caused by poor nutrition. At the same time, more people are developing non-communicable diseases like diabetes, heart disease, cancer, and chronic respiratory diseases. Many of these countries have very limited healthcare resources. Unlike states with larger national programs, these countries may depend more heavily on external financing, humanitarian assistance, and international

procurement mechanisms to provide even basic NCD services.¹⁶⁹ There are often not enough doctors, nurses, hospitals, medicine or medical equipment in many places. Especially in rural areas, people must travel long distances to reach a health center. Because of this, many people are diagnosed late and begin treatment only after their illness has become more serious.

While these countries believe that preventing NCDs is important, they cannot fight chronic diseases without first strengthening their health systems overall. Many clinics and hospitals were only built to treat short-term illnesses and not diseases that need care for many years. For this reason, they support more international funding for lower cost medicines, better access to basic medical tests, more healthcare workers and stronger local health services. They may also advocate for pooled procurement, regional manufacturing, technology transfer, debt-sensitive financing, and lower prices for essential medicines and diagnostics. They also support adding NCD care to existing health programs so people can receive care for infectious disease and NCDs in the same health center.

In committee, this bloc is likely to seek more financial and technical support in order to strengthen their healthcare systems and improve access to essential medicines. Representative countries may also include Ghana and Nepal, where rural access to NCD medicines, screening, diagnosis, and treatment remains limited. These barriers may make affordable basic services and assistance with implementation more immediate priorities than expensive new technologies.¹⁷⁰ These countries' health systems continue to face major challenges, while the burden of NCDs continues to grow. To combat this, Ethiopia has begun integrating NCD prevention and care into its long-standing Health Extension Program, which uses community health workers to bring basic services closer to households.¹⁷¹ Uganda's 2024 National Essential Health Care Package includes the management and control of NCDs, including hypertension and diabetes, within its framework for essential health services.¹⁷²

Sierra Leone has also included diabetes and hypertension screening and management in its essential-health-service policies, although shortages of funding, equipment, medicines, and trained personnel continue to limit implementation.¹⁷³

Committee Mission

The World Health Assembly (WHA) is the main decision-making body for the World Health Organization (WHO).¹⁷⁴ It brings together health ministers and representatives from all member states to discuss the world's biggest health issues and agree on ways to improve global health. Every year, the WHA adopts resolutions that set international health goals and priorities for the WHO. WHA also encourages countries to work together, share knowledge and support each other in solving these challenges.¹⁷⁵

The WHA cannot force countries to adopt or change certain health policies. Every Member State has the right to make its own decisions when organizing their health care systems. However, the WHA can help countries by creating global action plans, adopting recommendations, sharing successful ideas and encouraging international cooperation.¹⁷⁶ It can also support countries by promoting stronger health systems, better access to essential medicines and diagnostics and more investment in prevention and primary healthcare.

Countries have different economies, healthcare systems and public health needs. Therefore, there is no single solution to ending the NCD crisis. Some countries may focus on preventing disease through healthier lifestyles and strong public health policies. Others may give priority to expanding health care services or improving access to medicine and treatment. The WHA must account for these different views and work to find solutions that are realistic for countries with different levels of development.

As members of the World Health Assembly,

delegates must determine how Member States should balance prevention, early detection, and long-term treatment. Resolutions may address public health regulation, primary healthcare, financing, workforce training, access to essential medicines and diagnostics, resilient supply chains, and support for vulnerable populations. Delegates should also consider how the WHO can monitor progress and share successful policies while respecting national sovereignty and different levels of development.

Strengthening Global Mental Health Systems



Introduction

Mental health is an essential component of overall wellness and healthcare. However, it remains one of the most neglected areas of healthcare worldwide. The World Health Organization (WHO) states that nearly one billion people live with some form of mental health condition.¹⁷⁷ These include anxiety, depression, bipolar disorder, schizophrenia, and substance-use disorders. Despite how large an issue this is, many individuals with mental health conditions do not receive the care they need due to a lack of funding, workforce shortages, limited-service availability, and social stigma and discrimination. Further, treatment gaps continue to widen due to armed conflict, humanitarian emergencies, climate-related disasters, and other pressures. These factors can both increase the need for mental health support and disrupt the services available to provide it.

In recent years, the international community has increased its recognition of mental health as a priority in public health. Untreated mental health conditions can affect physical health, education, employment, family life, and economic development. Mental health conditions can affect educational attainment, workforce productivity, and economic growth. Improving mental healthcare is therefore important to achieving the Sustainable Development Goals (SDGs) and universal health coverage.¹⁷⁸ Recent events, including the COVID-19 pandemic and ongoing conflicts in areas such as Ukraine and Gaza, have exposed longstanding weaknesses in mental health systems. Due to these issues, governments have attempted to shift toward community-based approaches. This involves reducing excessive reliance on specialized psychiatric institutions and building systems that provide prevention, early intervention, and accessible treatment within communities. However, mental health services remain underfunded and understaffed in many regions. Low- and middle-income countries (LMICs) may also face geographic inequalities, limited infrastructure, and persistent stigma.

The World Health Assembly recognizes these global challenges. In recent years, it has made mental health a central component of international public health policy. One of its

primary initiatives, the Comprehensive Mental Health Action Plan 2013-2030, provides a global strategy to improve mental health systems through better leadership, community-based care, prevention, and research.¹⁷⁹ Mental health has also received greater attention within the broader international discussion of noncommunicable diseases, universal health coverage, and sustainable development. Since countries have different resources, infrastructure, and healthcare needs, delegates must consider which services should receive priority, how reforms should be financed, and how international standards can accommodate different national circumstances.

History and Description of the Issue

STIGMA AND DISCRIMINATION SURROUNDING MENTAL ILLNESS

For much of the nineteenth and twentieth centuries, mental healthcare relied heavily on large psychiatric institutions, primarily in the Western World. Although these hospitals provided specialized inpatient care, they were often separated from community

life. Some institutional systems were also associated with overcrowding, involuntary detention, poor treatment, and violations of patients' human rights.¹⁸⁰ Beginning in the late twentieth century, governments began to pursue deinstitutionalization. This sought to move patients from long-term institutions into community-based care. However, some countries reduced their institutional capacity without adequately funding community mental-health services and other forms of continuing support. This left many people without consistent care and, in some cases, contributed to homelessness or movement into other institutional settings, including prisons and residential facilities.¹⁸¹

The development of mental healthcare followed a different path in many colonized regions. Colonial governments sometimes established a single centralized psychiatric hospital in an administrative center, but formal mental healthcare remained unavailable to most of the population.¹⁸² Colonial health systems also prioritized officials and European settlers, while Indigenous populations received limited attention. As a result, families, spiritual communities, and traditional healers continued to provide much of the care for people experiencing mental distress.¹⁸³ This did not mean that mental illness was less common; rather, many people remained outside formal healthcare systems.

These different histories of mental health treatment continue to shape mental healthcare today. Some countries are replacing large institutions with community services, while others are trying to build formal mental-health systems in places where such services were never widely available.¹⁸⁴ International mental health policy now increasingly emphasizes human rights, community-based services, and integration into primary healthcare. The WHO's Mental Health Gap Action Programme and Comprehensive Mental Health Action Plan 2013–2030 encourage states to train nonspecialist providers, strengthen local services, improve data collection, and reduce reliance on isolated institutions.¹⁸⁵ Despite this shift, implementation remains uneven

because countries differ widely in funding, workforce capacity, infrastructure, and political commitment.

Further, stigma and discrimination remain major barriers to treatment, recovery, employment, education, and participation in community life.¹⁸⁶ Stigma includes negative beliefs and stereotypes about people with mental health conditions, while discrimination occurs when those beliefs result in unequal or harmful treatment.

Stigma can come in many different forms. Public stigma refers to negative attitudes held by society against individuals with mental illness. Key components of public stigma include stereotypes, prejudice, and discrimination that harms people living with mental illness.¹⁸⁷ Another form of stigma is self-stigma. Self-stigma occurs when individuals face internalized negative beliefs. Individuals who internalize these beliefs may develop poor self-esteem or experience the “why-try effect,” in which they stop pursuing opportunities because they expect rejection or failure. In a case of self-stigma, a person may refuse to apply for a job because they assume they will not be hired.¹⁸⁸ As a result, many people with self-stigma may not attempt to improve their quality of life. This leads to further feelings of isolation and hopelessness.¹⁸⁹

A leading cause of mental health stigma is misinformation.¹⁹⁰ Through media portrayals and online consumption, the public may believe that people with mental illness are violent and unstable. As a result, fear-based assumptions are common. This can prevent patients from receiving proper care.¹⁹¹ Inaccurate media portrayals can reinforce these assumptions, while responsible public-health campaigns and reporting standards may help reduce misinformation. Stigma exists across many cultures and socioeconomic groups, although its causes and expression differ between communities.¹⁹² However, these issues are still significant barriers to solving this problem.

Cultural and religious beliefs can also influence

how communities understand and express mental distress, where people seek help, and whether they trust and continue using formal mental health services.¹⁹³ In some communities, mental illness may be associated with personal weakness, family shame, spiritual causes, or moral failure.¹⁹⁴ However, religion and spirituality can also provide meaning, emotional support, a sense of belonging, and ways of coping with distress. Cultural beliefs may also shape how symptoms are expressed; for example, some people may describe depression or anxiety through physical symptoms rather than psychological language.¹⁹⁵ However, minority populations may distrust health systems because of historical discrimination, language barriers, or previous mistreatment.¹⁹⁶ Services that dismiss patients' beliefs or apply Western treatment models without adapting them to the local context may further weaken trust. International strategies must therefore avoid treating stigma as identical everywhere and should involve local communities, faith leaders, educators, healthcare workers, and people with lived experience.

Stigma presents a larger issue that not only affects individuals, but society as a whole. The World Health Organization has recognized

stigma's contribution to socioeconomic issues. Unemployment, poverty, homelessness, and reduced participation in community life have largely been prevalent amongst people with mental health conditions.¹⁹⁷ As a result, the strain and burden on families, healthcare systems, and governments can increase. Stigma and discrimination remain a significant challenge for individuals who struggle with mental illness across the world. Therefore, delegates must consider how the WHA can encourage public education and rights protections while allowing campaigns to reflect local languages, cultures, and sources of trust.

MENTAL HEALTH WORKFORCE AND PROVIDER SHORTAGES

Strengthening the mental health workforce remains a pressing issue in international healthcare. The rising demand for psychiatrists, counselors, and social workers has been met with a shortage of qualified practitioners, especially in low and middle-income countries (LMICs). As a result, many individuals with mental health conditions do not receive the proper diagnosis, treatment, and support. A study of 29 mental health projects across Africa, Asia, Latin

Mental Health awareness rally

Credit: Chinchu.c



America, and the Caribbean found that limited staffing, heavy workloads, insufficient supervision, cultural differences, and difficulties retaining trained workers could prevent new services from continuing after initial training.¹⁹⁸

A shortage of providers creates a major gap in mental health services and disproportionately harms vulnerable populations. The availability of mental health professionals varies dramatically between countries, with some low-income countries reporting fewer than one psychiatrist per 100,000 people.¹⁹⁹ This is especially concerning because many of these countries also experience a high burden of depression, bipolar disorder, and suicide.²⁰⁰ This burden is often measured in disability-adjusted life years (DALYs), which combine years lost to premature death with years lived with illness or disability.

Workforce shortages are caused not only by inadequate training and scarce resources. Internationally, mental health professionals also face difficult working conditions that can contribute to burnout, compassion fatigue, secondary traumatic stress, and workforce attrition.²⁰¹ Repeated exposure to patients' trauma and suffering can cause secondary traumatic stress, including emotional numbness and other symptoms resembling post-traumatic stress disorder. Compassion fatigue refers to physical and emotional exhaustion that can result from this prolonged exposure.²⁰²

Positions lost through burnout, retirement, or staff turnover cannot always be filled quickly. For example, the COVID-19 pandemic placed additional strain on mental health providers,

which intensified shortages in the industry.²⁰³ On the patient side, long wait times, limited appointment availability, and reduced consistency of care have contributed to overall worsened mental health outcomes. The shortage issue goes beyond just mental health systems, as provider shortages affect entire healthcare systems. The WHO projects a global shortage of approximately 11 million health workers by 2030, mostly in low- and lower-middle-income countries.²⁰⁴

Underfunding also limits the ability of mental health systems to train, support, hire, and retain qualified workers. This attrition worsens existing shortages and places even greater pressure on the staff who remain.²⁰⁵ Moreover, unequal funding and working conditions can also contribute to "brain drain." Brain drain occurs when individuals from LMICs who are qualified in their fields migrate to more developed countries in search of better pay, opportunities, and working conditions.²⁰⁶

Brain drain reduces the number of workers and services in LMICs as it creates a loss of human capital and deprives some communities of essential resources. It also means that source countries may pay to educate and train health professionals without receiving the full benefit of that investment.²⁰⁷ One estimate found that nine sub-Saharan African countries lost more than USD 2 billion by training doctors who later migrated to four major destination countries: the United States, the United Kingdom, Canada, and Australia.²⁰⁸ For psychiatrists, a source country may lose at least 11 years of investment in education and specialized training, as well as the

Low pay, high caseloads, inadequate supervision, and limited opportunities for development can cause workers to leave their positions.

worker's potential contributions to patient care, teaching, and service development.²⁰⁹

Ultimately, workforce shortages remain a major barrier to improving mental healthcare worldwide. Countries must train more workers, reduce burnout, and keep qualified professionals in their jobs if they hope to close treatment gaps. However, this will be difficult. Possible solutions include expanding training programs, improving pay and working conditions, creating international training partnerships, and allowing trained nonspecialists to provide some basic services. States may disagree over whether this task-sharing approach safely expands access to care or gives workers responsibilities beyond their level of training.

AFFORDABILITY OF MENTAL HEALTH SERVICES

Many individuals with mental illnesses are unable to afford services and counseling. While mental health disorders account for a large portion of the global burden of diseases, the investment in mental health services has remained low. Many individuals do not receive treatment due to unavailable services, high out-of-pocket payments, and limited insurance coverage. LMICs are disproportionately affected. This leaves millions of people with untreated mental health conditions, which can increase school absenteeism and dropout rates, reduce workforce participation and earnings, and reinforce cycles of poverty and economic inequality.²¹⁰ Mental health conditions can impair daily functioning, making it harder for people to attend school, work consistently, or maintain employment. This can lead to school dropout, reduced productivity and earnings, and unemployment. Families may also face medical expenses and lost income. As a result, unmet mental health needs can reduce economic opportunities and quality of life for individuals, families, and entire communities.²¹¹

Mental health services remain severely

underfunded in many countries. Low-income countries spend as little as 0.04 US dollars per person, while high-income countries spend up to 65 US dollars per person.²¹² This spending gap is reflected in the availability of professionals: low-income countries have roughly one psychiatrist per million people, while high-income countries have 70 times more.²¹³ As a result, many people cannot receive adequate treatment. Globally, only about 9 percent of people with major depressive disorder receive minimally adequate care, falling to approximately 2 percent in sub-Saharan Africa.²¹⁴

Additionally, there is a significant divide between rural and urban populations. In many LMICs, mental health services are concentrated in large psychiatric hospitals located within urban centers. This forces rural populations to travel long distances, which leads to increased transportation costs and a loss of income from missed work.²¹⁵ A study of approximately 5,670 hospitalized mental health patients in Kenya estimated costs over USD 13.3 million. This included medical expenses and lost productivity, which was equal to 10 percent of Kenya's Ministry of Health budget.²¹⁶ The true cost has been assumed to be higher; because the study focused on hospitalized patients, it may not capture the full cost of informal care, untreated illness, family caregiving, or lost income. Overall, expanding mental health services in rural areas is essential to reducing financial burdens and ensuring that people can access the care they need.

Mental health conditions also have massive economic costs. Depression and anxiety are estimated to cost the global economy approximately one trillion USD annually.²¹⁷ In 2019, global health data estimated that mental disorders were responsible for 418 million disability-adjusted life years. This is about 16 percent of the world's total disease burden.²¹⁸ For comparison, all forms of cancer combined accounted for approximately 250 million DALYs that year.²¹⁹ However, this is not a direct one-to-one comparison because the estimates

may use different methods, and the mental-health figure includes both the direct burden of mental disorders and additional health effects associated with them. Nevertheless, the comparison helps illustrate the scale of mental disorders relative to widely recognized physical-health challenges.

The economic effect is largely due to reduced productivity, absenteeism, unemployment, and healthcare expenditure. It affects labor markets and national productivity. Presenteeism, or working while physically or mentally unwell, is another important part of this burden.²²⁰ According to the WHO, depression and anxiety cause an estimated 12 billion working days to be lost globally each year, costing approximately USD 1 trillion in lost productivity.²²¹ A review of 38 studies also found clear evidence that poor mental health, particularly depression and anxiety, is associated with both absenteeism and reduced productivity while at work. Therefore, untreated mental health conditions can create significant economic losses even when affected employees remain in the workforce.²²²

Countries can improve healthcare access and efficiency by strengthening primary healthcare, expanding community-based

services, developing the healthcare workforce, and improving prevention and early diagnosis. These reforms can allow more patients to receive care in community settings rather than relying entirely on hospitals or specialists.²²³ For mental healthcare, this may include training primary-care providers and other nonspecialist workers to identify common conditions, provide basic support, and refer patients who require specialized treatment.²²⁴

Universal Health Coverage (UHC) is one broader framework through which governments can support these changes. UHC aims to ensure that everyone can obtain necessary, high-quality health services without experiencing financial hardship.²²⁵ This includes prevention and treatment, as well as rehabilitation and palliative care. However, UHC has three separate dimensions: the number of people covered, the services included, and the degree of financial protection provided. Therefore, declaring healthcare “universal” does not necessarily mean that every service is available or affordable.²²⁶ For mental healthcare to be meaningfully included in UHC, national benefit packages may need to cover services such as psychiatric consultations, counseling, and essential psychotropic



Zimbabwe's Friendship Bench

Credit: Costa Juta

medicines.²²⁷ This is particularly important because approximately two billion people globally experience financial hardship from healthcare costs.

Global technological innovations like telemedicine and digital therapy also help with access and affordability for mental health services. These platforms have lowered service delivery costs and extended care to remote locations.²²⁸

However, unequal internet access and limited digital infrastructure prevent many populations from benefiting in many low-income countries. Investment in health technologies will help ensure equitable access to digital mental health services.

Affordability continues to be a barrier for mental health care globally. Therapy, medication, and specialized services remain out of budget for many individuals, as they are too expensive and typically not covered by national health insurance. LMICs are disproportionately affected because they have fewer providers available to diagnose and treat mental-health conditions. Untreated mental illness not only harms the individual but also reduces productivity and costs the global economy billions of dollars. However, access to mental health care is achievable through sustained public investment and community-based efforts. For example, Zimbabwe's Friendship Bench program offers one example of lower-cost community care. The program trains local lay health workers to provide support from benches located at primary healthcare clinics. Patients receive up to six individual sessions of structured problem-solving therapy, during which they identify major problems in their lives and develop practical steps for addressing them.²²⁹ This model demonstrates how task-sharing may expand access when specialist providers are scarce.

ACCESSIBILITY IN CRISIS AND CONFLICT ZONES

Armed conflicts, natural disasters, and humanitarian emergencies can make mental

health care inaccessible. These crises can destroy hospitals and clinics, displace healthcare workers, disrupt medication supply chains, and strain healthcare systems. All of these factors can reduce patients' access to mental healthcare. This is especially important because the effects of conflict, such as exposure to violence, displacement, and loss of loved ones, significantly increase the need for mental health care systems. In fact, the WHO estimates that approximately one in five people living in conflict-afflicted areas experience some form of mental health conditions.²³⁰

Access to mental healthcare becomes extremely limited if health systems prioritize physical injuries, shelter, and containment of infectious diseases. Mental health care also remains underfunded in times of crisis. Forced displacement also limits access to mental health services. In temporary camps or new communities, mental health care is scarce or nonexistent.²³¹ This leaves refugees and internally displaced people (IDPs) with the inability to receive care. Displaced populations face elevated risks of depression, anxiety, and post-traumatic stress.²³² However, over 74 percent of IDPs live in regions where systematic mental health support is nonexistent.²³³

Women may face additional mental health risks arising from caregiving burdens, displacement, gender-based violence, and unequal access to resources.²³⁴ Cost, stigma, restrictions on women's movement, damaged healthcare systems, and shortages of services can further prevent women from receiving treatment. Support may be especially difficult to reach for women fleeing rural areas or active frontlines.²³⁵ For example, UN Women reported that 77 percent of the women it interviewed in Gaza were responsible for feeding and caring for children while also coping with displacement, deprivation, and their own psychological distress. In Ukraine, women have performed up to 56 hours of childcare per week during the war, while 42 percent were considered at risk of depression.²³⁶

Other vulnerable populations, including children and older adults, may face additional barriers to treatment. Children's developmental stage and dependence on adults can affect their ability to recognize, communicate, and receive help for mental-health conditions. Their symptoms may also appear as changes in behavior, such as anxiety, aggression, nightmares, or declining school performance.²³⁷ Older adults may have complex healthcare needs because they are more likely to experience disability, multiple chronic conditions, and the effects of taking several medications.²³⁸

The consequences of not having access to mental-health care extend beyond individual well-being. When psychological effects are ignored, they can last for years and make it harder for affected people to cope, recover, and rebuild their lives. Humanitarian responses are increasingly recognizing psychological recovery as an essential part of emergency response and reconstruction. In 2024, the World Health Assembly adopted its first resolution calling for mental-health and psychosocial support across emergency preparedness, response, and recovery.²³⁹ The World Health Organization has emphasized that mental-health care is not a luxury, but rather an essential service that supports survival, dignity, and long-term recovery. Although 85 percent of countries experiencing emergencies now report providing some mental-health support, the WHO warns that its coverage and quality remain inadequate.²⁴⁰

International organizations have also pushed to promote community-based mental health and psychological support (MHPSS). This integrates

clinical care with social interventions to support emotional well-being and strengthen local resilience. They focus on reuniting separated families or establishing youth hubs to help restore stability and routine. Along with that, they attempt to provide basic services and security to help alleviate immediate psychological stress. This moves systems away from relying solely on psychiatric hospitals. Programs train primary healthcare workers through initiatives such as WHO's Mental Health Gap Action Programme, which has allowed non-specialist providers to diagnose and treat mental health conditions.²⁴¹ With these initiatives, community centers, schools, and mobile clinics have expanded within many humanitarian settings.

Countries that have experienced conflicts or natural disasters such as Lebanon, Kosovo, and Sri Lanka have expanded their community-based services and decentralized care to address mental health conditions that are created by those experiences.²⁴² Humanitarian mental health programs also often depend on international assistance that may be inconsistent or insufficient. As emergencies continue, organizations may reduce or end their operations because of funding limitations, competing priorities, logistical challenges, and security risks, leaving refugees with fewer services.²⁴³ With limited infrastructure, shortages of trained professionals, and insufficient investment from governments and international donors, conflict-affected populations may remain unable to obtain the mental-health care they need. Delegates thus must consider how emergency mental health programs can continue after international

Many countries that experience crises and conflict have shown ways to strengthen long-term mental health systems.

funding declines and how crisis services can be incorporated into permanent national health systems.

Current Status

EXPANSION AND REGULATION OF DIGITAL MENTAL HEALTHCARE

Digital technology has transformed the delivery of healthcare. Telehealth, mobile applications, and electronic health records can improve the reach and efficiency of mental healthcare. This has allowed many countries to overcome geographic barriers to treatment, rising demand for services, and shortages of healthcare professionals.

Digital mental health services expanded rapidly at the start of the COVID-19 pandemic. Professionals were able to provide mental healthcare online as many services became remote. Mental health telehealth use saw a surge from just one percent to over 50 percent of outpatient behavioral health appointments during the peak of the pandemic.²⁴⁴ While many of these initiatives began as temporary emergency responses, many governments have integrated digital mental health strategies since.

The WHO's Global Strategy on Digital Health 2020–2025 and the Comprehensive Mental Health Action Plan 2013–2030 are two major global frameworks that focus on using technology to expand access to services. One relevant global target is that 80 percent of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems by 2030.²⁴⁵ These indicators measure areas such as the use of primary and outpatient care, hospital admissions, treatment outcomes, suicide mortality, the prevalence of mental-health conditions, and the physical health of people with mental-health conditions. The WHO also

monitors broader system indicators, including workforce levels, community-based facilities, prevention programs, and the integration of mental health into primary healthcare.²⁴⁶ Digital systems may make this information easier to collect and analyze, particularly in countries where health data remain limited. This target reflects the growing role of digital systems in monitoring needs and expanding care, particularly in LMICs.

Australia has emerged as a leading example in combining digital technology and mental health. Healthcare inequalities and geographic barriers persist, but digital solutions such as Head to Health or Medicare Mental Health have caused change. These are government-funded programs that provide free, confidential mental health support. Originally starting in 2017, Head to Health also provides mental health resources that include self-assessment tools, educational materials, and connections to licensed providers.²⁴⁷ These resources can help people who are struggling with mental health get access to medical treatments. This organization also started a national telephone hotline. This hotline was staffed by triage workers who assessed callers and paired them to regional support. Along with that, they maintained a centralized website and featured online therapy programs, apps, and self-help tools. Starting in March of 2025, they rebranded to Medicare Mental Health, where they have helped bridge the gap for rural and remote patients in accessing online care and resources. Their walk-in and in-person centers also do not require diagnosis, referral, or appointments. Overall, this has significantly improved rates of efficiency and accessibility, as early pilot data showed that 92 percent of people who used the service reported an improvement in their mental health.²⁴⁸

Australia has also expanded telehealth consultations through the Medicare Benefits Schedule. The Medicare Benefits Schedule allows eligible telehealth appointments to receive government reimbursement, helping make remote consultations more affordable. Within

the mental health sector, this allows mental health practitioners to provide assistance and schedule crucial appointments and then get certain payment afterward.²⁴⁹ With the initiative widely implemented across Australia, people living in remote and rural regions can access these consultations while reducing travel costs and improving continuity of their care. MindSpot is another Australian Government initiative that operates as a free national digital psychology clinic. It provides online and telephone-based assessments and treatments for conditions including anxiety and depression. Patients can discuss their assessment results with an experienced therapist and receive therapist support throughout treatment.²⁵⁰ In total, these initiatives allow for many Australians to access structured online therapy while creating outcomes that are comparable to face-to-face psychological services.

The ongoing war in Ukraine has severely strained health services and damaged essential infrastructure. Since February 2022, nearly 2,600 attacks on Ukraine's healthcare system have been documented, including more than 1,380 attacks that damaged or destroyed hospitals and clinics.²⁵¹ In response, the WHO has provided

mental-health and psychosocial-support training to more than 1,400 people, while its Mental Health Gap Action Program (mhGAP) trained 338 healthcare workers across 117 locations.²⁵² The mhGAP program uses online courses and university programs to train more health professionals and regularly monitor digital mental health services.²⁵³

Further, digital tools may provide additional support when trained professionals are scarce. One study involving 104 women with anxiety disorders in active war zones found that an AI chatbot called “Friend” could complement the work of human therapists.²⁵⁴ However, long-term recovery will require workforce training, stronger primary healthcare, and the integration of mental-health support into community health services.

Despite its potential, digital mental healthcare creates new barriers. Limited internet access, unreliable electricity, low digital literacy, language barriers, and the cost of devices may exclude already underserved populations. Governments must also address patient privacy, cybersecurity, informed consent, clinical quality, and the regulation of mental health applications. The WHA could promote common standards for digital care or allow states to develop different



rules, based on their legal systems and technological capacity.

GOVERNMENT COMMITMENT TO COMMUNITY-BASED MENTAL HEALTH SYSTEMS AND PRIMARY CARE INTEGRATION

Mental healthcare in many countries remains centered on psychiatric hospitals that provide treatment only after mental health conditions have worsened or become severe. Institutional care is a necessary and crucial aspect of care for intensive treatment. However, this model often has many obstacles and difficulties for individuals suffering from mental health conditions. Separation from families, limited access in rural areas, and long waiting periods may deter individuals from receiving formal institutional care. The WHO has identified community-based mental health services integrated into primary healthcare as one of the most effective methods for reducing the global treatment gap.²⁵⁵ This strategy can promote recovery, protect human rights, and improve long-term health outcomes.

Community-based mental health systems bring services closer to where people live by

integrating mental healthcare into local clinics, schools, family health centers, and social services.²⁵⁶ Some models place behavioral-health specialists directly within primary-care teams. Others use care managers, primary-care physicians, and consulting psychiatrists to coordinate treatment.²⁵⁷ Although the exact structure differs, these approaches seek to identify conditions earlier, reduce pressure on psychiatric hospitals, and connect mental and physical healthcare.

The shift moves away from large psychiatric institutions. Instead, it focuses on delivering services through local clinics, family health centers, schools, and other community-centered organizations. The WHO supports this transition as an important part of achieving Universal Health Coverage, especially as demand for mental-health services continues to grow following the COVID-19 pandemic and humanitarian crises. One initiative supporting this transition is the WHO's Mental Health Gap Action Programme, or mhGAP. The program trains nonspecialist healthcare workers to identify and manage selected mental, neurological, and substance-use conditions under appropriate supervision. It provides evidence-based

Mental health partnership in Saint Kitts and Nevis

Credit: Andrea Jenkins



guidelines and training materials that help primary-care workers assess and manage conditions such as depression, psychosis, and epilepsy in settings where specialists are scarce. It has been introduced in more than 100 countries.²⁵⁸

Implementing these programs may include a “train-the-trainer” model, in which experienced trainers prepare local supervisors, who can then train and support additional healthcare workers to bridge the worker shortage. Local community primary health professionals are provided with adequate evidence-based training manuals that equip primary care staff with the knowledge to manage conditions such as depression, psychosis, and epilepsy in under-resourced areas.²⁵⁹ By allowing trained nonspecialists to provide basic care and then refer more complex cases, mhGAP can help countries expand services, despite shortages of mental-health specialists.

Chile provides one example of integrating mental healthcare into primary and community care.²⁶⁰ Chile’s public health sector, which serves most of the population, operates approximately 2,000 primary-care facilities throughout the country.²⁶¹ This includes family and community health centers. Through these facilities, the country expanded a national depression-treatment program that combined patient education, regular follow-up, medication when appropriate, and referrals for patients requiring specialized care.²⁶² This approach allowed people to receive mental-health support through the same local system that provided their general healthcare. Chile’s experience demonstrates how integrating mental health into primary care can expand access, although implementation still requires sufficient staff, resources, training, and connections with specialized services.²⁶³

Community-based care and primary-care integration have become central strategies for strengthening mental health systems. However, reform should not simply close psychiatric institutions without first creating adequate

local services. Delegates must determine how states can expand community care, while also preserving safe inpatient treatment for people who require intensive or emergency support.

CASE STUDY: SWEDEN’S PROGRESSIVE APPROACH TO MENTAL HEALTH CARE

Sweden has developed comprehensive, community-based approaches to mental health care and promoted the integration of mental health services into universal healthcare. It has also focused on prevention, early intervention, social inclusion, and rehabilitation. Sweden provides one example of sustained government investment, strong social welfare policies, and a decentralized model.

Sweden’s decentralized system shares responsibility across the national government, 21 regional councils, and 290 municipalities within the country. Each has its own responsibilities. The government establishes healthcare laws and national policies, the regional councils provide medical and psychiatric help, and the municipalities drive social assistance such as housing, employment assistance, and rehabilitation.²⁶⁴ Sweden primarily finances its healthcare through taxation, which means residents have access to these services regardless of their income or financial status. This system depends on sustained public funding and coordination across national, regional, and municipal authorities.²⁶⁵ Thus, sustained public funding and shared responsibility help create accessible and long-lasting mental healthcare.

Sweden’s community-based system developed after several decades of deinstitutionalization. Its 1995 Community Mental Healthcare Reform sought to move people receiving long-term institutional care back into their communities and clarified municipal responsibility for housing, daily activities, rehabilitation, and social support.²⁶⁶ By the mid-1990s, Sweden no longer maintained beds in standalone mental hospitals, although psychiatric inpatient care continued in general and forensic hospitals.²⁶⁷ However, the reform

revealed the continuing challenge that regional psychiatric services and local social services did not always coordinate effectively when both were responsible for the same patient. Currently, Sweden is continually implementing and improving its mental healthcare systems.

Mental healthcare in Sweden is also viewed as an essential component of overall health rather than a separate or specialized service. This mindset has allowed for new solutions to address mental health issues before they become severe. The Swedes have created digital health solutions and promoted e-health, but their focus has largely remained on early intervention. Following the pandemic, Swedish telehealth and digital consultations leveled out to roughly 319 digital teleconsultations per 1,000 citizens, remaining a vital component of primary healthcare.²⁶⁸ Further, a variety of preventative programs in schools educate children on safe coping mechanisms, mindfulness, and stress management. Sweden has also implemented youth clinics for people under 25. These cover basic mental health issues but also sexual health, relationships, and substance abuse.²⁶⁹ As the entirety of its mental healthcare system is decentralized, these programs are run and staffed by a multidisciplinary team which includes social workers, nurses, and psychologists.

This emphasis on youth is not a coincidence. The government has recognized that youth mental health risks serve as a public health priority because of young people's increased rates of depression, anxiety, and stress.²⁷⁰ Their commitment to and investment in young people has created early support mechanisms and reduced long-term consequences. An example of this is the Child and Adolescent Psychiatry system, a publicly funded specialist mental healthcare system for children under the age of 18. It provides assessment, therapy and treatments for different conditions such as ADHD, autism, depression, and anxiety.²⁷¹ However, growing demand for psychiatric support has created long waiting times and placed additional strain on staff.²⁷² In response,

organizations such as the Swedish Association of Local Authorities and Regions have worked alongside regional health authorities to improve coordination, monitor service performance, and implement strategies that improve efficiency and stability of the country's mental health system.

Sweden has also continued to maintain a strong mental health workforce. From 2020 to 2023, they have retained approximately 19-23 psychiatrists per 100,000 citizens.²⁷³ These numbers are significantly greater than the average for many high-income countries, which average approximately 10-13 per 100,000 people. However, there are challenges that persist. Between 2011 and 2024, the proportion of Swedes aged 16-84 reporting feelings of anxiety or stress increased from 31 percent to 44 percent.²⁷⁴ Of that percentage, 8 percent reported having severe symptoms related to those feelings in 2024. To combat this, the Swedish government announced a 10-year national strategy for mental health and suicide prevention in January 2025. This was created to improve mental well-being, decrease suicide rates, reduce preventable mental-health inequalities, and improve outcomes for individuals with mental-health conditions. The strategy treats mental health and suicide prevention as responsibilities that extend across society and relevant policy areas. Its priorities are intended to guide planning, implementation, and follow-up at the national, regional, and local levels. A separate action plan for 2025-2026 identifies concrete measures for beginning implementation.²⁷⁵

Sweden demonstrates how public financing, local administration, primary care, youth services, and specialist treatment can operate within one mental health system. However, rising demand and long waiting periods show that even well-funded systems face capacity problems. Delegates should therefore consider which elements of Sweden's approach can be adapted elsewhere and which depend on financial and institutional resources that may not be available in every country.

Bloc Analysis

Member States broadly agree that mental healthcare should become more accessible, but they disagree over how reform should occur. The first point of division is about specialized institutions and community-based care. Some states support a rapid transition toward local clinics, primary-care integration, and independent living. Others argue that psychiatric hospitals remain necessary and that reform should proceed gradually to avoid eliminating intensive services before community alternatives exist.

A second division concerns workforce policy, since some states support training nonspecialist healthcare workers to provide basic mental health services, whereas others emphasize professional licensing, specialist supervision, and the risks of asking workers with limited training to manage complex conditions.

A third division concerns financing and international responsibility. Lower-income states may seek international funding, workforce training, affordable medicines, and technical assistance. Donor states may disagree over the amount, conditions, and oversight of that assistance. States may also differ over whether mental healthcare should be included in publicly financed universal health coverage or supported through a mixture of public, private, and community providers. Finally, states disagree over digital mental healthcare. Telehealth and mobile applications could be affordable ways to reach underserved populations. However, other states face unequal internet access and raise concerns such as patient privacy, cybersecurity, clinical quality, and the need to regulate private technology companies.

BLOC 1: STATES PRIORITIZING BASIC ACCESS AND INTERNATIONAL ASSISTANCE

This bloc includes primarily low- and lower-middle-income countries, as well as other states with limited mental-health system capacity. These

states have limited mental health accessibility and notable treatment gaps. Systemic barriers include underinvestment in mental health resources, shortages of trained professionals, geographic isolation, costs of treatment, and lack of general healthcare infrastructure.²⁷⁶ WHO estimates that approximately four out of five people in low- and middle-income countries who need mental, neurological, or substance-use services do not receive them.²⁷⁷ Therefore, many people may experience worse health outcomes and a diminished quality of life.

These states are likely to prioritize basic services, workforce training, essential medicines, and the integration of mental healthcare into existing primary-care systems.²⁷⁸ Across all countries, the median government allocation to mental health remains approximately 2 percent of government health spending, while spending in low-income countries may be as little as USD 0.04 per person.²⁷⁹ Further, some countries in this bloc may have fewer than a single psychiatrist per 100,000 individuals. Rural populations may also face obstacles such as limited transportation infrastructure, lack of community-wide services, and limited finances.²⁸⁰ However, a commitment to developing mental healthcare systems from early-stage intervention to long-term care can help mitigate these challenges.

In committee, this bloc is likely to seek international financing, technical assistance, affordable medicines, training for nonspecialist providers, and support for community clinics. These states may favor flexible targets and gradual reform because ambitious international standards could be difficult to implement without additional resources. Representative countries for this bloc may include India, Kenya, and Nigeria.²⁸¹ All three continue to face significant shortages of mental-health workers and substantial gaps in access to services, making basic access and health-system capacity important priorities.²⁸²

BLOC 2: STATES SUPPORTING GRADUAL REFORM AND NATIONAL FLEXIBILITY

Countries in this bloc have recognized mental health as a growing public health priority and have begun implementing reforms. These countries have generally introduced mental-health legislation or national policies, developed community-based programs, trained healthcare workers, or begun integrating mental-health services into primary healthcare.²⁸³ Despite these improvements, demand for mental-healthcare services continues to exceed existing workforce, funding, and infrastructure capacity. These countries will thus focus on the transition from building foundational services to expanding the coverage, quality, and accessibility of existing systems.

Countries in this bloc will focus on expanding the initiatives and systems that have previously proven successful. However, governments may disagree about how quickly reform should occur, how much authority should remain with national and local governments, and whether international targets should be mandatory or adjusted to each country's resources and institutions.

Brazil provides one example of a currently successful program with its Psychosocial Care Centers, known as CAPS. These serve as a foundation of the country's community-based mental-health network and are integrated with primary healthcare.²⁸⁴ The Philippines has also used its Mental Health Act and WHO's mhGAP program to train specialized and nonspecialized workers, strengthen referral pathways, and move services closer to local communities.²⁸⁵ Chile and Thailand have also both integrated mental-health services into primary healthcare, demonstrating that countries in this bloc already possess national programs which can be expanded, rather than replaced.²⁸⁶

Countries in this bloc may include Brazil, South Africa, Mexico, Thailand, Chile, and the Philippines.²⁸⁷ Brazil and South Africa illustrate countries with greater mental-health capacity

than many states with less-developed systems, but that have continuing gaps in funding, workforce, and access.²⁸⁸ In committee, these states may support a practical expansion of successful national programs while preserving flexibility over the pace and structure of reform. They may support community care, workforce training, primary-care integration, and digital services, yet resist uniform requirements that do not account for national resources, culture, and existing institutions.

BLOC 3: STATES SUPPORTING COMPREHENSIVE, RIGHTS-BASED MENTAL HEALTH SYSTEMS

Countries in this bloc have comparatively well-resourced mental-health systems. These countries also have strong general healthcare infrastructure and established national mental health policies. They provide a range of services that may include community-based treatment alongside regulated specialist and inpatient care. These countries already have substantial institutional capacity; therefore, they are likely to focus on how they can expand services for prevention, early intervention, community support, and acute treatment. Higher national income does not guarantee equal access to mental healthcare, but it generally gives governments greater capacity to finance services, employ specialists, and maintain national programs.²⁸⁹

This bloc may support international cooperation, stronger human-rights protections, community-based care, youth services, and digital tools that expand access. These countries may also promote policies that address inequalities faced by marginalized populations and give patients and people with lived experience a greater role in decision-making.²⁹⁰ In committee, they may support shared international targets, stronger reporting requirements, and financial or technical assistance for countries seeking to expand their services. However, they may disagree over how these standards should be monitored and how much assistance wealthier countries should

provide.

Countries that may fit this bloc include Sweden, Norway, Finland, Canada, and Australia. These countries generally have well-established healthcare infrastructure, national mental-health policies, and comparatively greater capacity to finance comprehensive services.²⁹¹ Recent initiatives show a particular focus on suicide prevention, youth care, community services, workforce development, and digital access. Sweden also adopted a ten-year mental-health and suicide-prevention strategy in 2025.²⁹² Canada established a CAD 500 million Youth Mental Health Fund, while Australia maintains national strategies for its mental-health workforce and digital services.²⁹³

Despite this capacity, these countries continue to face growing demand for care, workforce pressures, waiting periods, and unequal access among rural, Indigenous, and other underserved populations. For example, 2025 data also show that more than 8 percent of people in Canada and Finland reported unmet healthcare needs because of costs, distance, or waiting periods.²⁹⁴ This bloc's national systems provide useful examples of sustained public investment and national coordination, but they should not be presented as universally accessible or free from rights concerns. Other states may also question whether these countries' expensive models can be transferred to health systems with fewer workers and financial resources.

Committee Mission

Mental health is no longer a challenge that is confined to individual states. Instead, it is a global public health priority that demands coordinated action. As the decision-making body of the World Health Organization, the World Health Assembly can establish priorities, adopt strategies and recommendations, encourage reporting, and coordinate technical assistance. However, it cannot directly redesign national health systems

or require governments to adopt a single model of care.

Delegates must determine which mental health services should receive priority and how states with different resources can implement them. Resolutions may address community-based care, primary-care integration, workforce training, essential medicines, stigma and discrimination, crisis response, digital services, and the protection of patient rights. Delegates should also consider how reforms will be financed and how countries can measure progress without creating reporting requirements that overburden weaker health systems.

The WHA treats mental health as a core global priority through the Comprehensive Mental Health Action Plan 2013–2030, focusing on universal health coverage, integration into primary care, and crisis response.²⁹⁵ Key agenda items should prompt WHA delegates to consider how governments can report on their progress in increasing investment in mental-health services, transitioning to community-based care, expanding access for young people, and improving crisis response.

Successful resolutions should clarify the appropriate roles of specialists, nonspecialist providers, schools, community organizations, private technology companies, national governments, and international partners. They should also preserve necessary emergency and inpatient care while reducing excessive reliance on isolated institutions. Ultimately, the committee must create flexible recommendations that expand access, protect human rights, and remain realistic for countries at different stages of mental health-system development.

Research and Preparation Questions

Your dais has prepared the following research and preparation questions as a means of providing guidance for your research process. These questions should be carefully considered, as they embody some of the main critical thought and learning objectives surrounding your topic.

TOPIC A

- 1 Which NCDs are most common in your country, and how do they affect its population, healthcare system, and economy?
- 2 What lifestyle, environmental, and social risk factors are contributing to the rise of NCDs in your country?
- 3 Which populations are most vulnerable to NCDs in your country, and what actions are being taken to protect them?
- 4 What policies has your country implemented to prevent NCDs, such as food labels, taxes, advertising restrictions, or health programs?
- 5 How does your country provide early diagnosis, affordable medicines, and long-term treatment for people living with NCDs?
- 6 How does your country balance funding for NCD prevention and treatment with its other public health priorities?
- 7 What actions has your country supported internationally to address NCDs, and what solutions would it propose in the World Health Assembly?

TOPIC B

- 1 How does the migration of trained mental health professionals from LMICs to high-income countries affect the countries they leave behind?
- 2 How have religious institutions, schools, and/or workplaces been effective spaces to reduce mental health stigma?
- 3 Which digital mental health programs have produced measurable improvements in patient outcomes, and could these models realistically be expanded to countries with limited internet access?
- 4 How are mental health services determined to be covered by public health insurance or not?
- 5 How can governments measure whether mental health funding is actually improving access and patient outcomes?
- 6 How do mental health services account for language, cultural, and religious differences between populations?

Important Documents

TOPIC A

- World Health Organization, “Noncommunicable Diseases,” World Health Organization, June 16, 2025, www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases.
- World Health Organization, “Protecting Children from the Harmful Effects of Food and Drink Marketing,” World Health Organization, March 3, 2023, www.who.int/news-room/feature-stories/detail/protecting-children-from-the-harmful-effects-of-food-and-drink-marketing.
- World Health Organization, “Obesity and Overweight,” World Health Organization, March 1, 2024, www.who.int/news-room/fact-sheets/detail/obesity-and-overweight.
- Robert Beaglehole et al., “Priority Actions for the Non-Communicable Disease Crisis,” *The Lancet* 377, no. 9775 (2011): 1438–1447, pmc.ncbi.nlm.nih.gov/articles/PMC2687091/.
- Organization for Economic Co-operation and Development, *The Health and Economic Benefits of Tackling Non-Communicable Diseases* (Paris: OECD Publishing, 2023), www.oecd.org/en/publications/the-health-and-economic-benefits-of-tackling-non-communicable-diseases_e20cbbc3-en.html.
- Afsheen Naaz, Ayman El-Menyar, and Hanan F. AbdulRahim, “How Maternal Nutritional and Mental Health Affects Child’s Health,” *Frontiers in Nutrition* 10 (2023), pmc.ncbi.nlm.nih.gov/articles/PMC10719542/.

TOPIC B

- Habeb, Mustafa. Stigma in mental health: The status and future direction - PMC. pmc.ncbi.nlm.nih.gov/articles/PMC12228425/
- From isolation to inclusion: Community-based Mental Health Care, www.who.int/news-room/commentaries/detail/from-isolation-to-inclusion---community-based-mental-health-care.
- Nisheet Patel, Global disparities in Mental Health Systems: A comparative cross-sectional study of ten countries with different income levels - PMC,, pmc.ncbi.nlm.nih.gov/articles/PMC12531183/.
- Justin Lo, Telehealth has played an outsized role meeting mental health needs during the COVID-19 pandemic | KFF, www.kff.org/mental-health/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/.
- Charlson van Ommeren, Mental Health in Emergencies, www.who.int/news-room/fact-sheets/detail/mental-health-in-emergencies.
- Barbara E. Johnson, Gender differences in Mental Health, Psychology, Research Starters, Ebsco Research, www.ebsco.com/research-starters/psychology/gender-differences-mental-health.

About the Authors

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Carolina Castilla is a dentistry student at Universidad de los Andes in Chile, with a particular interest in pediatric dentistry and maxillofacial surgery. She has been involved in Model United Nations since 2022, participating in NHSMUN as a delegate in 2022 and 2023. She later joined the NHSMUN staff, serving as Assistant Director of the Food and Agriculture Organization (FAO) during Session II in 2025 and as Director of UNICEF during Session I in 2026. She currently serves as Director of the World Health Assembly, where her academic background and interest in healthcare have allowed her to further explore global health challenges. Through her experiences as both a delegate and staff member, Carolina has developed a strong interest in international cooperation, public health, and the role of international organizations in addressing global health issues. She values Model United Nations as an opportunity to better understand different perspectives and develop solutions to complex global challenges.

TOPIC B: JOAQUIN ORQUIOLA

Joaquin Orquiola is a Political Science student at Santa Monica College with an interest in International Relations. He has been involved with Model UN since 2021 and joined the NHSMUN staff in 2026. He was the Assistant Director of C34 for Session II. Currently, he is the Session II Director for the World Health Assembly where his background in Political Science and interest in global policy have allowed him to further explore the role of governments and international organizations in addressing global challenges. He is particularly interested in how countries with different perspectives and priorities can work together to develop effective solutions to complex issues that go beyond national borders or the interests of a single country. He is looking forward to transferring to a California University to obtain a BA in Political Science.

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Endnotes

- 1 World Health Organization, "Noncommunicable Diseases," World Health Organization, June 16, 2025, www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases.
- 2 World Health Organization, "Noncommunicable Diseases,"
- 3 Leah N. Schwartz, Jonathan D. Shaffer, and Gene Bukhman, "The Origins of the 4 × 4 Framework for Noncommunicable Disease at the World Health Organization," *SSM – Population Health* 13 (2021): 100731, www.sciencedirect.com/science/article/pii/S2352827321000069.
- 4 World Health Organization, "Noncommunicable Diseases."
- 5 World Health Organization, "Protecting Children from the Harmful Effects of Food and Drink Marketing," World Health Organization, March 3, 2023, www.who.int/news-room/feature-stories/detail/protecting-children-from-the-harmful-effects-of-food-and-drink-marketing.
- 6 World Health Organization, "Protecting Children from the Harmful Effects of Food and Drink Marketing."
- 7 World Health Organization, "Noncommunicable Diseases."
- 8 Organisation for Economic Co-operation and Development, "The Benefits of Addressing Non-Communicable Diseases in OECD Countries (Paris: OECD Publishing, 2023), www.oecd.org/en/publications/the-benefits-of-addressing-non-communicable-diseases-in-oecd-countries_7e651851-en/full-report.html.
- 9 Robert Beaglehole et al., "Priority Actions for the Non-Communicable Disease Crisis," *The Lancet* 377, no. 9775 (2011): 1438–1447, pmc.ncbi.nlm.nih.gov/articles/PMC2687091/.
- 10 Beaglehole et al., "Priority Actions for the Non-Communicable Disease Crisis."
- 11 World Health Organization, "Cardiovascular Diseases (CVDs)," World Health Organization, [www.who.int/news-room/fact-sheets/detail/cardiovascular-diseases-\(cvds\)](http://www.who.int/news-room/fact-sheets/detail/cardiovascular-diseases-(cvds)).
- 12 World Health Organization, "Cardiovascular Diseases (CVDs)."
- 13 "Cardiovascular Disease," NHS, www.nhs.uk/conditions/cardiovascular-disease/.
- 14 Yuan M, Lu Y, Zhu X, et al., "Current Status and Future Directions of Cardiovascular Disease Prevention and Management," *Frontiers in Cardiovascular Medicine* (2024), pmc.ncbi.nlm.nih.gov/articles/PMC11274005/.
- 15 Aga Khan University, "Non-Communicable Diseases Continue to Rise Worldwide Despite Progress in Prevention and Treatment," Aga Khan University, www.aku.edu/news/Pages/News_Details.aspx?nid=NEWS-003795.
- 16 Sirwan Khalid Ahmed and Ribwar Arsalan Mohammed, "Obesity: Prevalence, Causes, Consequences, Management, Preventive Strategies and Future Research Directions," *Metabolism Open* 27 (September 2025): 100375, doi.org/10.1016/j.metop.2025.100375.
- 17 World Health Organization, "Cancer," World Health Organization, www.who.int/news-room/fact-sheets/detail/cancer.
- 18 World Health Organization, "Cancer."
- 19 World Health Organization, "Cancer."
- 20 Abdallah S. Daaret al., "Grand Challenges in Chronic Non-Communicable Diseases," *Nature* 450, no. 7169 (2007): 494–496, pmc.ncbi.nlm.nih.gov/articles/PMC4127616/.
- 21 Dean T. Jamison, *Global Health 2035: A World Converging Within a Generation* (Washington, DC: National Academies Press, 2014), www.ncbi.nlm.nih.gov/books/NBK223933/.
- 22 Christian Mattiuzzi and Giuseppe Lippi, "Current Cancer Epidemiology," *Journal of Epidemiology and Global Health* 13, no. 2 (2023): 217–222, pmc.ncbi.nlm.nih.gov/articles/PMC10014988/.
- 23 World Health Organization, "Tobacco Control," World Health Organization, www.who.int/teams/health-promotion/tobacco-control.
- 24 GBD 2019 Diseases and Injuries Collaborators, "Global Burden of 369 Diseases and Injuries in 204 Countries and Territories, 1990–2019: A Systematic Analysis for the Global Burden of Disease Study 2019," *The Lancet* 396, no. 10258 (2020): 1204–1222, pmc.ncbi.nlm.nih.gov/articles/PMC8034823/.
- 25 "Scholars Portal," Universitas Airlangga, scholar.unair.ac.id/en/.
- 26 Shanthi Mendis, "The Policy Agenda for Prevention and Control of Noncommunicable Diseases," *British Medical Bulletin* 147, no. 1 (2023): 3–12, pmc.ncbi.nlm.nih.gov/articles/PMC10495147/.
- 27 World Health Organization, "Household Air Pollution and Health," World Health Organization, www.who.int/news-room/fact-sheets/detail/household-air-pollution-and-health.
- 28 World Health Organization, "Air Pollution," accessed September 20, 2026, www.who.int/health-topics/air-pollution.
- 29 World Health Organization, "Household Air Pollution and Health."
- 30 International Diabetes Federation, "Diabetes Facts & Figures," International Diabetes Federation, idf.org/about-diabetes/diabetes-facts-figures/.
- 31 International Diabetes Federation, "Diabetes Facts & Figures."
- 32 J. J. Noubiap et al., "Diabetes Mellitus and Its Global Burden: Epidemiology, Trends, and Future Challenges," *The Lancet Diabetes & Endocrinology* (2024), pmc.ncbi.nlm.nih.gov/articles/PMC10958528/.
- 33 Rahul Basharat Rajput, "Pakistan Has the World's Highest Diabetes Prevalence – and Lacks Focus on Prevention," *Health Policy Watch*, November 14, 2024, healthpolicy-watch.news/pakistan-has-the-worlds-highest-diabetes-prevalence-and-lacks-focus-on-prevention/.
- 34 Rajput, "Pakistan Has the World's Highest Diabetes Prevalence – and Lacks Focus on Prevention,"
- 35 Rajput, "Pakistan Has the World's Highest Diabetes Prevalence – and Lacks Focus on Prevention,"
- 36 Mariachiara Di Cesare et al., "The Epidemiological Burden of Obesity and Its Contribution to Noncommunicable Diseases," *The Lancet Diabetes & Endocrinology* (2021), pmc.ncbi.nlm.nih.gov/articles/PMC8012321/.
- 37 Mariachiara Di Cesare, et al., "The Epidemiological Burden of Obesity and Its Contribution to Noncommunicable Diseases."
- 38 World Health Organization, "Social Determinants of Health," World Health Organization, www.who.int/health-topics/social-determinants-of-health.
- 39 Nicholas C. Coombs, Duncan G. Campbell, and James Caringi, "A Qualitative Study of Rural Healthcare Providers' Views of Social, Cultural, and Programmatic Barriers to Healthcare Access," *BMC Health Services Research* 22, no. 1 (2022): 438, pmc.ncbi.nlm.nih.gov/articles/PMC8976509/.
- 40 Coombs, Campbell, and Caringi, "A Qualitative Study of Rural Healthcare Providers' Views of Social, Cultural, and Programmatic Barriers to Healthcare Access."
- 41 Keerthana Dubbala, Wiebke Spahl, C. E. George, and Luc de Witte, "Perceptions of Health and Healthcare Needs in Low-Resource Settings: Qualitative Insights from Bengaluru's Urban Slum and Rural Areas," *Frontiers in Public Health* 13 (2025): 1530256, pmc.ncbi.nlm.nih.gov/articles/PMC11996843/.
- 42 World Health Organization Regional Office for the Eastern Mediterranean, "Sudan's Health Crisis: Holding the Line," World Health Organization Regional Office for the Eastern Mediterranean, July 1 2025, www.emro.who.int/sudan-news/sudans-health-crisis-holding-the-line.html.

- 43 Institute of Development Studies, "Critical Factors: Rebuilding Health Systems After Crises," Institute of Development Studies, archive.ids.ac.uk/eldis/keyissues/critical-factors-rebuilding-health-systems-after-crises.html.
- 44 Institute of Development Studies, "Critical Factors: Rebuilding Health Systems After Crises."
- 45 Vahid Yazdi-Feyzabadi et al., "Breaking Barriers: Challenges Faced by the Older Adults in Accessing Healthcare Services," *BMC Health Services Research* (2025), pmc.ncbi.nlm.nih.gov/articles/PMC12642197/.
- 46 World Health Organization, "Sugars and Dental Caries," World Health Organization, www.who.int/news-room/fact-sheets/detail/sugars-and-dental-carries.
- 47 Feyzabadi et al., "Breaking Barriers: Challenges Faced by the Older Adults in Accessing Healthcare Services" pmc.ncbi.nlm.nih.gov/articles/PMC12642197/.
- 48 Leibowitz et al., "Using Mobile Clinics to Deliver Care to Difficult-to-Reach Populations: A COVID-19 Practice We Should Keep," *Preventive Medicine Reports* 24 (2021): 101551, pmc.ncbi.nlm.nih.gov/articles/PMC8428151/.
- 49 Victor C. Ezeamii et al., "Revolutionizing Healthcare: How Telemedicine Is Improving Patient Outcomes and Expanding Access to Care," *Cureus* 16, no. 7 (2024): e63881, pmc.ncbi.nlm.nih.gov/articles/PMC11298029/.
- 50 World Health Organization, "Be Healthy, Be Mobile Country Programmes," accessed September 20, 2026, www.who.int/initiatives/behealthy/our-work/country-programmes.
- 51 World Health Organization, "Be Healthy, Be Mobile Country Programmes."
- 52 Afsheen Naaz, Ayman El-Menyar, and Hanan F. AbdulRahim, "How Maternal Nutritional and Mental Health Affects Child's Health," *Frontiers in Nutrition* 10 (2023), pmc.ncbi.nlm.nih.gov/articles/PMC10719542/.
- 53 Bente Mikkelsen et al., "Life Course Approach to Prevention and Control of Non-Communicable Diseases," *BMJ* 364 (2019): l257, pmc.ncbi.nlm.nih.gov/articles/PMC6349133/.
- 54 José G. B. Alves, "Early-Life Nutrition and Adult-Life Outcomes," *Annals of Nutrition and Metabolism* 79, no. 4 (2023), pmc.ncbi.nlm.nih.gov/articles/PMC10960187/.
- 55 Michael Marmot et al., "WHO European Review of Social Determinants of Health and the Health Divide," *The Lancet* 380, no. 9846 (2012): 1011–1029, pmc.ncbi.nlm.nih.gov/articles/PMC9182711/.
- 56 Michael Marmot et al., "WHO European Review of Social Determinants of Health and the Health Divide."
- 57 Benoît Stadelmann, et al., "The First 1,000 Days: Early-Life Exposures and Long-Term Health," *Communications Medicine* 5 (2025), www.nature.com/articles/s43856-025-01129-6.
- 58 United Nations Children's Fund, "Ensuring a Healthy Start in the First 1,000 Days," UNICEF Laos, www.unicef.org/laos/ensuring-healthy-start-first-1000-days-0.
- 59 World Health Organization, "Infant and Young Child Feeding," World Health Organization, June 20, 2025, www.who.int/news-room/fact-sheets/detail/infant-and-young-child-feeding.
- 60 United Nations Children's Fund, "Ensuring a Healthy Start in the First 1,000 Days."
- 61 Jack P. Shonkoff, et al., "The Lifelong Effects of Early Childhood Adversity and Toxic Stress," *Children and Youth Services Review* (2019), www.sciencedirect.com/science/article/pii/S0195666318313412.
- 62 Centers for Disease Control and Prevention, "Sleep," CDC, www.cdc.gov/physical-activity-education/staying-healthy/sleep.html.
- 63 Shoshana H. Berenzon Gorn, et al., "Healthy Lifestyle Behaviors and Prevention of Chronic Disease Across the Life Course," *Nutrients* 15, no. 6 (2023), pmc.ncbi.nlm.nih.gov/articles/PMC10047133/.
- 64 Emma Lisa Jane Eyre and Michael J. Duncan, "The Impact of Ethnicity on Objectively Measured Physical Activity in Children," *ISRN Obesity* 2013 (2013): 1–15, doi.org/10.1155/2013/757431.
- 65 Henry Saffer et al., "Racial, Ethnic, and Gender Differences in Physical Activity," *Journal of Human Capital* 7, no. 4 (Winter 2013): 378–410, doi.org/10.1086/671200.
- 66 Centers for Disease Control and Prevention, "About Adverse Childhood Experiences," Centers for Disease Control and Prevention, www.cdc.gov/aces/about/index.html.
- 67 Centers for Disease Control and Prevention, "About Adverse Childhood Experiences."
- 68 World Health Organization, "Noncommunicable Diseases."
- 69 A. Locke et al., "Impacts of Global School Feeding Programmes on Children's Health, Nutrition, Education, and Well-Being: A Systematic Review," *BMJ Open* 15, no. 10 (2025): e093244, pmc.ncbi.nlm.nih.gov/articles/PMC12496081/.
- 70 Finnish National Agency for Education, "School Meals in Finland," Finnish National Agency for Education, www.oph.fi/en/education-and-qualifications/school-meals-finland.
- 71 NCD Alliance, "Tobacco Use," NCD Alliance, accessed August 28, 2026, ncdalliance.org/explore-ncds/risk-factors/tobacco-use.
- 72 "Tobacco and nicotine," World Health Organization, June 26, 2026, www.who.int/en/news-room/fact-sheets/detail/tobacco.
- 73 "Tobacco and nicotine."
- 74 "Tobacco Products - Worldwide," Statista, accessed August 22, 2026, www.statista.com/outlook/cmo/tobacco-products/worldwide.
- 75 Troy Kickler, "Camel Cigarettes," North Carolina History Project, John Locke Foundation, accessed August 22, 2026, northcarolinahistory.org/encyclopedia/camel-cigarettes/.
- 76 Kickler, "Camel Cigarettes."
- 77 "Marilyn E. Jackler Memorial Collection of Tobacco Advertisements AC1224," Smithsonian Institution, accessed August 22, 2026, www.si.edu/media/NMAH/NMAH-AC1224-0000020.pdf.
- 78 R. J. Reynolds Tobacco Co. v. Federal Trade Commission, 192 F.2d 535 (7th Cir. 1951), law.justia.com/cases/federal/appellate-courts/F2/192/535/211078/.
- 79 R. L. Berger et al., "Thoracic surgery and the war against smoking: Richard H. Overholt, MD," *Ann Thorac Surg.* 53, no. 4 (April 1992): 719–25, doi.org/10.1016/0003-4975(92)90347-7.
- 80 Martha N. Gardner and Allan M. Brandt, "'The Doctors' Choice Is America's Choice,'" *American Journal of Public Health* 96 (October 2010): 222–232, doi.org/10.2105/AJPH.2005.066654.
- 81 "The 'More Doctors Smoke Camels' Campaign," The Center for the Study of Tobacco and Society, accessed August 23, 2026, csts.ua.edu/ama/more-doctors-smoke-camels/.
- 82 Gardner and Brandt, "'The Doctors' Choice Is America's Choice,'" 222–232.
- 83 "Collection: More Doctors Smoke Camels," Stanford University, accessed August 23, 2026, tobacco.stanford.edu/cigarettes/doctors-smoking/more-doctors-smoke-camels/.
- 84 Gardner and Brandt, "'The Doctors' Choice Is America's Choice,'" 222–232.
- 85 Antonia C. Lyons et al., "Evading Regulation: Young People's Exposure to Harmful Commodity Marketing in the Social Media Feeds of Their Favourite Influencers," *Health Promotion International* 41, no. 2 (March 2, 2026): daag037, https://doi.org/10.1093/heapro/daag037.
- 86 Federal Trade Commission, "Joe Camel Advertising Campaign Violates Federal Law, FTC Says," press release, May 28, 1997, www.ftc.gov/

news-events/news/press-releases/1997/05/joe-camel-advertising-campaign-violates-federal-law-ftc-says.

87 Federal Trade Commission, "Joe Camel Advertising Campaign Violates Federal Law, FTC Says."

88 John E. Calfee, "The Historical Significance of Joe Camel," American Enterprise Institute, October 1, 2000, www.aei.org/commentary/the-historical-significance-of-joe-camel/.

89 Paul M. Fischer et al., "Brand Logo Recognition by Children Aged 3 to 6 Years," *Journal of the American Medical Association* 266, no. 22 (December 1991): 3145-3148, <http://doi.org/10.1001/jama.1991.03470220061027>.

90 Paul Nowell, "R.J. Reynolds Drops Joe Camel," Associated Press, July 11, 1997, scholar.lib.vt.edu/VA-news/VA-Pilot/issues/1997/vp970711/07110576.htm.

91 Imti Choonara, "Advertising and Child Health," *BMJ Paediatrics Open* 9, no. 1 (January 9, 2025): e003260, <https://doi.org/10.1136/bmjpo-2024-003260>.

92 "Historical Timeline of Vaping & Electronic Cigarettes," CASAA, accessed August 23, 2026, casaa.org/education/vaping/historical-timeline-of-electronic-cigarettes/.

93 Centers for Disease Control and Prevention, "Health Effects of Vaping," Smoking and Tobacco Use, January 31, 2025, <https://www.cdc.gov/tobacco/e-cigarettes/health-effects.html>.

94 Centers for Disease Control and Prevention, "Health Effects of Vaping."

95 "Is Vaping Better Than Smoking?" American Heart Association, accessed August 23, 2026, www.heart.org/en/healthy-living/healthy-lifestyle/quit-smoking-tobacco/is-vaping-safer-than-smoking.

96 "Four marketing tactics e-cigarette companies use to target young people," Truth Initiative, February 19, 2026, truthinitiative.org/research-resources/tobacco-industry-marketing/4-marketing-tactics-e-cigarette-companies-use-target.

97 World Health Organization, "Obesity and Overweight," World Health Organization, March 1, 2024, www.who.int/news-room/fact-sheets/detail/obesity-and-overweight.

98 Organisation for Economic Co-operation and Development, *The Health and Economic Benefits of Tackling Non-Communicable Disease*.

99 World Health Organization, "Obesity and Overweight," World Health Organization.

100 World Health Organization, "Obesity and Overweight," World Health Organization.

101 World Health Organization, "Obesity and Overweight," World Health Organization.

102 World Health Organization, "Obesity and Overweight," World Health Organization.

103 World Health Organization, "Obesity and Overweight," World Health Organization.

104 Sirwan K. Ahmed and Rozh A. Mohammed, "Obesity: Prevalence, Causes, Consequences, Management, Preventive Strategies and Future Research Directions," *Metabolism Open* 27 (2025): 100375, www.sciencedirect.com/science/article/pii/S2589936825000313.

105 World Health Organization, *Report of the Commission on Ending Childhood Obesity* (Geneva: World Health Organization, 2017), www.who.int/publications/i/item/WHO-NMH-NHD-17.3.

106 World Health Organization, *Report of the Commission on Ending Childhood Obesity*.

107 United Nations Environment Programme, "9 Ways Food Systems Are Failing Humanity," United Nations Environment Programme, March 28, 2024, www.unep.org/news-and-stories/story/9-ways-food-systems-are-failing-humanity.

108 Jennifer M. Poti, Bianca Braga, and Bo Qin, "Ultra-Processed Food Intake and Obesity: What Really Matters for Health – Processing or Nutrient Content?," *Current Obesity Reports* 6, no. 4 (2017): 420–431, pmc.ncbi.nlm.nih.gov/articles/PMC5787353/.

109 World Bank, *The Growing Danger of Non-Communicable Diseases: Acting Now to Reverse Course* (Washington, DC: World Bank, 2011), openknowledge.worldbank.org/entities/publication/ef8377ed-ac06-5469-bce3-92c30b5df67e.

110 Agence France-Presse, "UN Agency Warns Cost of a Healthy Diet Has Spiked 25% Since 2021," *Medical Xpress*, July 16, 2026, medicalxpress.com/news/2026-07-agency-healthy-diet-spiked.html.

111 Devlin Peck, "Online Learning Statistics: The Ultimate List for 2026," Devlin Peck, last modified August 2, 2026, <https://www.devlinpeck.com/content/online-learning-statistics>.

112 Peck, "Online Learning Statistics: The Ultimate List for 2026."

113 Aaron Reuben, George W. Rutherford, Jameze James, and Nooshin Razani, "Association of Neighborhood Parks with Child Health in the United States," *Preventive Medicine* 141 (2020): 106265, pmc.ncbi.nlm.nih.gov/articles/PMC8034548/.

114 World Health Organization, "Physical Activity," World Health Organization, June 26, 2024, www.who.int/news-room/fact-sheets/detail/physical-activity.

115 "Ciclovía at 50: What we can learn from Bogotá's Open Streets initiative," World Economic Forum, November 12, 2024, www.weforum.org/stories/2024/11/50-years-ciclovía-open-streets-cycling-cars/.

116 World Obesity Federation, "Global Obesity Rankings," World Obesity Atlas, data.worldobesity.org/rankings/.

117 "Finland," World Action on Salt, Sugar & Health, accessed August 28, 2026, www.worldactiononsalt.com/worldaction/europe/finland/.

118 M. Arantxa Colchero, Mariana Molina, and Carlos M. Guerrero-López, "After Mexico Implemented a Tax, Purchases of Sugar-Sweetened Beverages Decreased and Water Increased: Difference by Place of Residence, Household Composition, and Income Level," *The Journal of Nutrition* 147, no. 8 (August 2017): 1552–1557, doi.org/10.3945/jn.117.251892.

119 Leszek Borysiewicz, "Prevention Is Better Than Cure," *Clinical Medicine* 9, no. 6 (2009): 572–583, pmc.ncbi.nlm.nih.gov/articles/PMC4952299/.

120 World Health Organization, *Tackling NCDs: Best Buys and Other Recommended Interventions for the Prevention and Control of Noncommunicable Diseases*, 2nd ed. (Geneva: World Health Organization, 2024), www.who.int/publications/i/item/9789240091078.

121 Fountain Life, "The Benefits of Early Disease Detection," Fountain Life, April 16, 2024, www.fountainlife.com/blog/benefits-of-early-disease-detection.

122 "Stanford Medicine Experts Go Deep on GLP-1s," Stanford Report, June 29, 2026, <https://news.stanford.edu/stories/2026/06/glp1-weight-loss-side-effects-safety>.

123 World Health Organization, "WHO Issues Global Guideline on the Use of GLP-1 Medicines in Treating Obesity," news release, December 1, 2025, www.who.int/news/item/01-12-2025-who-issues-global-guideline-on-the-use-of-glp-1-medicines-in-treating-obesity.

124 World Health Organization, "WHO Issues Global Guideline on the Use of GLP-1 Medicines in Treating Obesity."

125 World Health Organization, "WHO Issues Global Guideline on the Use of GLP-1 Medicines in Treating Obesity."

126 Danielle Valletti, "As GLP-1 Use Expands, Long-Term Safety Questions Remain Under Watch," *Pharmacy Times*, May 8, 2026, <https://www.pharmacytimes.com/view/as-glp-1-use-expands-long-term-safety-questions-remain-under-watch>.

127 Baylor Scott & White Health, "GLP-1 Medications Explained: Benefits, Risks and How They Work," *Scrubbing In*, October 15, 2025, <https://www.bswhealth.com/blog/glp-1-medications-explained-benefits-risks-how-they-work>.

128 Baylor Scott & White Health, "GLP-1 Medications Explained."

129 South Central Clinics of Odessa, "Primary Healthcare: Benefits, Services, and Why It Matters," South Central Clinics of Odessa, May 31, 2023, sccodessa.com/blogs/primary-healthcare-benefits-services-and-why-it-matters/.

- 130 Pan American Health Organization, Annual Report 2025: Driving Innovation, Delivering Impact, "Flagship Initiatives" (Washington, DC: Pan American Health Organization, 2026), <https://www.paho.org/pub/en/annual-report-2025/flagship-initiatives.html>.
- 131 Pan American Health Organization, "Better Care for NCDs Initiative," Pan American Health Organization, www.paho.org/en/better-care-ncds-initiative.
- 132 Pan American Health Organization, "Better Care for NCDs Initiative," Pan American Health Organization.
- 133 World Health Organization, "Obesity and Overweight," World Health Organization, March 1, 2024, www.who.int/news-room/fact-sheets/detail/obesity-and-overweight.
- 134 UN News, "Political Declaration on Non-Communicable Diseases a 'Beacon of Hope,' Says General Assembly President," UN News, May 13, 2011, news.un.org/en/story/2011/05/375072.
- 135 Gerald Yonga and Anastasia N. Nyalita, "Kenya Can't Afford to Neglect People with Underlying Conditions During COVID-19," The Conversation, May 6, 2020, theconversation.com/kenya-cant-afford-to-neglect-people-with-underlying-conditions-during-covid-19-137095.
- 136 Esther Njoroge, "Rising Diabetes Cases in Kenya Demand Early Screening," Kenyatta University Teaching, Referral & Research Hospital, March 13, 2026, <https://www.kutrrh.go.ke/rising-diabetes-cases-in-kenya-demand-early-screening/>.
- 137 World Health Organization, "WHO Issues Global Guideline on the Use of GLP-1 Medicines in Treating Obesity."
- 138 Hassan E. Muhammad and Asad Ali Ahmed Cheema, "From Prescription to Trend: The Misuse of Ozempic in the Age of Social Media," *Annals of Medicine & Surgery* 87, no. 10 (October 2025): 6876–6877, <https://doi.org/10.1097/MS9.0000000000003801>.
- 139 World Health Organization, "WHO Issues Global Guideline on the Use of GLP-1 Medicines in Treating Obesity."
- 140 Jonathan DiStefano and Donald C. Cooper, "Insulin Was Discovered 100 Years Ago, but It Took More Than One Scientific Breakthrough to Get a Diabetes Treatment to Patients," The Conversation, July 27, 2021, theconversation.com/insulin-was-discovered-100-years-ago-but-it-took-a-lot-more-than-one-scientific-breakthrough-to-get-a-diabetes-treatment-to-patients-162743.
- 141 M. A. Beran et al., "Access to Medicines and Diagnostics for Diabetes Mellitus in Low- and Middle-Income Countries: A Scoping Review," *PLOS Medicine* 18, no. 3 (2021): e1003495, pmc.ncbi.nlm.nih.gov/articles/PMC8012321/.
- 142 David Beran et al., "A Global Perspective on the Issue of Access to Insulin," *Diabetologia* 64, no. 5 (May 2021): 954–962, <https://doi.org/10.1007/s00125-020-05375-2>.
- 143 Beran et al., "A Global Perspective," 954–962.
- 144 Kristóf Bartha, "Back to the Future: When Insulin Access Disappears," *T1International*, May 11, 2026, <https://www.t1international.com/blog/2026/05/11/back-future-when-insulin-access-disappears/>.
- 145 Bartha, "Back to the Future."
- 146 Acibadem Healthcare Group, "Cancer Diagnosis Basics: Tests, Biopsy and Imaging Explained," Acibadem International, acibademinternational.com/health-library/cancer-diagnosis-basics-tests-biopsy-and-imaging-explained/.
- 147 WebMD Editorial Contributors, "What Diabetes Supplies Will I Need?," WebMD, www.webmd.com/diabetes/what-diabetes-supplies-will-i-need.
- 148 M. Beran et al., "Barriers to Accessing Insulin and Diabetes Care in Low- and Middle-Income Countries," *The Lancet Diabetes & Endocrinology* (2024), pmc.ncbi.nlm.nih.gov/articles/PMC10931869/.
- 149 A. T. Adepoju et al., "Improving Early Cancer Diagnosis Through Timely Access to Diagnostic Services," *Frontiers in Oncology* (2024), pmc.ncbi.nlm.nih.gov/articles/PMC12352939/.
- 150 College of American Pathologists Foundation, "See, Test & Treat," CAP Foundation, foundation.cap.org/see-test-treat/.
- 151 College of American Pathologists Foundation, "See, Test & Treat Grant Award," CAP Foundation.
- 152 World Health Organization, "Patient Safety at the Heart of Forthcoming WHO Asthma Guidelines," departmental update, September 17, 2026, www.who.int/philippines/news/detail-global/17-09-2026-patient-safety-at-the-heart-of-forthcoming-who-asthma-guidelines.
- 153 Isabel Cristina Martins Emmerick et al., "Farmácia Popular Program: Changes in Geographic Accessibility of Medicines during Ten Years of a Medicine Subsidy Policy in Brazil," *Journal of Pharmaceutical Policy and Practice* 8, no. 1 (March 2015): article 10, <https://doi.org/10.1186/s40545-015-0030-x>.
- 154 Brazil, Ministry of Health, "Farmácia Popular," Governo Federal do Brasil, 2024, www.gov.br/saude/pt-br/assuntos/balancos/2024/farmacia-popular.
- 155 Reuters, "Majority of Medical Equipment Supplies at 'Stock Zero' in Gaza, WHO Says," Reuters, May 26, 2025, www.reuters.com/business/healthcare-pharmaceuticals/majority-medical-equipment-supplies-stock-zero-gaza-who-says-2025-05-26/.
- 156 World Health Organization Regional Office for the Eastern Mediterranean, "Noncommunicable Diseases in Fragile and Conflict-Hit Settings," World Health Organization, October 11, 2023, <https://www.emro.who.int/media/news/noncommunicable-diseases-in-fragile-and-conflict-hit-settings.html>.
- 157 World Health Organization, "Palliative Care," World Health Organization, August 5, 2020, www.who.int/news-room/fact-sheets/detail/palliative-care.
- 158 David A. Watkins, et al., "Financing policies to sustain improved prevention, control, and management of non-communicable diseases and mental health conditions," *The Lancet Global Health* 13 no. 11 (November 2025): e1973–e1982, [doi.org/10.1016/S2214-109X\(25\)00347-X](https://doi.org/10.1016/S2214-109X(25)00347-X).
- 159 Iris R. Joosse, et al., "Availability of essential medicines for non-communicable diseases: a scoping review of challenges and opportunities," *BMJ Global Health* 10, no. 11 (November 27, 2025), doi.org/10.1136/bmjgh-2025-019634.
- 160 Lukas Radbruch et al., "The Key Role of Palliative Care in Responding to the COVID-19 Pandemic," *The Lancet* 395, no. 10235 (2020): 1467–1469, pmc.ncbi.nlm.nih.gov/articles/PMC7309216/.
- 161 C. M. Silva et al., "Strengthening Primary Health Care to Improve Noncommunicable Disease Prevention and Control," *Frontiers in Public Health* 13 (2025): 1653043, www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2025.1653043/full.
- 162 Mark Fordjour Owusu et al., "Tackling the Non-Communicable Disease Epidemic: A Framework for Policy Action in Low- and Middle-Income Countries," *Pan African Medical Journal* 47 (2024): article 82, <https://doi.org/10.11604/pamj.2024.47.82.41089>.
- 163 Anu Linnansaari, Hanna Ollila, Charlotta Pisinger, et al., "Towards Tobacco-Free Generation: Implementation of Preventive Tobacco Policies in the Nordic Countries," *Scandinavian Journal of Public Health* 51, no. 8 (2023): 1108–1121, pmc.ncbi.nlm.nih.gov/articles/PMC10642214/.
- 164 Agence France-Presse, "Denmark Could Eradicate Cervical Cancer by 2040: Study," *Medical Xpress*, April 14, 2025, medicalxpress.com/news/2025-04-denmark-eradicate-cervical-cancer.html.
- 165 Eurostat, Health in the European Union – Facts and Figures (Luxembourg: Publications Office of the European Union), ec.europa.eu/eurostat/statistics-explained/SEPDF/cache/37393.pdf.
- 166 World Health Organization, "Urban Health," fact sheet, March 19, 2025, <https://www.who.int/news-room/fact-sheets/detail/urban-health>.
- 167 Owusu et al., "Tackling the Non-Communicable Disease Epidemic," article 82.
- 168 David K. Jones and David A. Chokshi, "Brazil's Family Health Strategy: Using Community Health Workers to Provide Primary Care," The Commonwealth Fund, December 13, 2016, www.commonwealthfund.org/publications/case-study/2016/dec/brazils-family-health-strategy-using-community-health-care-workers.

- 169 Luke Nelson Allen, "Financing National Non-Communicable Disease Responses," *Global Health Action* 10, no. 1 (2017): article 1326687, <https://doi.org/10.1080/16549716.2017.1326687>.
- 170 Owusu et al., "Tackling the Non-Communicable Disease Epidemic," article 82.
- 171 Azeb Gebresilassie Tesema, Improving the Prevention and Management of Non-Communicable Diseases in Ethiopia (The George Institute for Global Health and WHO Global NCD Platform, May 7, 2024), https://knowledge-action-portal.com/sites/default/files/policy_brief_ethiopia_improving_the_prevention_and_management_of_non-communicable_diseases_in_ethiopia.pdf.
- 172 Uganda Ministry of Health, The National Essential Health Care Package for Uganda (Kampala: Ministry of Health, August 1, 2024), <https://library.health.go.ug/sites/default/files/resources/Uganda%20National%20Essential%20Health%20Care%20Package%202024.pdf>.
- 173 Sierra Leone Ministry of Health and Sanitation, Non-Communicable Diseases (NCDs) Strategic Plan 2020–2024 (Freetown: Ministry of Health and Sanitation, February 23, 2020), <https://portal.mohs.gov.sl/download/33/publications/1602/sierra-leone-ncd-strategic-plan-2020-2024-feb2020.pdf>.
- 174 World Health Organization, "World Health Assembly," World Health Organization.
- 175 World Health Organization, "World Health Assembly," World Health Organization.
- 176 World Health Organization, "The World Health Assembly Adopts Updated Global Action Plan on Antimicrobial Resistance (2026–2036)," World Health Organization, May 25, 2026, [www.who.int/news/item/25-05-2026-the-world-health-assembly-adopts-updated-global-action-plan-on-antimicrobial-resistance-\(2026-2036\)](https://www.who.int/news/item/25-05-2026-the-world-health-assembly-adopts-updated-global-action-plan-on-antimicrobial-resistance-(2026-2036)).
- 177 World Health Organization, "Mental Disorders," fact sheet, September 11, 2026, <https://www.who.int/news-room/fact-sheets/detail/mental-disorders>.
- 178 N Votruba, G Thornicroft, "Sustainable development goals and mental health: learnings from the contribution of the FundaMentalSDG global initiative," *National Library of Medicine*, September 9, 2016, [pmc.ncbi.nlm.nih.gov/articles/PMC5454784/](https://pubmed.ncbi.nlm.nih.gov/articles/PMC5454784/).
- 179 "Comprehensive Medical Action Plan," World Health Organization, 2013, iris.who.int/server/api/core/bitstreams/69921758-6229-49ba-bd3d-c24736e35829/content.
- 180 Verusca Calabria and Lynsey T. Cullen, "Deinstitutionalisation and the Move to Community Care: Comparing the Changing Dimensions of Mental Healthcare after 1922 in the Republic of Ireland and England," *History of Psychiatry* 35, no. 2 (June 2024): 141–157, <https://doi.org/10.1177/0957154X241231057>.
- 181 Calabria and Cullen, "Deinstitutionalisation and the Move to Community Care," 141–157.
- 182 Rob Whitley, "Global Mental Health: Concepts, Conflicts and Controversies," *Epidemiology and Psychiatric Sciences* 24, no. 4 (August 2015): 285–291, <https://doi.org/10.1017/S2045796015000451>.
- 183 Whitley, "Global Mental Health," 285–291.
- 184 Whitley, "Global Mental Health," 285–291.
- 185 World Health Organization, Comprehensive Mental Health Action Plan 2013–2030 (Geneva: World Health Organization, 2021), <https://www.who.int/publications/i/item/9789240031029>.
- 186 Habeb M, Ciobanu AM, Al-Ani M, Mottershead R, "Stigma in Mental Health: The Status and Future Direction," *Cureus*, 2025 Jun 5;17(6), [pmc.ncbi.nlm.nih.gov/articles/PMC12228425/](https://pubmed.ncbi.nlm.nih.gov/articles/PMC12228425/).
- 187 Parcesepe AM, Cabassa LJ, "Public stigma of mental illness in the United States: a systematic literature review. *Adm Policy Ment Health*," 2013, 40(5):384–99. doi: 10.1007/s10488-012-0430-z. PMID: 22833051; PMCID: PMC3835659.
- 188 "The overwhelming case for ending stigma and discrimination in Mental Health," World Health Organization, June 26, 2024, www.who.int/europe/news/item/26-06-2024-the-overwhelming-case-for-ending-stigma-and-discrimination-in-mental-health.
- 189 Katherine Ponte, "The many impacts of self-stigma," *National Alliance on Mental Illness*, 2026, www.nami.org/Blogs/NAMI-Blog/February-2021/The-Many-Impacts-of-Self-Stigma.
- 190 Nikhita Singhal, "Stigma, prejudice and discrimination against people with mental illness," *American Psychiatric Association*, accessed August 25, 2026, www.psychiatry.org/patients-families/stigma-and-discrimination.
- 191 Heather Stuart, "Media portrayal of mental illness and its treatments: What effect does it have on people with mental illness?," *Pubmed*, 2006, pubmed.ncbi.nlm.nih.gov/16478286/?dopt=Abstract.
- 192 World Health Organization, "The overwhelming case for ending stigma and discrimination in Mental Health."
- 193 Angie Cucchi and M. Walid Qoronfleh, "Cultural Perspective on Religion, Spirituality and Mental Health," *Frontiers in Psychology* 16 (April 2, 2025): article 1568861, <https://doi.org/10.3389/fpsyg.2025.1568861>.
- 194 Sheila Modir, "Understanding the role of cultural stigma on seeking mental health services," *Rady Children's Health*, August 4, 2020, health.choc.org/understanding-the-role-of-cultural-stigma-on-seeking-mental-health-services/.
- 195 Cucchi and Qoronfleh, "Cultural Perspective on Religion, Spirituality and Mental Health."
- 196 E.J Finkel, "Tribalism: The mental health cost of division," *NY Mental Health Center*, July 3, 2025, nymentalhealthcenter.com/tribalism-the-mental-health-cost-of-division/.
- 197 Laura C Potts and Claire Henderson, "Moderation by socioeconomic status of the relationship between familiarity with mental illness and stigma outcomes," *PMC*, 2020, [www.ncbi.nlm.nih.gov/pmc/articles/PMC7378684/](https://pubmed.ncbi.nlm.nih.gov/pmc/articles/PMC7378684/).
- 198 Tarik Endale, "Barriers and drivers to capacity-building in Global Mental Health Projects," *International Journal of Mental Health Systems*, December 3, 2020, link.springer.com/article/10.1186/s13033-020-00420-4.
- 199 Nisheet M. Patel et al., "Global Disparities in Mental Health Systems: A Comparative Cross-Sectional Study of Ten Countries with Different Income Levels," *Indian Journal of Psychological Medicine*, published online October 15, 2025, <https://doi.org/10.1177/02537176251379999>.
- 200 Monica Acuña-Rodríguez, "Mental health workforce inequities across income levels," *PMC*, June 17, 2025, [pmc.ncbi.nlm.nih.gov/articles/PMC12182244/](https://pubmed.ncbi.nlm.nih.gov/articles/PMC12182244/).
- 201 Suha Ballout, "Trauma, Mental Health Workforce Shortages, and Health Equity: A Crisis in Public Health," *International Journal of Environmental Research and Public Health* 22, no. 4 (April 16, 2025): article 620, <https://doi.org/10.3390/ijerph22040620>.
- 202 Ballout, "Trauma, Mental Health Workforce Shortages, and Health Equity."
- 203 Ballout, "Trauma, Mental Health Workforce Shortages, and Health Equity."
- 204 Emma Schwartz "The global health care worker shortage: 9 numbers to note," *Project HOPE*, March 27, 2026, www.projecthope.org/news-stories/story/the-global-health-care-worker-shortage-10-numbers-to-note/.
- 205 Ballout, "Trauma, Mental Health Workforce Shortages, and Health Equity."
- 206 Patel NM, Savaliya GV, Mehta PJ, Kataria LR, "Global Disparities in Mental Health Systems: A Comparative Cross-sectional Study of Ten Countries with Different Income Levels," *Indian J Psychol Med*, October 15, 2025, [pmc.ncbi.nlm.nih.gov/articles/PMC12531183/](https://pubmed.ncbi.nlm.nih.gov/articles/PMC12531183/).
- 207 Bibilola D. Oladeji and Oye Gureje, "Brain Drain: A Challenge to Global Mental Health," *BJPsych International* 13, no. 3 (August 2016): 61–63, <https://doi.org/10.1192/S2056474000001240>.
- 208 Oladeji and Gureje, "Brain Drain," 61–63.

- 209 Oladeji and Gureje, "Brain Drain," 61–63.
- 210 Emmanuel M. Ngui et al., "Mental Disorders, Health Inequalities and Ethics: A Global Perspective," *International Review of Psychiatry* 22, no. 3 (2010): 235–244, <https://doi.org/10.3109/09540261.2010.485273>.
- 211 Ngui et al., "Mental Disorders, Health Inequalities and Ethics," 235–244.
- 212 Ali Hasnain, "Financing Mental Health for all", UHC, [unitedgms.org/app/uploads/2024/06/03.2022-%E2%80%93Financing-mental-health-for-all-%E2%80%93March-2022.pdf](https://www.unitedgms.org/app/uploads/2024/06/03.2022-%E2%80%93Financing-mental-health-for-all-%E2%80%93March-2022.pdf).
- 213 Max Roser, "Mental Health Care Is Scarce Everywhere—but in Poor Countries, It Barely Exists," *Our World in Data*, March 31, 2026, <https://ourworldindata.org/data-insights/mental-health-care-is-scarce-everywhere-but-in-poor-countries-it-barely-exists>.
- 214 Roser, "Mental Health Care Is Scarce Everywhere."
- 215 "Over a billion people living with mental health conditions – services require urgent scale-up," World Health Organization, September 2, 2025, www.who.int/news/item/02-09-2025-over-a-billion-people-living-with-mental-health-conditions-services-require-urgent-scale-up.
- 216 McDaid D, Knapp M, Raja S, "Barriers in the mind: Promoting an economic case for mental health in low- and middle-income countries," *PMC*, [pmc.ncbi.nlm.nih.gov/articles/PMC2408399/](https://pubmed.ncbi.nlm.nih.gov/articles/PMC2408399/).
- 217 "Quantifying the global cost of Mental Disorders," Center for Health Decision Science, December 2, 2022, chds.hsph.harvard.edu/quantifying-the-global-cost-of-mental-disorders/.
- 218 Center for Health Decision Science, "Quantifying the global cost of Mental Disorders."
- 219 Jonathan M. Kocarnik et al., "Cancer Incidence, Mortality, Years of Life Lost, Years Lived with Disability, and Disability-Adjusted Life Years for 29 Cancer Groups from 2010 to 2019: A Systematic Analysis for the Global Burden of Disease Study 2019," *JAMA Oncology* 8, no. 3 (March 2022): 420–444, <https://doi.org/10.1001/jamaoncol.2021.6987>.
- 220 Presenteeism Costs More Than Sick Leave: The Silent Drain," *ReachLink*, May 14, 2026, <https://www.reachlink.com/advice/mental-health-of-men-and-boys/presenteeism/>.
- 221 World Health Organization, "Mental Health at Work," fact sheet, September 2, 2024, <https://www.who.int/news-room/fact-sheets/detail/mental-health-at-work>.
- 222 Claire de Oliveira et al., "The Role of Mental Health on Workplace Productivity: A Critical Review of the Literature," *Applied Health Economics and Health Policy* 21, no. 2 (March 2023): 167–193, <https://doi.org/10.1007/s40258-022-00761-w>.
- 223 Solmaz Azimzadeh et al., "Reforms and Innovations in Primary Health Care in Different Countries: Scoping Review," *Primary Health Care Research & Development* 25 (April 23, 2024): e22, 1–14, <https://doi.org/10.1017/S1463423623000725>.
- 224 Azimzadeh et al., "Reforms and Innovations in Primary Health Care," 1–14.
- 225 "Universal Health Coverage," World Health Organization, accessed August 25, 2026, www.who.int/health-topics/universal-health-coverage#tab=tab_1.
- 226 Akilu Endalamaw et al., "Universal Health Coverage—Exploring the What, How, and Why Using Realist Review," *PLOS Global Public Health* 5, no. 3 (March 18, 2025): article e0003330, <https://doi.org/10.1371/journal.pgph.0003330>.
- 227 Lucinda Orsini, "Improving access to care and support for mental health conditions: A call to action," *ISPOR*, www.ispor.org/publications/journals/value-outcomes-spotlight/vos-archives/issue/view/mental-health-the-silent-pandemic/improving-access-to-care-and-support-for-mental-health-conditions-a-call-to-action.
- 228 Max Roser, "Mental health care is scarce everywhere – but in poor countries, it barely exists," *Our World in Data*, March 31, 2026, ourworldindata.org/data-insights/mental-health-care-is-scarce-everywhere-but-in-poor-countries-it-barely-exists.
- 229 "Zimbabwe Friendship Bench," ASRA Network, April 29, 2025, www.asranetwork.org/srr-series/zimbabwe-friendship-bench.
- 230 Charlson van Ommeren, "Mental Health in Emergencies", World Health Organization, www.who.int/news-room/fact-sheets/detail/mental-health-in-emergencies.
- 231 "The potential impact of CHATGPT in clinical and Translational Medicine," *PubMed*, pubmed.ncbi.nlm.nih.gov/36854881/.
- 232 "Expert opinion: 5 key findings on internal displacement and mental health" *Reliefweb*, reliefweb.int/report/world/expert-opinion-5-key-findings-internal-displacement-and-mental-health.
- 233 Sandeep Sabhlok and Vivian Pender, "Addressing the gaps in mental health care for internally displaced persons," *PMC*, [pmc.ncbi.nlm.nih.gov/articles/PMC7183250/](https://pubmed.ncbi.nlm.nih.gov/articles/PMC7183250/).
- 234 Barbara E. Johnson, "Gender differences in Mental Health," *Ebsco Research*, www.ebsco.com/research-starters/psychology/gender-differences-mental-health.
- 235 UN Women, "Inside the Crisis You Don't See: How War Impacts Women's Mental Health," UN Women, April 7, 2025, www.unwomen.org/en/articles/explainer/inside-the-crisis-you-dont-see-how-war-impacts-womens-mental-health.
- 236 UN Women, "Inside the Crisis You Don't See."
- 237 Kimberly Ernstmeier and Elizabeth Christman, eds., *Nursing: Mental Health and Community Concepts* (Eau Claire, WI: Chippewa Valley Technical College, 2022), chap. 17, "Vulnerable Populations," <https://www.ncbi.nlm.nih.gov/books/NBK590046/>.
- 238 Ernstmeier and Christman, *Nursing: Mental Health and Community Concepts*, chap. 17.
- 239 Dévora Kestel, "Mental Health in Emergencies: A Lifeline, Not a Luxury," World Health Organization, October 8, 2025, <https://www.who.int/news-room/commentaries/detail/mental-health-in-emergencies--a-lifeline--not-a-luxury>.
- 240 Kestel, "Mental Health in Emergencies."
- 241 Mehrdad Salehi, *PubMed Central (PMC)*, [pmc.ncbi.nlm.nih.gov/](https://pubmed.ncbi.nlm.nih.gov/).
- 242 Doron Amsalem, "The effects of war-related experiences on mental health symptoms of individuals living in conflict zones: A Longitudinal Study," *Scientific Reports*, www.nature.com/articles/s41598-024-84410-3.
- 243 Peter Ventevogel et al., "Improving Mental Health Care in Humanitarian Emergencies," *Bulletin of the World Health Organization* 93, no. 10 (October 1, 2015): 666–666A, <https://doi.org/10.2471/BLT.15.156919>.
- 244 Justin Lo, "Telehealth has played an outsized role meeting mental health needs during the COVID-19 pandemic," *KFF*, www.kff.org/mental-health/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/.
- 245 World Health Organization, "Comprehensive Mental Health Action Plan 2013–2030."
- 246 World Health Organization, *Mental Health Atlas 2024* (Geneva: World Health Organization, 2025), <https://iris.who.int/handle/10665/382452>.
- 247 Australian Department of Health, Disability, and Aging, "About Medicare Mental Health."
- 248 "Head to Health update for GPs: When and how to refer," North Western Melbourne Primary Health Network, accessed August 26, 2026, nwmpnhn.org.au/news/head-to-health-update-for-gps-when-and-how-to-refer/.
- 249 "Medicare Benefits Schedule", Australian Government, Department of Health, Disability, and Aging, accessed August 25, 2026, www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=GN.1.2&qt=noteID.
- 250 "Free, Digital Psychological Care with MindSpot," *MindSpot*, accessed September 23, 2026, <https://www.mindspot.org.au/lifeline-h2hs/>.
- 251 Elizabeth Kuiper, "Building Resilience: Mental Health and Ukraine's Future," *European Policy Centre*, February 23, 2026, <https://www.epc.eu/publication/building-resilience-mental-health-and-ukraines-future/>.

- 252 Kuiper, "Building Resilience."
- 253 "Ukraine showcases national-scale adoption of who's mhgap, inspiring Eastern Partnership neighbours," World Health Organization, accessed August 25, 2026, www.who.int/ukraine/events/item/2025/11/18/default-calendar/ukraine-showcases-national-scale-adoption-of-who-s-mhgap--inspiring-eastern-partnership-neighbours.
- 254 Kuiper, "Building Resilience."
- 255 Mark van Ommeren, "From Isolation to Inclusion: Community-Based Mental Health Care," World Health Organization, July 24, 2025, www.who.int/news-room/commentaries/detail/from-isolation-to-inclusion---community-based-mental-health-care.
- 256 "From isolation to inclusion: Community-based Mental Health Care," World Health Organization, accessed August 25, 2026, www.who.int/news-room/commentaries/detail/from-isolation-to-inclusion---community-based-mental-health-care.
- 257 "Behavioral health integration fact sheet," World Health Organization, accessed August 25, 2026, www.apa.org/health/behavioral-integration-fact-sheet.
- 258 Roxanne Keynejad and Jessica Spagnolo, "Mental Healthcare in primary and community-based settings: Evidence beyond the who mental health gap action programme (mhgap) intervention guide," - PMC, accessed August 25, 2026, [pmc.ncbi.nlm.nih.gov/articles/PMC9811100/](https://pubmed.ncbi.nlm.nih.gov/articles/PMC9811100/).
- 259 Charlotte Hanlon, "Task sharing for the care of severe mental disorders in a low-income country (tascs): Study protocol for a randomised, controlled, non-inferiority trial," PMC, accessed August 25, 2026, [pmc.ncbi.nlm.nih.gov/articles/PMC4750210/](https://pubmed.ncbi.nlm.nih.gov/articles/PMC4750210/).
- 260 Angelina Dois, "[Attributes and Features of a Community Health Model from the Perspective of Practitioners]," accessed August 25, 2026, pubmed.ncbi.nlm.nih.gov/.
- 261 Jorge Calderon and Graciela Rojas, "Integration of Mental Health into Primary Care: A Chilean Perspective on a Global Challenge," *BJPsych International* 13, no. 1 (February 2016): 20–21, <https://doi.org/10.1192/S2056474000000945>.
- 262 "Chile Commonwealth Fund," The Commonwealth Fund, accessed August 25, 2026, www.commonwealthfund.org/international-health-policy-center/countries/chile.
- 263 Jorge Calderon and Graciela Rojas, "Integration of mental health into Primary Care: A Chilean perspective on a Global Challenge," PMC, accessed August 25, 2026, [pmc.ncbi.nlm.nih.gov/articles/PMC5618894/](https://pubmed.ncbi.nlm.nih.gov/articles/PMC5618894/).
- 264 Christer Allgulander, "Mental Health Care in Sweden," *Taiwanese Journal of Psychiatry*, accessed August 25, 2026, journals.lww.com/tpsy/fulltext/2020/34030/mental_health_care_in_sweden.1.aspx.
- 265 Christer Allgulander, "Mental Health Care in Sweden."
- 266 Helena Silfverhielm and Claes Göran Stefansson, "Sweden," *International Psychiatry* 3, no. 1 (January 2006): 9–12, <https://pubmed.ncbi.nlm.nih.gov/articles/PMC6734714/>.
- 267 Silfverhielm and Stefansson, "Sweden," 9–12.
- 268 Annamaria Pakai, "Trends and shifts in Swedish telemedicine consultations during the pre-covid-19, covid-19, and post-covid-19 periods: Retrospective observational study," PMC, [pmc.ncbi.nlm.nih.gov/articles/PMC12101801/](https://pubmed.ncbi.nlm.nih.gov/articles/PMC12101801/).
- 269 "A progressive approach to mental health," *Healthcare World*, accessed August 25, 2026, healthcareworld.com/a-progressive-approach-to-mental-health/.
- 270 "7.5 mental health - national policies platform," European Union, accessed August 25, 2026, national-policies.eacea.ec.europa.eu/youthwiki/chapters/sweden/75-mental-health.
- 271 "Bup - Sweden," Lucy Faithfull Foundation, accessed August 25, 2026, ecs.lucyfaithfull.org/bup-sweden.
- 272 "Bup - Sweden," Lucy Faithfull Foundation.
- 273 "Sweden," commonwealth fund.
- 274 "Statistics on Mental Health in Sweden," *din psykiska hälsa*, accessed August 26, 2026, dinpsykiskahalsa.se/artiklar/other-languages/engelska/statistics-on-mental-health-in-sweden/.
- 275 National Centre for Suicide Research and Prevention, "National Strategy for Suicide Prevention in Sweden," *Karolinska Institutet*, last modified February 24, 2026, <https://ki.se/en/nasp/about-us/national-action-programme-for-suicide-prevention-in-sweden>.
- 276 World Health Organization, *Mental Health Atlas 2024*.
- 277 World Health Organization, "Mental Health Gap Action Programme (mhGAP)," World Health Organization, accessed September 23, 2026, <https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme>.
- 278 World Health Organization, *Mental Health Gap Action Programme (mhGAP) Guideline for Mental, Neurological and Substance Use Disorders*, 3rd ed. (Geneva: World Health Organization, 2023), <https://www.who.int/publications/i/item/9789240084278>.
- 279 World Health Organization, *Mental Health Atlas 2024*.
- 280 World Health Organization, *World Mental Health Report: Transforming Mental Health for All* (Geneva: World Health Organization, 2022), <https://www.who.int/publications/i/item/9789240049338>.
- 281 World Health Organization, *Mental Health Atlas 2020 Country Profile: Kenya* (Geneva: World Health Organization, April 15, 2022), <https://www.who.int/publications/m/item/mental-health-atlas-ken-2020-country-profile>; World Health Organization, *Mental Health Atlas 2020 Country Profile: Nigeria* (Geneva: World Health Organization, April 15, 2022), <https://www.who.int/publications/m/item/mental-health-atlas-nga-2020-country-profile>; World Health Organization, *Mental Health Atlas 2017 Country Profile: India* (Geneva: World Health Organization, January 1, 2017), <https://www.who.int/publications/m/item/mental-health-atlas-2017-country-profile-india>.
- 282 Nisheet M. Patel et al., "Global Disparities in Mental Health Systems: A Comparative Cross-Sectional Study of Ten Countries with Different Income Levels," *Indian Journal of Psychological Medicine*, October 15, 2025, doi.org/10.1177/02537176251379999.
- 283 Faith Atewologun et al., "A Comprehensive Review of Mental Health Services across Selected Countries in Sub-Saharan Africa: Assessing Progress, Challenges, and Future Direction," *Discover Mental Health* 5, no. 1 (April 2025): article 49, <https://doi.org/10.1007/s44192-025-00177-7>.
- 284 World Health Organization, "Community-Based Mental Health Services Using a Rights-Based Approach," World Health Organization, June 10, 2021, <https://www.who.int/news-room/feature-stories/detail/community-based-mental-health-services-using-a-rights-based-approach>.
- 285 World Health Organization, "Philippines," WHO Special Initiative for Mental Health, accessed September 23, 2026, <https://www.who.int/initiatives/who-special-initiative-for-mental-health/philippines>.
- 286 Pan American Health Organization, "Chile celebra 10 años de integración de la salud mental en la Atención Primaria con la estrategia mhGAP," PAHO/WHO, September 4, 2025, www.paho.org/es/noticias/4-9-2025-chile-celebra-10-anos-integracion-salud-mental-atencion-primaria-con-estrategia; World Health Organization, "Thailand," WHO Results Report 2024–2025, accessed September 23, 2026, <https://www.who.int/about/accountability/results/who-results-report-2024-2025/country-profile/2024/thailand>.
- 287 South Africa National Department of Health, *Department of Health Strategic Plan 2015/16–2019/20* (Pretoria: National Department of Health, 2015), extranet.who.int/cpcd/sites/default/files/public_file_repository/ZAF_South-Africa_National-Health-Strategic-Plan_2021-2020.pdf; Elizabeth Ruiz Jaimes, "Secretaría de Salud y OPS firman la Estrategia de Cooperación de País con México 2026–2030 para fortalecer la salud pública," Pan American Health Organization, July 2, 2026, <https://www.paho.org/es/noticias/2-7-2026-secretaria-salud-ops-firman-estrategia-cooperacion-pais-con-mexico-2026-2030-para>.

288 Patel et al., "Global Disparities in Mental Health Systems."

289 World Health Organization, Mental Health Atlas 2024 (Geneva: World Health Organization, 2025), <https://www.who.int/publications/i/item/9789240114487>.

290 World Health Organization, Guidance on Community Mental Health Services: Promoting Person-Centred and Rights-Based Approaches (Geneva: World Health Organization, 2021), <https://www.who.int/publications/i/item/9789240025707>.

291 Patel et al., "Global Disparities in Mental Health Systems."

292 Government Offices of Sweden, "Mental Health and Mental Health Care," Government.se, accessed September 23, 2026, <https://www.government.se/government-policy/mental-health-and-mental-health-care/>.

293 Public Health Agency of Canada, "Youth Mental Health: About the Youth Mental Health Fund," Government of Canada, last modified August 5, 2026, www.canada.ca/en/public-health/topics/mental-health-wellness/about-youth-mental-health-fund.html; Australian Government Department of Health and Aged Care, National Mental Health Workforce Strategy 2022–2032 (Canberra: Department of Health and Aged Care, 2023), <https://www.health.gov.au/resources/publications/national-mental-health-workforce-strategy-2022-2032>.

294 Organisation for Economic Co-operation and Development, A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health (Paris: OECD Publishing, 2021), <https://doi.org/10.1787/4ed890f6-en>.

295 World Health Assembly recommends reinforcement of measures to protect mental health during Public Health Emergencies, "World Health Organization," accessed August 25, 2026, www.who.int/news/item/31-05-2021-world-health-assembly-recommends-reinforcement-of-measures-to-protect-mental-health-during-public-health-emergencies.

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