

# QTMUN 2023

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## World Health Organization

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## Equity Disclaimers

Throughout this committee, delegates will be engaging in complex debates and discussions covering a wide array of topics. As UTMUN seeks to provide an enriching educational experience that facilitates understanding of the implications of real-world issues, the content of our committees may involve sensitive or controversial subject matter for the purposes of academia and accuracy. We ask that delegates be respectful, professional, tactful, and diplomatic when engaging with all committee content, representing their assigned country's or character's position in an equitable manner, communicating with staff and other delegates, and responding

This Background Guide presents topics that may be distressing to some Delegates, including but not limited to: war, violence, death, bombings, famine, illness, and mental health. Great care will be taken by staff in handling any/all of these topics should they arise.

UTMUN recognizes the sensitivity associated with many of our topics, and we encourage you to be aware of and set healthy boundaries that work for you. This may include: refraining from reading certain parts of the background guide, preparing yourself before reading this background guide, doing some self-care or seeking support after reading the background guide, or anything that can help make you feel more comfortable. We ask that all Delegates remain considerate of the boundaries that other Delegates set.

UTMUN expects that all discussions amongst delegates will remain productive and respectful of one another. If you have any equity concerns or need assistance in setting boundaries or navigating sensitive subject matter, please do not hesitate to reach out to me or our Equity Director, Aidan Thompson, at [equity@utmun.org](mailto:equity@utmun.org). We want you to feel safe and comfortable at UTMUN!

If you wish to switch committees after having read the content warnings for this committee, please:

- a) Contact your Faculty Advisor/Head Delegate with your request if you are a part of a group delegation
- b) Email our Director of Academics, Elaine Wang, with a brief explanation of why you would like to switch committees if you are NOT a part of a group delegation.

## Model United Nations at U of T Code of Conduct

The below code of conduct applies to the behaviour of all attendees of UTMUN for the entire duration of the conference, while engaging in any conference-related activities, including but not limited to committee sessions, conference socials, committee breaks, and the opening and closing ceremonies.

1. Harassment and bullying in any form will not be tolerated, the nature of which includes, but is not limited to, discrimination on the basis of race, national origin, ethnicity, colour, religion, sex, age, mental and physical disabilities, socioeconomic status, sexual orientation, gender identity, and gender expression,
  - a. Harassment and bullying include, but are not limited to, insulting and/or degrading language or remarks; threats and intimidation; and intentional (direct or indirect) discrimination and/or marginalization of a group and/or individual;
    - i. The above prohibition on harassment, bullying, and inappropriate behaviour extends to any and all behaviour as well as written and verbal communication during the conference, including notes, conversation both during and outside committees, and general demeanour at all conference events;
    - ii. UTMUN reserves the right to determine what constitutes bullying and/or inappropriate behaviour toward any individual and/or group;
  - b. Attendees must not engage in any behaviour that constitutes physical violence or the threat of violence against any groups and/or individuals, including sexual violence and harassment, such as, but not limited to,
    - i. Unwelcome suggestive or indecent comments about one's appearance;
    - ii. Nonconsensual sexual contact and/or behaviour between any individuals and/or groups of individuals;
    - iii. Sexual contact or behaviour between delegates and staff members is strictly forbidden;
2. UTMUN expects all attendees to conduct themselves in a professional and respectful manner at all times during the conference. Specific expectations, include, but are not limited to,
  - a. Attendees must, if able, contribute to the general provision of an inclusive conference and refrain from acting in a manner that restricts other attendees' capacity to learn and thrive in an intellectually stimulating environment;
  - b. Attendees must adhere to the dress code, which is Western business attire;
    - i. Exceptions may be made on a case-by-case basis depending on the attendees' ability to adhere to the previous sub-clause;
    - ii. Attendees are encouraged to contact Director of Equity, Aidan Thompson, with questions or concerns about the dress code or conference accessibility;
  - c. Attendees must refrain from the use of cultural appropriation to represent their character

and/or country, including the use of cultural dress, false accent, and any behaviour that perpetuates a national or personal stereotype;

d. Delegates must not use music, audio recordings, graphics, or any other media at any time unless approved and requested to be shared by the Dais and/or the Director of Equity, Aidan Thompson;

e. Attendees must abide by instructions and/or orders given by conference staff members;

- i. Attendees are exempt from this above sub-clause only if the instructions and/or orders given are unreasonable or inappropriate;

3. Delegates, staff, and all other conference participants are expected to abide by Ontario and Canadian laws and Toronto by-laws, as well as rules and regulations specific to the University of Toronto. This includes, but is not limited to,

- a. Attendees, regardless of their age, are strictly prohibited from being under the influence and/or engaging in the consumption of illicit substances, such as alcohol or illicit substances for the duration of the conference;

- b. Attendees are prohibited from smoking (cigarettes or e-cigarettes, including vapes) on University of Toronto property;

- c. Attendees must refrain from engaging in vandalism and the intentional and/or reckless destruction of any public or private property, including conference spaces, venues, furniture, resources, equipment, and university buildings;

- i. Neither UTMUN nor any representatives of UTMUN is responsible for damage inflicted by attendees to property on or off University of Toronto campus;

- ii. Individuals will be held responsible for any damages.

4. The Secretariat reserves the right to discipline delegates and/or attendees for not adhering to/violating any of the above stipulations. Disciplinary measures include, but are not limited to,

- a. Suspension from committee, in its entirety or for a specific period of time;

- b. Removal from the conference and/or conference venue(s);

- c. Disqualification from awards;

- d. Disqualification from participation in future conference-related events.

5. If online, additional rules apply to delegate and staff conduct, including but not limited to Zoom background usage. Delegates must use either conference-provided Zoom backgrounds, the blurred background, solid colours, or no background.

6. UTMUN reserves the right to the final interpretation of this document.

For further clarification on University of Toronto Model United Nations' policies regarding equity, questions, concerns, or for any equity violations that attendees would like to raise, please contact [equity@utmun.org](mailto:equity@utmun.org), or fill out this [anonymous form](#).

## Letter from the Director

Dear Delegates,

Welcome to the World Health Organization (WHO)! My name is Amelia Marlowe, and I'm so excited to meet all of you at UTMUN 2023. I am currently in my third year at UofT, majoring in Ethics, Society and Law and Health Studies with a minor in Anthropology.

This year, WHO will consider two topics: 1) the provision of medical aid to conflict zones, and 2) equalizing access to mental health care worldwide. As I will mention later in the background guide, these two topics are extremely important to discuss, and delegates should come to the committee room prepared to debate in a nuanced manner that reflects their complexity and multi-level nature.

To help guide your research and give you an overview of the topics, the dais has prepared the following background guide. Each topic is given an introduction, as well as several sub-topics which delve into more specific issues and areas about the topic. It is, however, recommended that you go beyond the information provided in this guide! Delegates are strongly encouraged to research their country's stance on particular issues related to this topic, and what solutions they might propose in committee.

Joining me on the dais team are Grace Choi, as your Moderator, and Roxanne Huang, as your Vice Director. Roxanne is a first-year life science student, while Grace is a first-year social science student, both at the University of Toronto. They, along with myself, are extremely excited for the conference, and wish you the best of luck in preparing for the conference.

Finally, if you have any questions about anything - research, the conference, MUN - please don't hesitate to send me an email - I am more than happy to help!

Best of luck,  
Amelia Marlowe  
Director, World Health Organization  
[who@utmun.org](mailto:who@utmun.org)

## Position Papers

At UTMUN 2023, position papers are required to qualify for awards. Each committee will also give out one Best Position Paper award. Only delegates in Ad Hoc are exempt from submitting a position paper. To learn more about position paper writing, formatting, and submission, please check out the position paper guidelines. Please read through the guidelines carefully as this page will describe content recommendations, formatting requirements, and details on citations. If you have any questions about position paper writing, feel free to contact your Dais via your committee email or reach out to [academics@utmun.org](mailto:academics@utmun.org)

## Introduction to the Background Guide & Committee

The World Health Organization (WHO), founded in 1948, is the United Nations' (UN) primary body focussed on promoting health, leading projects and movements around the world to expand health coverage and coordinate responses to health emergencies around the globe. In their efforts to fulfill this mission, WHO works extensively with multiple partners around the world, including governments, civil societies, foundations, advocates, international organizations, researchers, health workers, and more. Internally, the organization is governed by its 1948 Constitution and led in decision-making by the World Health Assembly, which is a body attended by all UN Member States. WHO has recently obtained a new level of international recognition for its lead in the response to the COVID-19 global pandemic; in early January 2020, they published their first package of guidance documents relating to the virus, which was ultimately followed later in the month by the declaration of COVID-19 to be a public health emergency of international concern. Since January 2020, they have taken a number of actions to help reduce the spread of the virus and guide governments as they create policy and restrictions relating to outbreaks.

At UTMUN 2023, delegates in the World Health Organization will focus on two major problems in the global community: 1) the provision of medical aid in conflict zones, and 2) creating equal and equitable access to mental health care worldwide. Both of these topics will require delegates to think with a solution-oriented mindset, considering things such as health inequities, WHO's limitations and country sovereignty, technological developments, privacy concerns, and more.

# Topic A: The Provision of Medical Aid in Conflict Zones

## Introduction

Providing medical aid to conflict zones has long been a topic of great importance and prevalence throughout history. In essence, as long as conflict has occurred, medical aid has been needed, and the question of how to provide that aid has endured. Within this topic, delegates will need to think about the positives and negatives of various methods of aid provision, with the goal being to create a standard set of guidelines, parameters, and regulations that will govern aid provision worldwide. As this topic may lead to discussion of conflicts, both ongoing and historical, it is crucial that delegates come to the committee room with a mindset focussed on equity and remember the severity and serious nature of these conflicts.

## Historical Background & Past UN Action

Naturally, given the WHO's role in global health worldwide, it has always played a major role in the provision of medical aid to conflict zones. As such, it would likely be beyond the confines of this background guide to overview every action the WHO has taken in relation to aid provision; instead, it will focus on a few key developments directly relating to actions taken by the WHO and UN .

## Relevant Geneva Convention Articles

The Geneva Conventions are significant to our understanding of what is permissible in war and more importantly for this topic, the protections rendered necessary to victims. This convention consists of a series of treaties that are meant to provide legal protection to civilians, soldiers and prisoners of war who are no longer a part of the conflict or are unable to fight. There are four Geneva conventions of 1949 and Additional Protocols of 1977.

The primary relevance of the Geneva Convention to this topic comes from its regulatory articling relating to the protection of medical personnel. Article 2 of the 1864 Geneva Convention and Article 9 of the 1906 Geneva Convention set out the initial premise of neutrality.

*“Hospital and ambulance personnel, including the quarter-master's staff, the medical, administrative and transport services ... shall have the benefit of the same neutrality [as military hospitals and ambulances] when on duty, and while there remain any wounded to be brought in or assisted.” (Article 2, 1864).*

*“The personnel charged exclusively with the removal, transportation, and treatment of the sick and wounded, as well as with the administration of sanitary formations and establishments ... shall be respected and protected under all circumstances. If they fall into the hands of the enemy they shall not be considered as prisoners of war”. (Article 9, 1906).*

As one can see, these two articles leave no room for interpretation: those providing aid must be treated with neutrality, meaning they should not be treated as combatants.

A neutral person includes people who are employed in hospitals and ambulances, more specifically staff who provide medical care, transport the wounded and members of relief associations. Later provisions in the Geneva Conventions reinforced this, relating the same principle that medical personnel in conflict zones must be treated as neutral persons.

Additionally, Article 55 of the fourth Geneva Convention of 1949 (which focuses primarily on the protection of civilian persons’ rights during conflict) further states that:

*“To the fullest extent of the means available to it, the Occupying Power has the duty of ensuring the food and medical supplies of the population; it should, in particular, bring in the necessary foodstuffs, medical stores and other articles if the resources of the occupied territory are inadequate.”*

This section relates to medical aid provision in a slightly different way, instead focusing on the requirement that the Occupying Power in a time of conflict provides food and medical supplies to their occupied territory’s population if needed.

Article 56 and 57 offer similar principles: Article 56 centres on the Occupying Power’s duty to maintain medical facilities and standard of care in their occupied lands, while Article 57 deals with the regulations regarding the requisition of civilian hospitals for military use.

As delegates may note, the contents of the Geneva Conventions already provide a fair bit of guidance for medical aid provision - in essence, it is up to the Occupying Power to do so, and any medical personnel dispersed during conflict is protected.

However, many questions still remain unanswered. For example, what happens when there is no definite Occupying Power - whose responsibility is provision of aid? Moreover, is there an ethical responsibility for outside forces to intervene to provide aid when the Occupying Power does not - and, if there is, whose responsibility is that?

## WHO Red Book

In addition to the Geneva Convention, the Red Book is perhaps the WHO's most prominent contribution to discussion on medical aid provision to conflict zones.

Formally titled "A Guidance Document for Medical Teams Responding to Health Emergencies in Armed Conflicts and Other Insecure Environments", the document provides an outline and guidebook on how to best provide medical aid in conflict zones.

It was developed by the WHO as a part of a wide consultative process, and was created with the intention of supporting medical responses.

Each of the guide's chapters focuses on a different aspect of the medical response process. Chapter One overviews the international humanitarian law and ethical principles behind the process; Chapter Two sets standards for safety and risk management; Chapter Three offers guidance on coordination; Chapter Four reviews sexual and gender-based violence; Chapter Five focusses on technical aspects of emergency care and rehabilitation; Chapter Six reviews operations and logistics, and finally, Chapter Seven offers annexes and relevant appendices.

To access the Red Book, delegates can visit [this link](#), and click on the publication titled "A Guidance Document for Medical Teams Responding to Health Emergencies in Armed Conflicts and Other Insecure Environments" to download it to their personal devices.

## Other WHO Initiatives

Over the years, the WHO has launched multiple other initiatives with the intention of providing aid or doing research into aid provision. In December 2017, it launched the Surveillance System for Attacks on Healthcare. This allows for the consistent reporting on attacks, with the eventual aim of gaining evidence for different countries and documenting the attacks' impact, before then activating methods to prevent the attacks and protect civilians.

Another WHO-led initiative is 'Attacks on Healthcare', which serves to collect evidence and document best practices when it comes to preventing attacks.

## Current Issues and Topics of Consideration

The following section of this background guide covers a number of key issues and topics for delegates to consider as they address this topic. While it is not an exhaustive list and a number of case studies and issues could be raised, the following items were specifically highlighted for their direct relevance to the topic at hand and different ways of approaching the subject.

## Maintenance of Medical Neutrality

In short, 'medical neutrality' refers to the international principle to not interfere with the provision of medical aid during conflict.

The idea of medical neutrality emerged from both the belief that a physician's ethical responsibility during war should be the same as their responsibility during times of peace.

The legal basis of this can be found in international law without regard to sides in a conflict or political repercussions.

In practice, medical neutrality looks like the protection of medical/medicine-adjacent personnel from purposeful harm or attack, access to medical care, and humane and non-discriminatory treatment for all civilians and injured persons.

Medical neutrality is clearly outlined as being a strong international guiding principle in the Geneva Conventions; it is made clear that maintaining the neutrality of medical personnel during conflict is crucial to ensuring aid is successfully delivered.

However, despite the Geneva Conventions regulations, there are unfortunately many examples in which medical neutrality has not been maintained. At many points throughout history, hospitals, ambulances, and healthcare providers have been targeted as a part of war - an extreme violation of human rights.

Violations of medical neutrality have been documented by the organization Physicians for Human Rights.

They have reported on the violations occurring in Bahrain, Bangkok, the former Yugoslavia, El Salvador, Panama, and more.

In some cases, systemic attacks were carried out on medical personnel, and in others, hospitals were raided and health care workers were assaulted.

Particular attention must be given by delegates to PHR's investigation into El Salvador, where they found evidence of assault and intimidation on health care workers, which ultimately helped to initially define what medical neutrality meant.

## Case Study #1: 2015 US Bombing of Kunduz, Afghanistan

Content Warning: Please be advised that the following case studies discuss violence and war.

Although perhaps a less-known example of a violation of medical neutrality, the United States' bombing in Kunduz is an important case study for delegates to be familiar with.

In 2015, the US led an airstrike that struck the city of Kunduz in Afghanistan, harming the Kunduz Trauma Centre, which was the only medical facility in the area.

The strike killed forty-two people, including doctors, nurses, and patients, all of whom had been in the hospital.

The airstrike was a clear violation of Article 19 of the Geneva Convention, which states that medical units/establishments must be avoided when attacking and left free to work, leading to the denouncement of the airstrike by organizations like MSF and Amnesty International.

However, while the US did eventually accept responsibility for the damages caused by the attack, they still maintain that their attack was intended to protect Afghans from the Taliban who had been firing from near the hospital.



Source: New York Times

## Case Study #2: New Year's Day Attack on the Democratic Republic of the Congo

On New Year's Day in 2019, an attack was launched on an Ebola vaccination facility in Bunia, a city in the Democratic Republic of the Congo. While in the midst of vaccinating patients, men and women began to start throwing stones at the doctors and medical workers, causing some to lose consciousness and start to bleed.

Since then, between New Year's Day and late May 2019, there were 131 reported attacks on medical personnel working at Ebola sites.

This violation of medical neutrality is another interesting case study, especially when placed in comparison with the first case study discussed. While most violations we speak about often occur in the context of massive wars and conflicts, this attack happened on a much more local scale.

According to the WHO, the attack was likely incited out of fear and mistrust, caused by many years of conflict and instability in the region.

## Provision of Medical Supplies and NGOs

Of course, when discussing the provision of medical aid in conflict zones, one of the key questions to consider is where and how the resources to do so are acquired. While many governments may have their own country-based programs on how to deliver aid to conflict zones, one of the most common methods of resource acquisition is by means of non-governmental organizations, or NGOs, particularly Doctors Without Borders. Doctors Without Borders, alternatively known as Medecins Sans Frontières, is an international NGO that directly focuses on the provision of medical aid to conflict zones.

As their website reads, they "deliver urgently needed healthcare to people who have been made vulnerable by conflict, crisis, danger, or neglect", made possible by their medical teams located in almost seventy countries around the world.

They have a strong dedication to medical ethics and are

guided by the Chantilly Principles, their statement of values.

However, the reality remains that NGOs such as Doctors Without Borders, despite their contributions, are often volunteer-based, donation-funded, and have no documented duty to help in the same way that a country has a duty to their citizens. Delegates must consider how the WHO can more formally institutionalize medical aid and resource provision - whether that be still by working with NGOs or other alternatives.

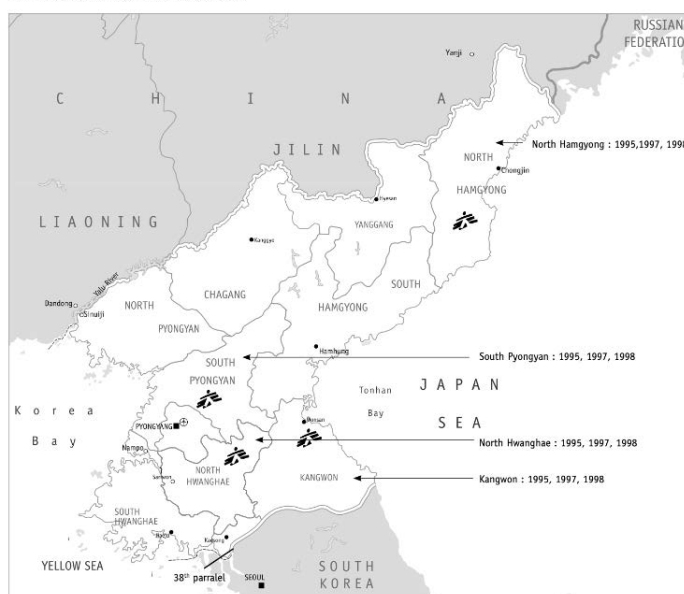
### Case Study #3: Doctors Without Borders Provides Aid in North Korea

August 1995 saw North Korea send out a call for help after the country had been hurt by flooding. After hearing this call, the Medecins Sans Frontières (MSF) also known as Doctors Without Borders began to set up a team to run a programme in North Korea, monitoring the health of the country's citizens.

While aid provision seemingly went well for a while, things began to fall apart after there had been reports by refugees that international aid to North Korea was being given to the army and "socially useful" individuals primarily and that there was large-scale famine and violence in the country.

After this occurred, the Memorandum of Understanding was up to be renegotiated, but the only deal the North Koreans would make did not fall under the mandate of MSF's medical humanitarianism.<sup>1</sup> As such, MSF withdrew from North Korea.<sup>2</sup>

MSF PROGRAMMES NORTH KOREA 1995-1998



Source: Medecins Sans Frontières

This situation left the MSF team with a number of ethical questions.<sup>3</sup> For one, should MSF agree to work with a totalitarian regime, and does agreeing to do so reinforce the regime's power?<sup>4</sup> As well, can MSF accept work without being able to apply the basic principles of

<sup>1</sup> "MSF and North Korea 1995-1998," Doctors Without Borders/Médecins Sans Frontières, last modified September 2013, [https://www.msf.org/sites/default/files/2019-04/MSF%20Speaking%20Out%20North%20Korea%201995-1998\\_0.pdf](https://www.msf.org/sites/default/files/2019-04/MSF%20Speaking%20Out%20North%20Korea%201995-1998_0.pdf).

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

humanitarian action?<sup>5</sup> Delegates may also choose to think about what ethical duty did MSF have to the doctors and teams who they sent to North Korea - what obligations are there to protecting their health and safety, and under what situations does it perhaps become unsafe to send personnel?

The other key issue to take away from this case study is that sometimes aid provided directly to governments is not always properly distributed. As seen in the case of North Korea, international aid was primarily given to those the government favoured, who were not necessarily those who needed it the most.<sup>6</sup> Perhaps this is an argument in favour of using non-governmental organizations to provide aid - there is less of a chance of the aid being misused or unfairly distributed amongst citizens.

## Balancing Medical Duties with Country Sovereignty

The last major point of discussion for delegates to consider is the balancing of country sovereignty with the medical responsibility to help. Each country has the right to exclusively rule their land, leading naturally to the right to control the provision of medical aid in the country, and this right to sovereignty must be maintained - or else the international system and idea of a modern state may collapse. However, if a government is neglecting their responsibility to provide aid during conflict, or is unable to, what happens then? Is it okay for the WHO or an NGO to enter the country to provide aid? What if the country's government notices the aid provision and asks it to be shut down, but people are still in the process of getting care?

## Conclusion

Throughout this section of the background guide, delegates have gained an exposure to some of the key topics of consideration and discussion: the principle of medical neutrality and examples of times in which it was violated, the role of NGOs and questions about how to best acquire the resources needed to provide aid, and the ethical/legal debate between respecting country sovereignty and providing aid to those who need it. A brief historical overview of the topic was also given, and past UN actions were highlighted, including the Geneva Convention. Of course, the topics and ideas noted in this backgrounder are not an exhaustive list; delegates are encouraged to do specific research into their own countries and the history they have with medical aid provision in conflict zones. A list of questions to help guide research and solution-building is below.

During debate, delegates should be focussed on working towards a solution that seeks to standardize medical aid provision in conflict zones internationally, keeping in mind the three main issues this backgrounder outlined.

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<sup>5</sup> Ibid.

<sup>6</sup> "MSF and North Korea 1995-1998," Doctors Without Borders/Médecins Sans Frontières, last modified September 2013, [https://www.msf.org/sites/default/files/2019-04/MSF%20Speaking%20Out%20North%20Korea%201995-1998\\_0.pdf](https://www.msf.org/sites/default/files/2019-04/MSF%20Speaking%20Out%20North%20Korea%201995-1998_0.pdf).

## Questions to Consider

- How do we ensure that no matter a country's size or power, the aid they receive in times of conflict is equal?
- What is the most effective strategy of delivering medical aid? How does this strategy change (if it does indeed change) when/if it is too difficult or dangerous to send personnel physically into the conflict zones?
- Is medical aid best provided by non-governmental organizations or governments? Where does the WHO fit into this system?
- How has the action the WHO has already taken impacted the provision of medical aid to conflict zones? Is there more of the same to be done, or is a different approach needed?
- When thinking about potential solutions, delegates must keep these types of questions in mind. Can sovereignty be infringed upon when providing aid during conflict, or does the nature of war and ethical duty of medical aid provision naturally disrupt the basics of sovereignty?
- Drawing upon case study #1, delegates should spend some time considering how the WHO should react to attacks that violate medical neutrality, when a violation was not intended. Furthermore, delegates should think about how different countries may be received when violating medical neutrality: would, perhaps, there be a difference between the international response to the US' violation if they were not a major global economic and political power?

## Topic B: Access to Mental Health Care Worldwide

### Introduction

In the last few years, access to mental health care has become a frequent topic of discussion. While some countries have made great strides in creating equitable access to mental health care, others have not been able to follow suit for various reasons. Whether this is caused by governmental negligence or a lack of resources, the reality is that the absence of equitable mental health care - no matter the reason- is a serious problem the WHO needs to address.

In this committee, delegates will be tasked with creating a WHO-led standardized mental health care program that can be rolled out worldwide - a lofty goal indeed. Delegates must consider the WHO's limitations and power, health inequities, country sovereignty, privacy concerns, funding, technological limitations, and more while doing so.

### Historical Background & Past UN Action

The history of mental healthcare provision is certainly an intense one. Understanding that only recently did mental health begin to be treated in ways that respected the patient and did not punish anyone for having poor mental health, this section seeks to give an overview of the basic history of mental health care. Please note that delegates are encouraged to exercise caution when reading the following section, as it may discuss some sensitive topics.

### Brief Timeline of Mental Health Care Provision Until the 2000s

The following is a timeline highlighting some of the major events in the history of mental healthcare leading up to the present day, in order to help delegates get an understanding of how the international community reached the point it is at today.

European Middle Ages	In Europe, those with mental health issues were generally free to do as they pleased, as long as they caused no harm/danger to those around them. <sup>7</sup>
1600s	Europeans began to isolate those with mental health issues from society. <sup>8</sup>
Late 1700s	More attention began to be paid to the treatment of those with mental health issues. Occasional reforms to patient care began to happen. <sup>9</sup>

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<sup>7</sup> "Treatments for Mental Illness," American Experience, PBS, accessed September 10, 2022, <https://www.pbs.org/wgbh/americanexperience/features/nash-treatments-mental-illness/>.

<sup>8</sup> Ibid.

<sup>9</sup> Ibid.

Pre-18th Century	Before scientific knowledge about mental health began to emerge, most doctors thought mental health issues to be one of two things: either demonic possession or physical illness. Treatments ranged from herbal supplements to invasive medical procedures. Mentally ill people were also often shut out from society and put in jail or mental hospitals. <sup>10</sup>
Early 1900s	Mental asylums become more prominent, as a method of punishing those with mental illnesses. <sup>11</sup>
19th and 20th Centuries	Lobotomy, electroshock, antipsychotic drugs, and Freudian therapeutic techniques emerge as the prominent mental health treatment methods. However, these treatments were more focussed on fixing the societal perception of those with mental health issues, rather than the problem itself. <sup>12</sup>
1930s	Treatments such as drugs, lobotomies, electro-convulsive therapy, and surgery emerge as methods of treating schizophrenia and consistent mental illness. <sup>13</sup>
July 3rd, 1946	The Nation Mental Health Act was signed by US President Harry S. Truman, which sought to research mental illness. <sup>14</sup>
1950s	Successful efforts are made to treat psychosis, but they do not cure it. <sup>15</sup>
Mid-1960s	Many people with mental health issues are removed from mental institutions, large amounts of which were made possible by the roll out of antipsychotic drugs. Many though experience chronic homelessness and suffer after leaving the insitutions. <sup>16</sup>
1979	The National Alliance for the Mentally Ill is formed in the United States, intended to be a support and advocacy institution. <sup>17</sup>
1990s	A more successful and effective generation of antipsychotic drugs is invented and enters the marketplace for treatment options. <sup>18</sup>

<sup>10</sup> “The Surprising History of Mental Illness Treatment,” Baton Rouge Behavioural Hospital, accessed September 10, 2022, <https://batonrougebehavioral.com/the-surprising-history-of-mental-illness-treatment/>.

<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

<sup>13</sup> “Treatments for Mental Illness,” American Experience, PBS, accessed September 10, 2022, <https://www.pbs.org/wgbh/americanexperience/features/nash-treatments-mental-illness/>.

<sup>14</sup> Ibid.

<sup>15</sup> Ibid.

<sup>16</sup> “Treatments for Mental Illness,” American Experience, PBS, accessed September 10, 2022, <https://www.pbs.org/wgbh/americanexperience/features/nash-treatments-mental-illness/>.

<sup>17</sup> Ibid.

<sup>18</sup> Ibid.

## WHO Special Initiative

Since the 1990s, great strides have been made to improve access to mental health care, including development of online mental health programs and the WHO Special Initiative for Mental Health. The Special Initiative in particular has made a major impact on mental health care today. This project was launched in 2018 by the WHO Director General, Dr Tedros Adhanom Ghebreyesus. The goal of this initiative is to expand mental health care to 100 million more people by 2023.

Eight countries have been the subject of work through the Special Initiative - Bangladesh, Ghana, Jordan, Nepal, Paraguay, the Philippines, Ukraine, and Zimbabwe. Each country received an individual assessment to determine what measures would be taken to address mental health care.

Individual information on the specific mental health actions taken in each country addressed through the Special Initiative can be found [here](#). Moreover, delegates can read the full Special Initiative document [here](#), if so inclined.

## The Diagnostic and Statistical Manual Development

Another key point of study in the history of mental health care is the *Diagnostic and Statistical Manual*, otherwise known as the DSM.

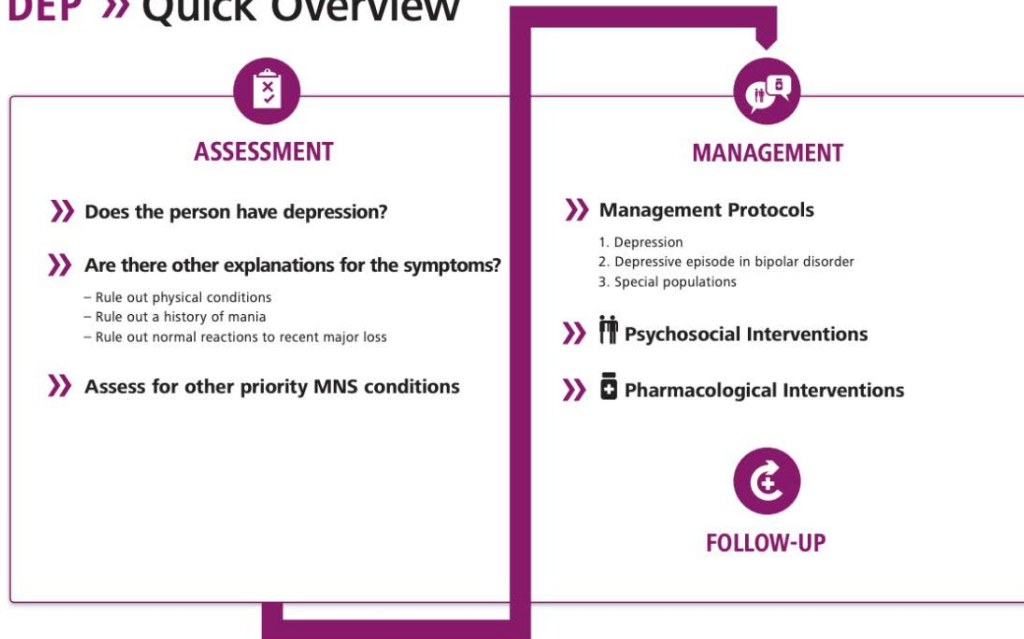
The DSM is a classification and diagnostic manual for mental disorders, which has gone through various stages of evolution and change as a result of criticisms. While the entire history of the diagnostic system's development is beyond the scope of this backgrounder and topic, delegates, if interested, are encouraged to familiarize themselves with its history using [this article](#).

## WHO Mental Health Gap Action Programme (mhGAP)

mhGAP is a WHO-led initiative directed towards helping lower and middle income countries address mental health issues in their country - specifically, mental, neurological, and substance abuse disorders - through increasing access to proper care.

A main focus of the program is relationship-building in order to allow the 'scaling up' of care. Delegates may find this program interesting to do further research into, especially in relation to the international cooperation aspect of this topic.

## DEP » Quick Overview



Source: mhGAP Intervention Guide - Version 2.0

## Current Issues and Topics of Consideration

Given the expansive nature of the subject of mental health, there is - like many things in this background guide - a number of sub-topics and issues that could be addressed. Because of the inherent confines of this paper, only a select few key ones will be discussed - 1) the challenges regarding different 'starting points' for each country, 2) WHO's restrictions, 3) existing mental health care mechanisms, 4) Culturally sensitive mental health care, and 5) Equitable access to mental health care. These sub-topics and case studies have been chosen as they represent the four key themes and topics delegates should keep in mind when debating and solution-building.

## Challenges Posed By Unequal Initial 'Starting Points' & WHO's Restrictions

While there is perhaps a more eloquent way to name this topic, it in essence refers to the problem faced by many UN committees and action groups: not all countries start from the same point and with the same materials available to them. This is evidently very true with the topic of mental health. Every country has a different financial and healthcare starting point; this is not to mention that countries may also differ greatly on their view of the importance of addressing mental health care and supporting their citizens.

At the same time, the WHO must toe the line between respecting government sovereignty

and the (potentially debatable) legitimate right non-mental health supporting governments have to their country's governance. The WHO can do a lot - but it cannot do everything. While in the past, the WHO has exercised its emergency powers the response to this varies. For instance, during the SARS outbreak of 2003 there was positive response but their use of it during the H1N1 outbreak in 2009 was met with a much less positive response. Today, the WHO is governed and restricted in power by the *International Health Regulations*, which delegates can access [here](#). All of this is to say that WHO delegates must be careful with how far they step over the line of sovereignty with their solutions, and that delegates themselves must remember their own country's perspectives and beliefs on the subject, being careful to ensure that their sovereignty is not infringed.

## Types of Mental Health Care

Given the solution-oriented nature of this topic, this section of the background guide is intended to give delegates some ideas on places from which to start. It will not mention outdated care methods, which are addressed in the historical section of this background guide.

Online mental health care has had an increase in popularity and use over the past couple years. These programs often involve being matched up with a therapist online, who then people will speak with via video call, phone, or online messaging. Helplines and text lines also would generally fall under this category. There are numerous benefits to online mental health care including easy access to mental health care practitioners and the accessibility of care from home amongst other benefits. An example of this online form of mental health care is the initiative by Swinburne University's National eTherapy Centre called Mental Health Online. This initiative aims to provide effective and free online services to help people who are experiencing mental distress.

Despite these benefits, people have raised concerns on this online mode of care. Anecdotally, many students in particular find them to be impersonal and it difficult to connect with the therapists they are matched with. There are also issues regarding privacy and the effectiveness of the treatment for addressing emergencies.

On the other hand, there is the conventional form of mental health care, in which patients visit an office and speak with a designated therapist, often on an ongoing basis. Again, however, anecdotal complaints about wait times and difficulty finding openings with therapists reveal that this form of care once again has significant issues.

Finally, there are a number of more unique mental health care forms. Mental health courses, apps, and modules in particular have begun to be explored - in essence, these are self-guided programs that people can enroll in and use to understand their emotions and mental health. Other smaller strides in mental health care include the rise in 'gratitude' journals and other books intended to help people take a more structured approach to mental health.

Of course, this is only a brief overview of potential mental health care methods. Delegates

are highly encouraged to research specific actions and programs that are used in their own countries and consider whether they could be implemented globally and equitably.

## Virtual Mental Health Care

### Case Study #1: Science Brief on the Efficacy of Virtual Mental Health Care in Ontario during the Pandemic.

There has been an unprecedented growth of virtual mental health care during the pandemic. This science brief found that in comparison to in person care, virtual care is as effective for depression, anxiety and post-traumatic stress disorder.

There is however, inconclusive evidence on severe mental illnesses like schizophrenia or bipolar disorder. Virtual care received a lot of positive feedback from a variety of patients and will continue to be widely used even after the pandemic.

Although there are many benefits to virtual care, there is a need to acknowledge how this form of care may perpetuate existing health inequities or even create new ones. There needs to be a consideration of the availability of internet, housing, privacy, digital literacy and cultural beliefs that can all affect one's ability to access virtual mental health care.

Therefore, there is a need to incorporate cultural, social and economic contexts into the provision of virtual mental health care to ensure that the benefits can be distributed equitably.

### Case Study #2: Telehealth at Yale Medicine

Adult and pediatric providers at Yale Medicine say that providing mental health care virtually through telehealth has been crucial during the pandemic and even now when people are coming in person.

The doctors comment that virtual mental health care has been very convenient for patients because they can call their care providers at any time or location. This convenience of receiving care from home also reduces transportation barriers wherein the families who are not able to come in person can still do their sessions from home. Although the doctors comment on the numerous benefits of telehealth, they also acknowledge the barriers of virtual care. For instance, some people may not have reliable access to wifi or technology needed to use telehealth and need to go in person.

## Culturally Sensitive Mental Health Care

Culturally sensitive provision of care is an integral aspect of ensuring that everyone has access to equitable healthcare. This is because evidence shows that people from different cultures may experience mental health differently or may require a practitioner who can cater and understand their needs better.

Historically, people from minority communities are often excluded from studies and diagnostic

assessments and thus have to seek mental health care that was not created with people of different cultures in mind. The provision of culturally sensitive mental health care can help patients feel comfortable and heard.

### Case Study #1: Grandmothers on the Bench

This case study looks at the non-professional mental health initiative in Zimbabwe—the Friendship Bench Programme. Local volunteers, also known as the grandmothers, were recruited to talk to people about their issues on a bench outside of healthcare facilities. While they lack professional psychiatric training, they are familiar with the cultural background and approach to help patients. The grandmothers use Indigenous concepts such as spirituality to connect with their patients.



Source: BBC News

This case is an example of limitations of a “one-for-all” universal mental health care. The results from the Friendship Bench Programme were found to be efficient and replicable in experimental settings. Thus, the program was expanded to multiple countries, with more diverse volunteers and patients.<sup>19</sup>

### Case Study #2: Biigajiiskaan: Indigenous Pathways to Mental Wellness

The Biigajiiskaan program is a partnership between St. Joseph’s Health Care London and atlohsa family healing services.<sup>20</sup> It is a referral-based mental health program that aims to provide Indigenous people with accessible and culturally sensitive mental health care. They offer a combination of Traditional Healing Services and Western psychiatric treatment.<sup>21</sup> The program also has a healing space at Parkwood Institute, an Indigenous-led mobile outreach time, Indigenous practices like healing circles and a knowledge carrier.<sup>22</sup>

This culturally specific program aims to address the immediate mental health needs of Indigenous peoples as well as the institutional and intergenerational trauma caused by Canada’s history of colonization.<sup>23</sup> Indigenous people have traditionally been stigmatized and discriminated

19 “How a bench and a team of grandmothers can tackle depression.” 15 Oct. 2018, <https://www.bbc.com/future/article/20181015-how-one-bench-and-a-team-of-grandmothers-can-beat-depression>.

20 St. Joseph’s Health Care London. “Biigajiiskaan: Indigenous Pathways to Mental Wellness.” Accessed October 10, 2022. <https://www.sjhc.london.on.ca/areas-of-care/mental-health-care/biigajiiskaan-indigenous-mental-wellness>.

21 Ibid.

22 Ibid.

23 News, C. B. C. “New Collaboration Hopes to Improve Mental Health Care for Indigenous People | CBC News.” CBC, August 6, 2020. <https://www.cbc.ca/news/canada/london/new-collaboration-hopes-to-improve-mental-health-care-for-indigenous-people-1.5675852>.

against in health care settings which prevents them from seeking care.<sup>24</sup> By providing culturally sensitive care, the program hopes to dismantle the barriers and ensure that Indigenous people receive culturally sensitive mental health care.

## Equitable Access To Mental Health Care

Equitable access to mental health care means taking into consideration the varied circumstances in people's lives -- some groups of people experience more social and economic disadvantages due to the unequal distribution of resources.<sup>25</sup> An equity lens to health care acknowledges the systematic disparities people experience with access to mental health care because of various underlying advantages or disadvantages.<sup>26</sup> An important concept to understand equitable access is the social determinants of health (SDH) that influences health outcomes and equity. The WHO defines SDH as, "... non-medical factors that influence health outcomes."<sup>27</sup> They are the broader conditions and circumstances of peoples lives that shape how they experience health.

## Case Study #1: Improving Equitable Access to Mental Health Care in the United States

There has been a surge in behavioral health cases in the United States, this crisis compounded with the COVID-19 pandemic has created even more inequitable conditions in accessing mental health care. This crisis disproportionately affects people of lower socio-economic backgrounds and people of colour. This is exemplified through the fact that Black and Hispanic Americans had higher reports of cost-related issues when accessing healthcare.<sup>28</sup> People with mental health conditions or substance use disorders are often unable to receive treatment because of high out-of-pocket costs, gaps in coverage and difficulty in reimbursement for services.<sup>29</sup> To tackle this, policymakers at the federal and state level have been working to improve mental health and substance use disorder care. The Commonwealth Fund outlined four key areas to further policy research and activities to improve equitable access in the U.S; first is expanding equitable access by addressing the structural and systemic inequities faced by racialized individual's, second is integrating primary and behavioural health care, third is diversifying behavioural health practitioners and fourth is leveraging of Medicaid and Medicare.<sup>30</sup>

## Health Care Provision Systems

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<sup>24</sup>Ibid.

<sup>25</sup> P Braveman and S Gruskin, "Defining Equity in Health," Journal of Epidemiology & Community Health (BMJ Publishing Group Ltd, April 1, 2003), <https://jech.bmj.com/content/57/4/254>.

<sup>26</sup> "Mental Health," CMHA Ontario, accessed October 19, 2022, <https://ontario.cmha.ca/equity/>.

<sup>27</sup> "Social Determinants of Health," World Health Organization (World Health Organization), accessed October 19, 2022, [https://www.who.int/health-topics/social-determinants-of-health#tab=tab\\_1](https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1).

<sup>28</sup> Rachel Nuzum et al., "Expanding Access to Equitable Behavioral Health Services," Commonwealth Fund (Commonwealth Fund, May 12, 2022), <https://www.commonwealthfund.org/blog/2022/expanding-access-equitable-behavioral-health-services>.

<sup>29</sup> Ibid.

<sup>30</sup> Ibid.

On the other end of types of mental health care is the various types of health care provision used by countries around the globe. From private to public methods, countries have found multiple ways through which to deliver health care - and delegates must keep this in mind when crafting solutions. The next three case studies will look at examples of some particular types of health care and mental health care provision, but - as always - delegates are encouraged to look beyond the background guide and research their individual countries in more depth.

## Conclusion

This background guide has exposed WHO delegates to the just tip of the iceberg of WHO's background with mental health care and the various actions that are occurring across the globe to try to address this problem. The hope is that through gaining this exposure, delegates are equipped (and are highly encouraged) to explore their own country's individual history and past actions relating to mental health care, and bring that knowledge to the conference, where collaboratively, the WHO will work together to equalize access to mental health care and develop a standard global system. As with the first background, a list of questions to help guide delegates' research and solution-building is below.

During debate, delegates should be mindful of sovereignty and the limits of the WHO, technological and privacy concerns with relation to online mental health care, logistical issues, the urgency of the issue, funding and financial backing, and equity concerns.

## Questions to Consider

- How can privacy concerns be eliminated or lowered in online mental health care?
- How can the issue of unequal resources and 'starting points' be addressed?
- To what extent is virtual mental health care an effective way to address unequal access to care?
- How does equity and the provision of mental health care intersect? Why is it important to take an equity lens when trying to improve the access to mental health care?
- Are there people who are disproportionately affected by the inequitable access to mental health care? If so, who are they and why? How can this be improved?
- What are some ways countries can reduce the inequitable access to mental health care?
- How can countries ensure that they are providing culturally sensitive mental health care?
- Can the WHO successfully create a world-wide mental health program?

## Tips for Research

This background guide is meant to provide a basic outline of the key details surrounding the three topics that will be discussed over the course of the conference. It introduces the topics and the relevant subtopics in order to provide delegates with a general understanding of the goals of the committee. This is not meant to be a comprehensive source of information. Delegates are advised to supplement the information provided in the background guide with their own research in order to better these topics and their individual positions in regards to them.

Begin by researching general details about the country that you are representing. This doesn't necessarily need to be in relation to the topics that are covered in this committee, but rather so that you will be able to speak to its current state of affairs and position in the world. Get to know the nation you're representing so that you will be able to portray its contemporary interests well.

Following this, go through the background guide, taking care to note any aspects of it that are relevant to the part of the world that your nation is in. Model UN is meant to highlight the interconnectedness of the world, so think beyond just your individual country and consider its surroundings to understand how it may be impacted. Follow the "Key Resources" provided below to better understand the general topics we will be discussing, looking at the bigger picture but also noting anything that is pertinent to your part of the world.

Once you are comfortable with the topics, begin compiling your research about your country's position on the issues that are highlighted. Use the subtopics to guide your research, and learn about your country's national and international response to them. Look at what your country's stakes are in relation to these subtopics. Don't be afraid to go into the specifics! Look at the different economic and social concepts covered in the Background Guide and connect them to your country's position. Look through the "Questions to Consider" at the end of each topic to further guide your research. The goal is to be able to comfortably defend the interests of the country you are representing and to be able to further those interests throughout the conference.

Lastly, begin thinking about solutions to the issues presented throughout the background guide. Remember that you are to take an objective stance based on what country you are representing, which is why it is so important to keep in mind your respective country's stakes in the issues. Think of how your country would go about presenting resolutions in relation to the two topics in order to prepare yourself for meaningful deliberation throughout the conference. This will allow for an engaging committee, where everyone can bring various perspectives.

Good luck!

## Key Resources

### Topic A

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Fakolujo, Dami. *Issues in Contemporary Ethics: Medical Neutrality*. Carleton University. <https://www.who.int/news-room/feature-stories/detail/taking-risks-to-provide-care-in-a-conflict-zone>.

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### Topic B

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