Houston Area Model United Nations
Standard Committee

WHO

Chair | Shriya Reddy
Topic A: Strengthening Regional Cooperation to Tackle the Growing Mental Health Crisis in South Asia
Houston Area Model United Nations 51
February 5 & 6, 2026

Chair Letter

Dear Delegates,

Welcome to the 51rst Annual Houston Area Model United Nations Conference. I am so excited to welcome you all and look forward to an engaging and meaningful weekend of discussion and collaboration. My name is Shriya Reddy, and I am honored to serve as your Chair for the World Health Organization committee.

I am a sophomore at the University of Texas at Austin, majoring in Philosophy with a minor in Business, and I am on the pre-law track. Outside of academics, I love spending time with my friends and family, reading and writing, watching shows and movies, and love all things makeup and beauty. I try to implement and enjoy creativity in my daily life!

Model United Nations has been a huge part of my life since high school, and my love for it has only grown over the years. Chairing this committee truly means a lot to me, and I am so excited to help create a welcoming, thoughtful, and collaborative space for all of you.

The topic we will be discussing addresses important global health challenges that require cooperation, empathy, and innovative thinking. I encourage you to approach committee with confidence, curiosity, and an open mind. Some of the best ideas come from working together and learning from one another.

Please do not hesitate to reach out if you have any questions, concerns, or just need support during the conference. I genuinely want this to be a positive and rewarding experience for everyone. I cannot wait to see your ideas and diplomacy in action, and I wish you all the very best of luck this weekend.

Sincerely,

Shriya Reddy

Shriya Reddy
Chair of WHO
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Topic Overview

INTRODUCTION

Mental health is an essential component of overall well-being and a cornerstone of sustainable development. In South Asia, a region home to nearly one quarter of the world's population, mental health challenges have reached critical levels. Millions of individuals across countries such as India, Pakistan, Bangladesh, Sri Lanka, Nepal, Bhutan, Afghanistan, and the Maldives experience mental health conditions ranging from depression and anxiety to severe disorders such as schizophrenia and bipolar disorder. Despite the scale of the crisis, access to mental health care remains limited, underfunded, and deeply stigmatized.

The mental health burden in South Asia is shaped by poverty, rapid urbanization, unemployment, conflict, displacement, natural disasters, and social inequality. These pressures have been further intensified by the COVID-19 pandemic, which disrupted social networks, strained health systems, and increased psychological distress across all age groups. Untreated mental illness contributes to reduced productivity, increased physical health risks, educational disruption, and rising suicide rates, making it both a public health emergency and a development challenge.

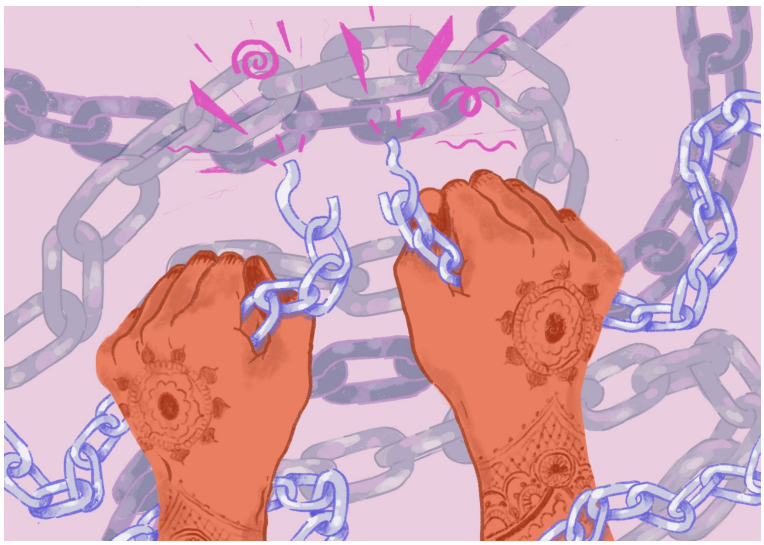
While national governments have begun to recognize the importance of mental health, fragmented policies, limited resources, and weak regional coordination have slowed progress. Strengthening regional cooperation offers an opportunity to share best practices, pool resources, address cross-border challenges, and build resilient mental health systems that serve diverse populations across South Asia.

HISTORY

Mental health care in South Asia has historically been shaped by colonial legacies, limited public investment, and social attitudes that prioritize physical health over psychological well-being. During the colonial period, mental health services were largely custodial, centered on psychiatric institutions rather than community-based care. Treatment often focused on confinement rather than rehabilitation, reinforcing fear and stigma around mental illness..

Following independence, many South Asian countries inherited underdeveloped mental health infrastructures and shortages of trained professionals. Public health priorities were directed toward infectious diseases, maternal mortality, and malnutrition, leaving mental health marginalized in policy planning. Although traditional and community-based approaches to mental well-being existed, these were rarely integrated into formal health systems.

In recent decades, economic growth, urban migration, and changing family structures have altered social support systems, increasing vulnerability to mental health disorders. Armed conflict, political instability, and humanitarian crises in parts of the region have further exacerbated psychological trauma. Despite these evolving challenges, regional collaboration on mental health has remained limited, with most initiatives confined to national boundaries.



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SOCIOECONOMIC AND CULTURAL BARRIERS

Stigma and Social Norms

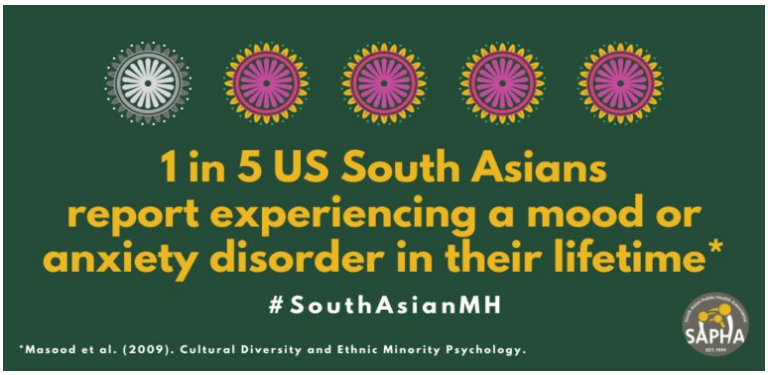
Stigma remains one of the most significant barriers to addressing mental health in South Asia. Mental illness is often perceived as a personal weakness, spiritual failing, or source of family shame. Individuals experiencing mental health conditions may face discrimination, social exclusion, or pressure to conceal symptoms, discouraging them from seeking professional help.

In many communities, mental health concerns are addressed through informal or religious channels rather than medical care. While community support can be beneficial, exclusive reliance on non-clinical approaches may delay diagnosis and treatment for severe conditions. Fear of social repercussions also affects employment opportunities, marriage prospects, and educational participation, reinforcing silence around mental illness.

Poverty and Economic Stress

Poverty and economic insecurity are closely linked to mental health outcomes. High unemployment rates, informal labor, debt, and income inequality contribute to chronic stress and anxiety. For many households, the cost of mental health care is unaffordable, particularly in systems where services are concentrated in private facilities or urban centers.

Economic hardship also limits government's' ability to invest in mental health services. In most South Asian countries, mental health receives a small fraction of national health budgets, leading to shortages of medications, facilities, and trained professionals.



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HEALTH SYSTEM AND SERVICE DELIVERY CHALLENGES

Mental health systems across South Asia face severe structural limitations. The region has one of the lowest ratios of mental health professionals to population globally. Psychiatrists, psychologists, and psychiatric nurses are concentrated in urban areas, leaving rural and remote communities underserved.

Primary health care systems are often ill-equipped to diagnose or manage mental health conditions. Health workers may lack training in mental health screening, and referral pathways are weak or nonexistent. Institutional care, where available, is frequently overcrowded and under-resourced, raising concerns about quality of care and human rights protections.

Access to medications for mental health conditions remains inconsistent, and supply chains are vulnerable to disruption. In humanitarian and conflict-affected settings, mental health services are often deprioritized despite high levels of trauma and psychological distress.

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POPULATION-SPECIFIC CHALLENGES

Children and Adolescents

Adolescent girls are particularly disadvantaged by intersecting barriers. Limited menstrual education, school infrastructure deficits, and social stigma contribute to high absenteeism and dropout rates. These educational disruptions reduce future employment opportunities and perpetuate gender disparities in socioeconomic outcomes..

Women

Women face unique mental health risks due to gender-based violence, caregiving burdens, economic dependency, and social restrictions. Postpartum depression, anxiety disorders, and trauma related to domestic violence are widespread but often unaddressed due to stigma and lack of accessible services.

Displaced and Conflict-Affected Populations

Refugees, internally displaced persons, and communities affected by conflict experience elevated levels of post-traumatic stress disorder, depression, and anxiety. Limited cross-border coordination complicates service delivery for mobile and displaced populations.

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KEY STATISTICS AND REGIONAL TRENDS

South Asia accounts for a significant share of the global burden of depression and anxiety disorders. Suicide rates in several South Asian countries have risen in recent years, particularly among young people. Despite this, mental health spending remains below two percent of total health budgets in many states. Large treatment gaps persist, with the majority of individuals with mental health conditions receiving no formal care.

ROLE OF THE WORLD HEALTH ORGANIZATION

The World Health Organization plays a central role in addressing the mental health crisis through policy guidance, technical assistance, and coordination. WHO supports Member States in developing national mental health strategies, integrating mental health into primary care, and promoting rights-based approaches to treatment.

At the regional level, WHO encourages cooperation through shared frameworks, data collection, workforce development, and emergency mental health response. By facilitating collaboration among South Asian states, WHO can help strengthen regional preparedness, harmonize standards of care, and promote sustainable mental health systems.

INTERNATIONAL AND REGIONAL RESPONSES

Global frameworks such as the Sustainable Development Goals recognize mental health as integral to health and well-being. Regional organizations in South Asia have begun to acknowledge mental health, but coordinated action remains limited. Non-governmental organizations and academic institutions have piloted community-based models, digital mental health platforms, and task-sharing approaches, demonstrating the potential for scalable solutions.

BLOC ANALYSIS

The growing mental health crisis in South Asia divides Member States based on economic capacity, cultural attitudes toward mental illness, health system development, and approaches to regional cooperation. While all states acknowledge the importance of mental well-being, differences remain regarding funding priorities, service delivery models, and the extent of cross-border collaboration.

South Asian States

Countries within South Asia emphasize the urgency of addressing mental health as a public health and development issue. Governments recognize the social and economic costs of untreated mental illness but face constraints related to limited budgets, workforce shortages, and competing health priorities. While supportive of regional cooperation, many stress the need for context-specific solutions that respect cultural norms and national sovereignty.

High-Income and Donor States

High-income Member States generally advocate for increased mental health funding, evidence-based interventions, and integration of mental health into universal health coverage. These countries support regional collaboration through technical assistance, capacity building, and research partnerships. However, debates may arise over financing mechanisms and the role of external actors in shaping domestic mental health policies.

Countries with Conservative Social Frameworks

Some states approach mental health cautiously due to cultural or religious norms that influence perceptions of mental illness. These countries may support improvements in service delivery while favoring community-based and family-centered approaches over institutional expansion. They often emphasize gradual reform and public education to reduce stigma.

Neutral or Mixed Positions

States with neutral positions prioritize broader health system strengthening rather than mental health-specific initiatives. They may support regional cooperation in principle while avoiding strong commitments to policy harmonization or cross-border programming.

Delegates should recognize that these blocs are not rigid and that cooperation across differing perspectives is essential to developing sustainable regional solutions.

POSSIBLE POLICY RESPONSES

1. Strengthen regional cooperation through shared mental health frameworks, data exchange, and joint training initiatives.
2. Integrate mental health into primary health care systems across South Asia.
3. Expand community-based and culturally sensitive mental health services.
4. Increase investment in mental health workforce development and task-sharing models.
5. Promote regional collaboration on crisis response, humanitarian mental health support, and suicide prevention.
6. Support public awareness campaigns to reduce stigma and encourage early care-seeking behavior.

QUESTIONS TO CONSIDER

1. How can South Asian countries strengthen regional cooperation while respecting national sovereignty and cultural diversity?
2. What role should WHO play in coordinating cross-border mental health initiatives and data sharing?
3. How can mental health services be expanded equitably in rural and underserved communities?
4. Should mental health be prioritized within universal health coverage frameworks across the region?
5. How can stigma reduction efforts be implemented effectively at both national and regional levels?
6. To what extent can regional cooperation improve mental health outcomes during humanitarian crises and emergencies?

POSSIBLE POLICY RESPONSES

1. Expand national health policies to explicitly include menstrual health and menstrual hygiene management as integral components.
2. Invest in WASH infrastructure in schools and health facilities to ensure privacy, dignity, and hygiene.
3. Strengthen reproductive health services by training providers in adolescent-friendly care and reducing stigmatizing practices.
4. Subsidize or reduce tariffs on menstrual products to improve affordability.
5. Support culturally relevant education campaigns that engage communities, parents, and youth on menstrual and reproductive health.
6. Improve data collection and monitoring to inform policy and program design.

QUESTIONS TO CONSIDER

1. How can Member States address menstrual and reproductive health barriers in a way that improves public health outcomes while respecting cultural diversity and community norms?
2. What role should the World Health Organization play in coordinating international efforts without undermining national sovereignty or local ownership of health systems?
3. Should menstrual health products be classified as essential health items, and how can affordability be ensured without creating long-term dependency on external aid?
4. How can water, sanitation, and hygiene infrastructure be expanded sustainably in schools and health facilities across rural and underserved areas?
5. To what extent should international funding prioritize adolescent-friendly reproductive health services, and how can confidentiality and accessibility be improved for young people?
6. How can better data collection and monitoring strengthen policy design while ensuring ethical standards and respect for privacy?

TOPIC A APPENDIX & SOURCES

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