WARMUN 2022

World Health Organisation (WHO)

Agenda I:
Promoting Cancer Prevention and Control

Agenda II:
Providing Better Mental Healthcare to Everyone, Everywhere

Written by: Head Chair Ariana Chin and Deputy Chair Ainhoa Comino

Table of Contents:

LETTER FROM THE CHAIRS:

Dear Delegates,

Welcome to the 2022 Warwick Model United Nations (WARMUN). We are pleased to introduce you to our committee, the World Health Organisation (WHO). Our names are Ariana Chin and Ainhoa Comino, and we will be your chairs for the 2022 WHO. It is our privilege to have the opportunity to chair WHO and interact with intelligent and passionate delegates like yourselves.

We hope that you will have a wonderful time at this conference practicing diplomacy, making speeches, and learning about the United Nations (UN)—all while being respectful and maintaining courteous behaviour. To have the best experience at WARMUN, we strongly encourage you to step out of your comfort zone and actively participate throughout council sessions. The topics were carefully selected to urge delegates to think critically and engage with meaningful issues that impact the globe, while giving you sufficient insight into the world of diplomacy, politics, current events, and international relations. As experienced delegates, we believe that being prepared, engaged, and interacting with others throughout the conference makes the experience more enjoyable. Should you experience any difficulties, we will be present to assist, support, and guide you.

As a reminder, this study guide serves as an introduction to the topics for this committee. However, it is not intended to replace individual research. We recommend that you explore your Member States' policies in depth to further your knowledge on these topics. Additionally, we want to emphasise that any instances of sexual harassment or discrimination at the conference will not be tolerated.

We hope that you will have a meaningful and positive experience engaging in the topics and interacting with fellow delegates.

If you have any questions or concerns, please feel free to contact us.

We wish you all the best in your preparations and look forward to meeting everyone at the conference.

Sincerely,

Ariana Chin (陳韻琪) and Ainhoa Comino

YOUR CHAIRS:

	
Head Chair Ariana Chin (陳韻琪)	**Deputy Chair Ainhoa Comino**
A fourth-year study abroad student from Gonzaga University's Honours Programme in the United States, Ariana is a quadruple major in Political Science, International Studies, Criminology, and Sociology with a minor in Psychology. For this semester, she is studying at Queen Mary University of London. Ariana began her MUN journey in 2015, participating as a delegate, chair, assistant director, and is currently the Secretary General of the Gonzaga University MUN team. She loves how delegates can have lively and diplomatic debates about various global issues within MUN while learning about how the UN functions and making memories that will last a lifetime. Outside of MUN, Ariana enjoys swimming competitively, playing the violin, traveling, skydiving, snowboarding, rock climbing, playing mah-jong, and hanging out with friends. Her hope is for delegates to have fun, make new friends, learn new things, and have an overall positive experience.	Ainhoa is a third-year Business Administration student at Hult International Business School. Despite only having discovered MUN last year, when she began her university studies, she has had a rewarding career as a delegate and is now leading Hult's own MUN team. Her first ever MUN conference was last year's WARMUN, where she participated as a delegate in WHO. Now, she is very much looking forward to meeting this year's committee! Having been born and raised in Spain, she enjoys how MUN allows for a look into the world's most long-lasting issues and encourages delegates to construct innovative ideas to solve them. Outside of MUN, she can either be found training in synchronised swimming, travelling around the world, or getting lost in some of London's hidden corners (probably whilst eating something sweet).

INTRODUCTION TO THE WHO:

Founded in 1948, the World Health Organisation (WHO) is a specialised agency of the UN, reporting to the Economic and Social Council (ECOSOC) while working to improve everyone's ability to enjoy good health and well-being. As the UN's agency that connects Member States, partners, and people to promote health and safety, WHO leads the world's efforts to expand universal health coverage while coordinating and directing the globe's response to health emergencies. WHO works to assist its 194 Member States across six regions in the development of their respective health systems; the eradication of noncommunicable diseases (NCDs); the promotion of good lifelong health; the prevention, treatment, and care of communicable diseases; the preparedness, surveillance, and response with respect to international health emergencies; and the extension of corporate services to the organisation's public and private partners. From addressing epidemics such as COVID-19 and Zika to responding to communicable and chronic diseases including malaria and diabetes, WHO continues to confront the biggest health challenges while serving those who are vulnerable.

Carrying out various projects, campaigns, and partnerships while simultaneously operating on global, regional, and country levels, WHO addresses a wide range of health topics. To promote international health, WHO partners with other UN bodies including the Joint United Nations Programme on HIV/AIDS (UNAIDS) as well as external public entities, nongovernmental organisations (NGOs), and private sector actors. Notably, WHO leads the Global Health Cluster (GHC) that is made up of 48 partners including UN bodies, academic institutions, and public stakeholders.

In accordance with Article 57 of the *Charter of the United Nations* (1945), the WHO's constitution established the organisation as a specialised agency of the UN. Notwithstanding its status as an autonomous organisation within the UN system, WHO operates within the purview of ECOSOC. Accordingly, WHO reports to ECOSOC concerning any agreement between the organisation and the UN. The 194 States that make up the WHO includes all UN Member States except for the Cook Islands and the Republic of Niue. While its secretariat is located in Geneva, Switzerland, WHO maintains a worldwide presence, staffing six regional offices across the globe and operating a total of 150 country offices and decentralized sub-offices.

Article 2 of the WHO's constitution mandates the organisation to foster child, maternal, and mental health while providing information, counselling, and assistance in the field of health. The mandate defines the WHO's role in advancing the eradication of diseases; coordinating and directing international health programmes and projects; and improving nutrition, sanitation, and other conditions. Additionally, WHO is responsible for advancing medical and health-related research; promoting scientific collaboration; improving standards of training in health, medical, and related professions; as well as developing international standards for food, biological, pharmaceutical, and other similar products.

WHO, *About Us*, 2022.
WHO, *Constitution of the World Health Organisation*, 1946.
WHO, *Health Topics*, 2022.
WHO, *Partnerships*, 2022.

Agenda I: Promoting Cancer Prevention and Control

STATEMENT OF THE ISSUE:

As the second leading cause of death globally, the burden of cancer continues to expand throughout the world—causing tremendous physical, emotional, and financial strains on individuals, families, communities, and health systems. Many health systems in low- and middle-income countries are less prepared to manage the burden that comes with cancer, and many cancer patients around the globe are unable to access timely quality diagnosis and treatment. Social, environmental, and economic disadvantages leave certain individuals to bear a disproportionate burden of cancer compared to others, leading to cancer disparities.

Having the ability to start in almost any organ or tissue of the body, cancer is a large group of diseases, beginning when abnormal cells grow uncontrollably while going beyond their usual boundaries to intrude upon adjoining parts of the body, spread to other organs, or both. Also known as a neoplasm or malignant tumour, cancer is a genetic disease caused by alterations to genes (usually proto-oncogenes, tumour suppressor genes, or DNA repair genes) that control the way one's cells function. External agents such as physical carcinogens, chemical carcinogens, and biological carcinogens can interact with a person's genetic factors, transforming a person's cells into tumour cells and causing cancer.

One of the most difficult diseases to treat, there is unfortunately no single cure for cancer. Widespread metastases are the primary cause of death from cancer. Approximately 400,000 children develop cancer each year, and in 2020, cancer accounted for nearly 10 million deaths, or one in six deaths. Within WHO resolution WHA70.12 (2017), the WHO recognised that cancer continues to be a leading cause of morbidity globally and a growing public health concern. According to the International Agency for Research on Cancer (IARC) in 2018, the annual number of new cancer cases is expected to increase to approximately 24 million per year and 13 million deaths by 2030.

The IARC continues to be the WHO's primary cancer research agency, maintaining a classification of cancer-causing agents while analysing the causes of cancer, cancer survival rates, as well as cancer today, tomorrow, and over time. The Global Cancer Observatory (GCO) utilises data from the IARC to present an interactive web-based platform illustrating global cancer data and statistics to inform cancer control and research.

INTRODUCTION TO THE TOPIC:

When highlighting the World Cancer Report in 2014, the UN stated, “treatment alone will not win the war on cancer: prevention is crucial” (UN 2014). The goal of this topic is to address and explore methods to prevent and control cancer within Member States as well as across the globe, looking at what initiatives and plans have or have not worked while developing solutions and ideas that could improve the current situation with regards to the topic of cancer. Health disparities and inaccessibility to proper care play key roles in the development and mortality rates of cancer, as seen when analysing developed versus developing Member States. Developing realistic goals and attainable plans while bearing in mind the economic, political, and social situations of various Member States is important while formulating solutions to address this topic.

According to the WHO, “between 30 and 50 percent of cancer deaths could be prevented by modifying or avoiding key risk factors and implementing existing evidence-based prevention strategies” (WHO 2022). These key risk factors include avoiding tobacco use, maintaining a healthy weight, limiting alcohol, eating and exercising healthily, reducing exposure to ultraviolet radiation, getting vaccinated against hepatitis B and human papillomavirus (HPV), preventing ionizing radiation exposure, avoiding urban air pollution, practicing safe sex, and getting regular medical care. Prevention provides the most cost-effective long-term strategy for the control of cancer.

Furthermore, some chronic infections are risk factors for cancer as people in low- and middle-income countries are more likely to develop cancer through chronic infections. In a joint statement made by the WHO Director-General and the International Atomic Energy Agency (IAEA) Director-General in February 2022, by 2040, over 70 percent of cancer deaths are expected to occur in low and middle-income countries. In many areas of the world, the recommended interventions for preventing cancer as well as other NCDs have not been adequately implemented while treatment remains elusive for many. Both the WHO Director-General and IAEA Director-General noted that “globally, an estimated half of people diagnosed with cancer may require radiotherapy as part of their care, yet many countries do not have a single radiotherapy machine” (WHO and IAEA 2022). This disparity is most notable within Africa, where nearly 70 percent of African countries reported that radiotherapy is generally unavailable and therefore, is inaccessible to their people.

Low- and middle-income countries will continue to remain the most vulnerable to the burden of cancer and its harms. When it comes to cancer, global inequities are explained by late diagnosis, inadequate services (insufficient diagnostic and treatment facilities), and low coverage (failure to include cancer in universal health coverage). The burden of cancer can be reduced through the early detection of cancer and efficient management of patients who develop cancer. When

identified early, cancer is more likely to respond to effective treatment, leading to a greater probability of surviving along with less morbidity and less expensive treatment. Within countries where health systems are strong, the survival rates of many types of cancers are improving due to accessible early detection, quality treatment, and survivorship care.

With over 100 different types of cancer, the most common cancers vary between countries with cervical cancer being the most common in 23 different countries. Within men, some of the most common types of cancer includes lung, prostate, colorectal, stomach, and liver cancer. Within women, some of the most common types of cancer includes breast, colorectal, lung, cervical, and thyroid cancer. In 2020, in terms of most new cases of cancer, the three most common types were breast (2.26 million cases), lung (2.21 million cases), and colon and rectum (1.93 million cases). The three most common causes of cancer death in 2020 were lung (1.80 million deaths), colon and rectum (916,000 deaths), and liver (830,000 deaths).

The primary mission of the WHO's work in cancer control is to promote national cancer control policies, plans, and programmes that are harmonised with strategies for NCDs and other health related concerns. The WHO's core functions are to set standards and norms for cancer control. This includes the development of evidence-based prevention, early diagnosis, accessible screening, accessible treatment, and palliative and survivorship care programmes while promoting monitoring and evaluation through cancer registries and research that are tailored to the local disease burden and available resources.

Because cancer knows no borders, cooperation and collaboration are necessary to reduce the burden of cancer nationally and internationally. WHO has partnered with the IAEA, the United Nations Population Fund (UNFPA), the European Society for Medical Oncology (ESMO), the Union for International Cancer Control (UICC), and many other intergovernmental organisations (IGOs) and NGOs to assist countries in preventing and controlling cancer.

HISTORICAL SITUATION:

The oldest description of cancer (although it was called something different in the past) dates back to circa 3000 B.C. in Egypt within the Edwin Smith Papyrus—a copy of part of an ancient Egyptian textbook on trauma surgery. It describes eight cases of tumours or ulcers in the breast that were removed via cauterization with a tool called the "fire drill." The origin of the word "cancer" is credited to the Greek physician, Hippocrates (460 – 370 B.C.) who used the terms "carcinos" and "carcinoma" to describe tumours, as these terms refer to "a crab" as that is what the disease looked like. The Roman physician, Celsus (25 B.C. to 50 A.D.) eventually translated the Greek term into "cancer," the Latin word for crab.

Throughout the 15th and 16th centuries, scientists developed a greater understanding of the human body. Autopsies performed throughout the 17th century led to an understanding of how various organs and blood circulation worked. In 1761, Giovanni Morgagni of Padua was the first person to complete autopsies in order to relate the patient's illness to pathological findings after death. This laid the foundation for scientific oncology. Scottish surgeon John Hunter suggested that certain cancers may be cured by surgery, noting that if a tumour had not invaded nearby tissue and was moveable, "there was no impropriety in removing it."

The birth of scientific oncology came in the 19th century with the use of the modern microscope in studying diseased tissues. Aiding in the understanding of the damage cancer can do as well as in the development of cancer surgery, Rudolf Virchow provided the scientific basis for the modern pathologic study of cancer by correlating microscopic pathology to illness.

The WHO has developed and passed many important resolutions in the past relating to the prevention and control of cancer, recognising that developing States along with low and middle-income families are most at risk. Most notable are WHO resolution WHA58.22 (2005) addressing *Cancer Prevention and Control* from the 58th World Health Assembly and WHO resolution WHA70.12 (2017) discussing *Cancer Prevention and Control in the Context of an Integrated Approach* from the 70th World Health Assembly.

WHO resolution WHA58.22 (2005) urges Member States to collaborate with the WHO, integrate national cancer-control programmes, encourage necessary scientific research to increase knowledge on the burden and harms of cancer, periodically assess cancer prevention and control programmes, improve access to appropriate technologies, and to develop cost-effective minimum standards for cancer treatment among other operatives. WHO resolution WHA70.12 (2017) updates many of the objectives laid out in WHO resolution WHA58.22, urging Member States to implement various national commitments set out in previous UN documents while promoting cost-effective vaccinations and aligning itself with the 2030 Agenda for Sustainable Development.

Both resolutions call for the Director-General to develop WHO's work and capacity in cancer prevention and control while continuing to promote effective, comprehensive cancer prevention and control strategies throughout the global order—emphasising the importance of this within developing Member States. Both resolutions also request for continued collaboration with other UN bodies, IGOs, and NGOs. Furthermore, WHO resolution WHA58.22 (2005) provides recommendations for national health authorities to implement within their national cancer control programmes to address specific types of cancers. The objectives and initiatives presented within these resolutions are of the utmost importance.

Other important resolutions recalled by the WHO include WHO resolution WHA51.8 (1998) and WHO resolution 53.17 (2000) on the *Prevention and Control of Noncommunicable Diseases*; WHO resolution WHA57.17 (2004) on the *Global Strategy on Diet, Physical Activity, and Health*; WHO resolution WHA56.1 (2003) on *Tobacco Control*; WHO resolution WHA57.12 (2004) on *Reproductive Health Strategy, Including Control of Cervical Cancer*; WHO resolution WHA57.16 (2004) on *Health Promotion and Health Lifestyles*; UN General Assembly resolution 66/2 (2011) on the *Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases*; WHO resolution WHA66.10 (2013) endorsing the *Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020*; and UN General Assembly resolution 68/300 (2014) on the *Outcome Document of the High-level of the General Assembly on the Comprehensive Review and Assessment of the Progress Achieved in the Prevention and Control of Noncommunicable Diseases*.

Bearing in mind Sustainable Development Goal (SDG) three (ensure healthy lives and promote well-being for all at all ages) of the 2030 Agenda for Sustainable Development, the WHO emphasises target 3.4 which works to reduce premature mortality from noncommunicable diseases by one-third by 2030 and target 3.8 on achieving universal health coverage.

To further its initiative to prevent and control cancer, the WHO has recently developed several guidelines for Member States to follow and implement. These include the second edition of the *Comprehensive Cervical Cancer Control: A Guide to Essential Practice* (2014), *Guide to Early Cancer Diagnosis* (2017), *WHO Guidelines for the Pharmacological and Radiotherapeutic Management of Cancer Pain in Adults and Adolescents* (2018), and *Guide for Establishing a Pathology Laboratory in the Context of Cancer Control* (2019). Each of these guidelines contains extensive research, analysis, and explanations of specific aspects of cancer prevention and control while providing individuals and Member States suggestions with regards to preventing and controlling cancer.

Reemphasising the fact that cervical cancer is the most common cancer in 23 different countries, the UN through the United Nations Inter-Agency Task Force on the Prevention and Control of

Noncommunicable Diseases (UNIATF) (which was established in 2013 and placed under the leadership of the WHO) established a five-year UN Joint Programme to prevent and control cervical cancer. Noting that worldwide, 266,000 women died from cervical cancer in 2012, with 90 percent of those deaths occurring in low- and middle-income countries, the Joint Programme builds on what already exists while enhancing progress with regards to preventing and controlling cervical cancer. This programme works with global and national partners, initially in six low- and middle-income countries including the Plurinational State of Bolivia, the United Republic of Tanzania, the Kingdom of Morocco, Kyrgyz Republic (Kyrgyzstan), Republic of the Union of Myanmar, and Mongolia. There are seven UN agencies that are a part of the UNIATF including the WHO, IAEA, IARC, UNAIDS, UNFPA, the United Nations International Children's Emergency Fund (UNICEF), and United Nations Women. This is an example of one of the many programmes the UN has in addressing the prevention and control of cancer.

Another example can be seen through the Programme of Action for Cancer Therapy (PACT) which was established in 2004 by the IAEA and works with the WHO with "the goal of ensuring the integration of radiotherapy in comprehensive cancer control" while engaging with IGOs and NGOs (IAEA 2022).

Along with the mental and physical burden of cancer, there is also the economic burden of cancer. Although the global economic burden of cancer is unknown, in 2010, the estimated total annual economic cost of cancer was 1.16 trillion US dollars. Productivity losses due to cancer represent a large economic burden in transitioning economies.

WHO has and continues to prioritise addressing the issue of cancer around the globe through its various resolutions, initiatives, strategies, and programmes while encouraging Member States to implement and utilise the WHO's suggestions.

CURRENT SITUATION:

WHO continues to promote and encourage Member States to implement WHO resolution WHA70.12 (2017) along with SDG three. When it comes to managing cancer, the WHO currently notes that there are two distinct stages that promote early detection: early diagnosis and screening. As of 2022, treatment options include surgery, cancer medicines, and/or radiotherapy, administered by itself or in combination. The option of treatment should be informed by the patients' preferences and should consider the capacity of the health system. Additionally, the WHO continues to emphasise the importance of palliative care (which focuses on improving the quality of life of cancer patients and their families) along with survivorship care (which focuses on including a plan for monitoring cancer recurrence and detection of new cancers, analysing and managing long-term effects associated with cancer and its treatments, and services to ensure that the needs of cancer survivors are met).

WHO currently has three ongoing initiatives addressing breast, cervical, and childhood cancer.

Established in 2021, the World Health Organisation's Global Breast Cancer Initiative (GBCI) "brings together stakeholders from around the world and across sectors with the shared goal of reducing breast cancer by 2.5 percent per year" (WHO 2022). The GBCI employs three key strategies to achieve its listed objectives: health promotion and early detection, timely diagnosis, and comprehensive breast cancer management. Its framework includes multisectoral partnerships, promoting sustainable capacity building, stakeholder convening, operational guidance, utilising innovation and data for monitoring and decision making, and in-country engagement. WHO continues to update and publish its documents on breast cancer to provide individuals with more information on the issue, creates infographics to spread awareness, and features stories of individuals who have been impacted by breast cancer.

Breast cancer is the most common cancer worldwide and is the leading cause of cancer death among women. Like other cancers, it disproportionately affects individuals in low- and middle-income countries as breast cancer survival rates in high-income developed countries exceed 90 percent while survival rates in the Republic of India are 66 percent and 40 percent in the Republic of South Africa. The 40 percent reduction in breast cancer mortality seen in high-income developed countries since the 1980s has yet to be achieved in the majority of low- and middle-income developing countries. The GBCI works to reduce these inequalities through its framework and objectives.

In May 2018, the WHO Director-General announced a global call for action to eliminate cervical cancer, and in August 2020, the World Health Assembly adopted the Global Strategy for Cervical Cancer Elimination. This initiative and its goals rests upon three key pillars and their corresponding targets: vaccination (HPV), screening, and treatment. Known as the 90-70-90

targets, WHO strongly urges countries to meet these targets by 2030 in order to get on the path to eliminate cervical cancer within the next century.

Although cervical cancer is preventable and curable, it remains the fourth most common form of cancer among women worldwide and in 2018, it claimed the lives of 300,000 women (an increase from 2012) with 90 percent of the deaths occurring in low- and middle-income countries. Since 2020, WHO continues to launch various movement and publish different articles to highlight the issue of cervical cancer. In January 2022, WHO launched the Cervical Cancer Elimination Initiative Knowledge Repository, providing a user-friendly portal with access to resources and tools that offer support for cervical cancer elimination. WHO continues to update its fact sheet on cervical cancer (most recently updated in February 2022) while developing infographics and newsletters to spread awareness and sharing the stories of individuals from around the world who have been impacted by cervical cancer.

Established in 2018, the World Health Organisation's Global Initiative for Childhood Cancer "brings together stakeholders from around the world and across sectors with the joint goal of increasing the survival rate of children with cancer globally to at least 60 percent by 2030 while reducing their suffering and improving their quality of life" (WHO 2022). In October 2021, the WHO Global Initiative for Childhood Cancer presented the CureAll Framework which acts as a guide for policymakers, cancer control programme managers, and hospital managers to assist their efforts to implement the WHO's initiative while strengthening their respective childhood cancer programmes.

Additionally, WHO's Global Initiative for Childhood Cancer created a Knowledge Action Portal (KAP), an interactive and multilingual online portal for information-sharing, establishing and managing partnerships, organising training programmes, and sharing resources. The initiative continues to share stories of children who have had cancer and provides updated fact sheets and news. Through this initiative, WHO partners with many IGOs, NGOs, programmes, and hospitals to address childhood cancer. In 2021, WHO and St. Jude Children's Research Hospital began a partnership plan to establish a platform that dramatically increases access to childhood cancer medicines around the globe.

Launched in February 2022, the IAEA announced the Rays of Hope initiative which aims to support Member States with diagnosis and treatment using radiation technologies, starting with Member States in Africa that are most in need. This initiative works closely with the WHO and IARC, as over 70 percent of the population of Africa does not have access to radiotherapy.

Since 2014, the IARC has come out with hundreds of various publications addressing cancer prevention, treatment, control, and research. Through the GCO, the IARC collects and analyses data and statistics on cancer from around the world, making it available for public utilisation.

With this information, the GCO is able to present time trends of cancer incidence and mortality over the last fifty years around the world. It can also predict future cancer incidences and mortality burdens worldwide up until 2040, provide high-quality cancer incidence data collected from population-based cancer registries from around the world, provide cancer data and statistics on specific countries and regions of the world, examine specific types and areas of cancer, analyse cancer risks, and much more.

According to the 2014 World Cancer Report, due to increasing and ageing populations, more than 60 percent of cases and 70 percent of deaths occur in Africa, Asia, and Central and South America. Access to effective and affordable cancer treatments in developing countries would significantly reduce mortality, even in areas where healthcare services are less well developed. The increasing spiralling costs of the burden of cancer continues to damage the economies of even the developed countries, emphasising how these costs are way beyond the reach of developing countries—placing impossible strains on healthcare systems.

The economic, social, mental, and physical burdens of cancer continue to be problematic for individuals and Member States. Within the European Union (EU), the economic burden of lost productivity due to premature death and morbidity from cancer is almost 60 percent of the total economic burden associated with cancer. Providing access to preventative measures such as vaccines while addressing the global issue of smoking creates progress and can help Member States to avert billions of US dollars in treatment costs and productivity losses. Additionally, low-tech approaches to early detection and screening have illustrated their efficacy in developing countries. This can be seen through cervical cancer screening, where visual inspection with acetic acid and cryotherapy or cold coagulation treatment of precancerous lesions is used. This sort of "screen-and-treat" programme has been successfully implemented within the Republic of India and the Republic of Costa Rica.

It is important to note that although it may seem like developing countries have low cancer incident rates, it is often due to a lack of national screening programmes.

The last time the WHO conducted and published cancer country and regional profiles was in January 2020, the same year that it published the WHO Report on Cancer.

MAJOR STANCES:

Commonwealth of Australia

Although it has one of the highest cancer rates in the world, the Commonwealth of Australia has one of the lowest cancer mortality rates. Nevertheless, cancer remains a leading cause of death within Australia, as breast and prostate cancer continue to be the most common diagnoses. With various organised cancer screening programmes, early detection programmes and guidelines, and a defined referral system, Australia continues to actively work to promote cancer prevention and control within its borders. Cancer Australia is the Australian government agency established to provide national leadership in cancer control. This agency continues to utilise campaigns, education programmes, and information resources to prevent cancer cases while working towards making screenings and treatments accessible.

People's Republic of China

As the world's most populous Member State, cancer has become a leading cause of death in the People's Republic of China with an alarmingly increasing burden of cancer incidence and mortality over the past 50 years. Throughout the past 60 years, population-based cancer registries through the National Cancer Centre of China have been operating in China and in 2018, these registries expanded to include the creation and evaluation of national cancer control programmes along with cancer patient care. The National Cancer Centre of China continues to work with the IARC to expand and implement cancer control programmes and policies while launching a series of projects on cancer screening and prevention in both urban and rural parts of the State. However, challenges that China continues to face in its efforts to prevent cancer include environmental pollution, heavy tobacco use, and poor diet.

Kingdom of Denmark

Known as the cancer capital of the world, the Kingdom of Denmark has a higher cancer mortality rate than many other western Member States. Both the Danish Cancer Society and the Danish Comprehensive Cancer Centre (DCCC) work towards preventing and controlling cancer, conducting research on cancer while finding ways to make cancer treatment and screening more accessible. Denmark offers free national screening programmes for many cancers including cervical, breast, and bowel and rectal cancer. The Ministry of Health in Denmark announced the Cancer Patient Pathways (CPPs) to link general practitioners, hospitals, and special diagnostic centres to improve the diagnostic process of cancer in 2008. The CPPs has illustrated its effectiveness as survival rates increased, excess mortality decreased, and diagnosis waiting times decreased. Nevertheless, Denmark continues to face challenges when it comes to overcoming the burdens and barriers of cancer, as cancer patients in Denmark are more frequently treated for advanced cancer that suggest significant delays in the diagnosis phase.

Republic of the Union of Myanmar

Cancer continues to be a major public health problem in the Republic of the Union of Myanmar, although there are no population-based cancer incidence and mortality estimates within the State. Cancer registration activities continue to be developed through both hospital-based and population-based approaches. Providing cancer care services continues to be an ongoing struggle for Myanmar, as there is often long waiting times for radiotherapy, lack of standardised cancer treatment, lack of quality assurance and control, lack of adequate facilities to provide medical oncology services, an unstable supply of oncology medicines, shortage of operating rooms to conduct surgery in, lack of necessary technology and equipment needed to treat or screen for cancer, and a lack of guidelines for palliative care. Many individuals in Myanmar find difficulty in accessing cancer prevention resources as well as treatment. In July 2016, along with the WHO, the Myanmar Ministry of Health and Sports created the *Myanmar National Comprehensive Cancer Control Plan 2017-2021*.

United Republic of Tanzania

The United Republic of Tanzania continues to experience rising cancer incidence and mortality while working to increase the number of cancer treatment centres. With one of the highest rates of cervical cancer in the world, individuals diagnosed with cancer in Tanzania struggle to receive timely cancer care which often leads to poorer outcomes. Cancer awareness and prevention efforts targeting patients and community-level health care workers are key to addressing the burden of cancer in Tanzania. Through the Foundation for Cancer Care in Tanzania, the government works to enhance cancer care to improve the lives of cancer patients while working to offer prevention education programmes, early detection and diagnosis, treatment, and palliative care. Founded in 1895 by the German colonial government, the Ocean Road Cancer Institute (ORCI) works to make cancer treatment accessible for everyone in Tanzania, regardless of their ability to pay and continues to work with the UICC.

United States of America

As rates of cancer risk factors such as obesity increase within the United States of America, so does the rate of cancer (although cancer morbidity rates have decreased over the past 28 years within the United States). It has been estimated that by the end of 2022, roughly 1.9 million people will be diagnosed with cancer, with breast cancer continuing to be the most common cancer diagnosis. Within the United States, in 2018, national expenditures for cancer care were estimated to be 150.8 billion US dollars and have only increased since then. The Centre for Disease Control and Prevention (CDC) continues to be a leader in efforts to prevent and discover cancers early and improve the health of cancer survivors. The United States has many various programmes, societies, and plans to promote the prevention and control of cancer including the American Cancer Society, the American Society of Clinical Oncology (ASCO), the American Association for Cancer Research (AACR), the National Comprehensive Cancer Network (NCCN), and the Yale Cancer Centre.

Oriental Republic of Uruguay

Following cardiovascular diseases, cancer is the second leading cause of death in the Oriental Republic of Uruguay, as almost 25 percent of all deaths are attributable to cancer. In the final weeks of 2021, the IAEA imPACT Review team met with many international experts to evaluate Uruguay's cancer control capacities and needs while identifying priority interventions to effectively respond to the burden of cancer within its borders. Uruguay announced in the beginning of 2022 that it would take decisive action to reverse high cancer incidence and mortality rates, working with the WHO, IAEA, IARC, and many other experts. Uruguay's cancer prevention and control efforts are comprised of private and public providers, a national registry (the Uruguay National Cancer Registry), civil society, administrations, and public institutions.

Republic of Yemen

After six years of war, cancer patients residing in the Republic of Yemen continue to experience the compounding pain of disease and conflict. Individuals living in Yemen find difficulty in accessing cancer screenings, medicine, treatment, and any sort of proper care, as many families are displaced, living in extreme poverty as basic items and resources grow expensive. In 2020, approximately 35,000 Yemenis had cancer with over 11,000 more people being diagnosed with the disease every year. In 2016, many cancer clinics were forced to shut down due to a lack of staff, medicines, and equipment, leading to long wait times and leaving many patients to face imminent and painful deaths. WHO-supported cancer and oncology centres along with other partners such as the King Salman Centre for Humanitarian Aid and Relief are often people's only hope within the State. The conflict that occurred and continues to occur within Yemen reverses years of progress and gains in cancer care as Yemen suffers the world's worst humanitarian crises.

POSSIBLE SOLUTIONS/FOCUS QUESTIONS:

1. What are some of the barriers to cancer prevention and control and how can Member States overcome or reduce these barriers?
2. What can Member States do to make cancer screenings, treatment, and care more affordable and accessible for individuals?
3. How can Member States be incentivized to implement programmes, strategies, and plans that commit to preventing and controlling cancer?
4. What solutions are there to addressing the cancer health disparity where individuals who are socioeconomically disadvantaged are at an increased risk for getting and dying from cancer?
5. In what ways can developed Member States, the UN, and the WHO assist developing Member States when it comes to promoting cancer prevention and control?
6. Should the WHO update its cancer country and regional profiles? How often should they do this? Furthermore, how often should the WHO publish a report on cancer?
7. Should resolution WHA70.12 (2017) or any other resolutions be updated to promote the prevention and control of cancer? If so, how?

ADDITIONAL RESEARCH:

American Cancer Society, and Live Strong. “The Global Economic Cost of Cancer - Pharmaceutical Research and ...” *The Global Economic Cost of Cancer*, American Cancer Society, 2010, http://phrma-docs.phrma.org/sites/default/files/pdf/08-17-2010_economic_impact_study.pdf.

American Cancer Society. “The Economic Burden of Cancer.” *The Cancer Atlas*, American Cancer Society, 2022, https://canceratlas.cancer.org/taking-action/economic-burden/.

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Agenda II: Providing Better Mental Healthcare to Everyone, Everywhere

STATEMENT OF THE ISSUE:

Healthcare is one of the fundamental motors of life and activity; without it, progress, development, and improvement are simply unsustainable. Even though healthcare has seen advancements in the last century, the topic of mental health is fairly new and, consequently, many nations are still lacking clear and effective responses and treatments to mental illnesses and disorders. Being more frequent in vulnerable populations and disadvantaged minorities, mental health conditions are still a cause for human rights violations, leading to unmet physiological and social needs.

The prevailing stigma around mental health acts as a barrier for modern society's progress, incarcerating individuals in an antique mindset that promotes discriminatory behaviours rather than preventing them. With this in mind, it is absolutely crucial to move towards initiatives that promote inclusivity and accessibility to high-quality mental healthcare systems, entitling mental health as the basic human right it is.

INTRODUCTION TO THE TOPIC:

Mental health is an integral aspect of well-being which enables individuals to carry out their daily activities and even cognitive tasks in an optimal manner. Whether it is working or learning, having good mental health is essential to ensure the brain can function properly in decision-making and relationship building abilities amongst other aspects, enhancing a person's contribution to their community and, most crucially, socio-economic development. In short, promoting mental health is critical to a well-functioning society, particularly during times of crises (*Mental Health*, n.d.).

As specified in the preambles of the WHO Constitution, health is not just the absence of diseases, but rather a continuous state of physical, mental, and social wellbeing (Bertolote, 2008). Even though it is not directly listed in the Universal Declaration of Human Rights, mental healthcare is indeed a basic human right (World Health Organization, 2022).

Mental health conditions can develop in the form of mental disorders and psychosocial abilities, including stress, anxiety, depression, and risk of self-harm. Some of the factors that affect the development of mental health problems include biological factors, life experiences and family history of mental health problems (U.S. Department of Health & Human Services, 2022). Moreover, exposure to factors such as adverse social, economic, geopolitical, and environmental circumstances can also increase an individual's risks of cultivating mental health conditions.

Nevertheless, it is essential to distinguish between poor mental health and mental illness. Even if someone has poor mental health, they might still never be diagnosed with a mental health illness and, equally, someone with a mental health disorder can still enjoy periods of good mental well-being (CDC, 2021). Therefore, having a good understanding of the concept of mental health and how it can be improved can result in being a life-changer.

As reflected in the Sustainable Development Goals for 2030, specifically on target 3.4, mental health and well-being have to be promoted worldwide to end stigmas and discrimination (United Nations, 2021). According to the World Health Organisation, there is an urgent need for transformation in both mental health and mental healthcare (WHO, 2022). In order to achieve this, there is not only an obligation for reformation but for a complete change in mindset. As WHO Director-General, Dr Tedros Adhanom Ghebreyesus, said 'Investment into mental health is an investment into a better life and future for all' and it is essential for nations to start seeing it as such.

HISTORICAL SITUATION:

The origins of mental health can be dated back to before the 20th century, when the 'healthy mental and physical development of the citizen' was included as one of public health's main objectives. During this time period, the term mental hygiene was most commonly used to refer to mental wellbeing.

Throughout the first decade of the 20th century, Adolph Meyer, one of the Swiss psychiatrists at the time, became one of the founders of the mental hygiene movement in the United States of America (Mandell, 1995). This campaign's main aim was to improve the care provided to individuals with mental health disorders. Shortly after, in 1909, the National Commission for Mental Hygiene was created to humanise the care of those with mental illnesses, eradicating the atrocities that they were forced to undergo and the social rejection they suffered. Later on, this led to the formation of national institutions and associations in countries such as Italy, Hungary, France and South Africa, which then formed the basis of the International Committee on Mental Hygiene, later overruled by the World Federation of Mental Health.

These advancements and any other research projects were heavily interrupted by the commencement of the First World War (1914-1918), when medical professionals were called upon to assist in the treatment of troops and individuals suffering from stress and/or trauma (Science Museum, n.d.). Nevertheless, this gave psychiatrists and health workers an opportunity to experiment with new treatments on conditions such as schizophrenia, opening the door to a whole new era of development in mental health.

However, it was not until 1946 that proactive developments started to be seen in the field and the term 'mental health' began to be widely used. After WWII, the mental hygiene movement had expanded from its aforementioned principle and turned into a more encompassing idea, touching upon matters such as non-psychiatric maladjustments, the roots of mental disorders, institutional programs to improve mental health and the integration of mental health principles within other major healthcare functions.

Ever since its inception and as requested by its member states, the World Health Organisation has always had a department for mental health. In 1948, the first ever International Congress on Mental Health was held in London, resulting in a number of recommendations for the improvement of mental health. During the second session of the WHO's Expert Committee on Mental Health in 1950, a difference between the concepts of 'mental health' and 'mental hygiene' was finally determined. Whilst the latter referred to *'all the activities and techniques which encourage and maintain mental health'*, the preceding was described as *'a condition, subject to fluctuations due to biological and social factors, which enables the individual to achieve a satisfactory synthesis of his own potentially conflicting, instinctive drives; to form and maintain harmonious relations with others; and to participate in constructive changes in his social and physical environment.'* (Bertolote, 2008).

Between 1950 and 2000, mental health went through a period of reformation and began becoming increasingly deinstituzionalised. Diverse countries started funding their own Community Mental Health Centers, enabling a more patient-centred and enriching approach to the provision of treatment. Thereby, society's view on mental illnesses progressively shifted to being seen as a spectrum rather than a sole matter. Moreover, treatment started being applied to less severe cases and the prescription of psychoactive drugs as medicine arose as a new treatment method, enhancing the incrementation of home care (*StudySmarter*, n.d.). By the 2000s, medicine was already widely used as a remedy for mental disorders and mental illnesses were acknowledged as being largely caused by biological factors.

In 2001, WHO's annual report focused exclusively on mental health under the title 'The World Health Report - Mental Health: new knowledge, new hope'. This document addresses three main areas that still have to be targeted in mental health: the effectiveness of prevention and treatment (including funding allocation), service planning and provision, and the establishment of policies to eradicate stigma and discrimination (Bertolote, 2008). Unfortunately, in comparison to the agenda set in the 20th century, there still remain similar concerns as to the ones which existed a hundred years ago, suggesting that progress has been slow and limited. One of the biggest differences between the two is the emphasis transition from psychiatric hospitals to the community. Nevertheless, the sought-out renovation of mental healthcare and annihilation of the inadmissible mistreatment to which individuals with mental health disorders are subject to is a prevailing concern in the progress towards providing better healthcare to everyone, everywhere.

CURRENT SITUATION:

Indisputably, mental health issues are a growing public health concern. According to the WHO, in 2019, one in every eight people (970 million people) in the world had a mental disorder (World Health Organization, 2022a). In the first year of the Covid-19 pandemic alone, the number of cases for anxiety and depression rose by over 25% (WHO, 2022). The lost productivity resulting from these conditions account for an annual cost of US $1 trillion to the global economy (WHO Special Initiative for Mental Health, n.d.).

Overall, mental, neurological and substance use disorders are accountable for over 10% of the world's disease burden (WHO Special Initiative for Mental Health, n.d.). Moreover, major depression is one of the primary contributors to suicide and ischemic heart disease (The Most Common Mental Health Problems: Statistics, n.d.).

Despite these alarming figures, most individuals continue to lack access to competent care. It has been estimated that, in developing nations, more than 75% of individuals suffering from mental disorders receive no treatment at all for their condition (WHO Special Initiative for Mental Health, n.d.). Furthermore, on average, individuals with grave mental health conditions die 10 to 20 years earlier than the general population, mostly due to preventable physical diseases (WHO, 2022). Not only does this portray the pressing need for improved access to treatment, but also the consequences that infrastructural failure on the provision of healthcare can lead to.

Research studies have shown a pattern in the distribution of mental health issues across society; economic disadvantages have proven to be the major influential factor. The most vulnerable groups and minorities are the ones most affected by mental health problems, yet the ones that most suffer from the lack of access to care. For example, 70% of people suffering from psychosis are reported to receive treatment in developed countries, whereas only 12% of individuals with this same condition enjoy mental health care in low-income countries (WHO, 2022). In addition, the following factors, most commonly found in developing nations, have been described as hazardous to mental health: social and economic inequalities, public health emergencies, military conflicts, and the environmental crisis. These figures suggest the existence of a clear gap between MEDCs and LEDCs, and it is the responsibility of the international community to address the issue and find solutions to promote the creation and implementation of better mental healthcare mechanisms in developing countries.

In addition to this, the stigma around mental health is still an issue to be addressed, particularly in African, Middle Eastern and South American states. In 2001, the World Health Organisation described both stigma and discrimination regarding mentally ill individuals as '*the single most important barrier to overcome in the community'* (Unite For Sight, 2019b). Apart from the human right violations that some individuals continue to suffer for their mental conditions, the prevailing stigma is a dilemma that prevents patients in need from seeking treatment and professional help due to a fear of social exclusion.

Currently, there still are 20 countries which continue to criminalise the act of attempted suicide, imposing a dynamic of repression and reinforcing discrimination towards individuals who experience mental health conditions (WHO, 2022). Rather than instaurating a climate of negative responses to mental illnesses and disorders, there is a clear need amongst the international community to transition to a mindset that allows for increased acceptance and inclusivity, acknowledging that mental health injuries are just as normal and human and physical health ones.

Existing Initiatives

As part of the developments of the last century, there exist affordable, effective and feasible procedures to promote, protect and restore mental health. The WHO has put numerous initiatives in place to achieve two main goals: the protection and promotion of mental well-being and the address of the needs of individuals with mental health conditions (World Health Organization, 2022). Through a community-based approach rather than institutional care, the organisation aims at improving recovery outcomes of patients and eradicating human rights violations.

The Comprehensive Mental Health Action Plan 2013-2030, a scheme which highlights the crucial role of mental health as an integral aspect of general health, is the primary framework under which global reformation is being conducted. The WHO ensures nations' compliance through three-year periodic reviews that measure the progress of member states against the predetermined targets.

Furthermore, in the WHO's latest mental health report 'World mental health report: transforming mental health for all', three clear paths to transformation are set in an attempt to assist countries in providing improved mental healthcare.

MAJOR STANCES:

European Union

Counting with some of the pioneer nations regarding the promotion and provision of mental healthcare, the European Union holds a privileged position compared to its international neighbours. Eight of its members have been ranked in the top ten leading nations for mental health worldwide.

The United States of America

Despite being one of the former leaders of the mental hygiene movement, the Centre of Disease Control and Prevention has estimated that over 50% of Americans will receive a diagnosis of mental disorder or illness at some point in their lifetime, questioning the effective functioning of a long-standing private healthcare system (CDC, 2021). Despite having a history of investment in the research of the causes and treatments for mental illnesses, statistics prove that the USA still has room for improvement regarding its provision of mental healthcare.

Western Pacific Region

The Western Pacific Region is currently being challenged with a mental health crisis, driven by social pressures, vulnerabilities and disadvantaged conditions. The COVID-19 pandemic contributed little to nothing in seizing these circumstances and, thus, over 215 million people are living with a mental health condition in the region (Mental Health, n.d.). Moreover, suicide continues to be a leading cause of death among young people, indicating a clear need for further assistance in mental health illness and disorder prevention. To do so, the WHO has implemented the Regional Framework for the Future of Mental Health in the Western Pacific.

Other Developing Nations (Middle East, Africa and South America)

As aforementioned, some developing nations in the Middle East, Africa and South America still have a rather antiquated approach to mental health (at least in the eyes of Western countries). These states are host to the most vulnerable groups and yet fail to provide access to competent mental healthcare. One of the root causes for this are long-standing cultural norms and religious beliefs which allow little room for acceptance and inclusivity.

POSSIBLE SOLUTIONS/FOCUS QUESTIONS:

1. Should the Universal Declaration of Human Rights directly address accessibility to mental healthcare?
2. What can be done to increase mental health awareness and eradicate the prevailing stigma around it?
3. What measures can be adopted to make mental healthcare more accessible for the most vulnerable populations and eliminate the existing gap between developed and developing nations?
4. What can the international community do to tackle discrimination due to mental health conditions?
5. What measures have already been implemented to tackle mental health conditions and how can these be improved?
6. Should there exist universal treatment programs for mental health disorders and treatments? If so, what would they look like?
7. How can we enhance effective mental health conditions' diagnosis and treatment prescription to prevent extreme cases of mental disorders globally?
8. What solutions can be enacted to achieve the transition to an acceptance and inclusivity based-approach towards mental healthcare in the long term?

ADDITIONAL RESEARCH:

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