

# National Model United Nations • New York

Conference B (13 - 17 April 2014)



Documentation of the Work of the  
World Health Organization (WHO)

# World Health Organization (WHO)

## Committee Staff

<i>Director</i>	Nyla Langford
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## Agenda

- I. Improving Access to Mental Health Resources in Industrializing Countries
- II. Strengthening Partnerships, Research, and Response Preparedness to Combat Pandemic and Resistant Disease
- III. Improving Women's Health by Integrating Gender, Equity and Human Rights

## Resolutions adopted by the Committee

Document Code	Topic	Vote
WHO/RES/1/1	Improving Access to Mental Health Resources in Industrializing Countries	Acclamation
WHO/RES/1/2	Improving Access to Mental Health Resources in Industrializing Countries	Acclamation
WHO/RES/1/3	Improving Access to Mental Health Resources in Industrializing Countries	21 / 0 / 2 / 0

# Summary Report

The Executive Board of the World Health Organization (WHO) held its annual session to consider the following agenda items:

- I. Improving Access to Mental Health Resources in Industrializing Countries
- II. Strengthening Partnerships, Research, and Response Preparedness to Combat Pandemic and Resistant Disease
- III. Improving Women's Health by Integrating Gender, Equity and Human Rights

The Session was attended by representatives of 25 countries. The first session opened with several statements concerning the adoption of the agenda followed by multiple attempts to set the agenda. After much debate at its first meeting, WHO adopted the agenda of 1-2-3 with a vote of 13 in favor and 12 against.

Upon adoption of the agenda, delegates discussed a variety of means by which to improve access to mental health resources in industrializing countries. Over the next few committee sessions, working groups formed to work on several key sub-topics. Solutions deliberated included community-based approaches to mental health care, educational initiatives to raise awareness and reduce social stigma, and training initiatives to maximize existing human resources and infrastructure to increase the proportion of care providers in underserved areas. By the end of the third committee session, three working papers had been submitted to the dais.

Throughout the fourth committee session, two additional working papers were submitted to the dais. Delegates engaged in debate regarding the common grounds of their positions in order to merge working papers. Some of the key issues brought up during merging were discrimination against the mentally ill, education advocacy programs, providing feasible access and availability, and the means for funding these programs and initiatives. Several groups worked together during the fifth and sixth sessions in merging their working papers after discussing the best ways to address these specific issues. The main challenge the delegates faced upon the merger was the strength in the wording of the paper. By the end of the session a merged working paper was submitted to the dais.

During the seventh session, the five working papers were merged into three and consequentially draft resolution 1/1 was accepted early in the session. Draft resolutions 1/2 and 1/3 were accepted by the end of session 7. During the eighth session and prior to entering voting bloc, ten friendly amendments were submitted to the dais for the three draft resolutions. These amendments did not make substantial changes to the draft resolutions, but mostly focused on modifying language to establish consensus within the committee. Upon closure of the debate for topic I, the delegations of Uzbekistan and Switzerland spoke against the closure, however the motion passed with overwhelming support. Draft resolutions 1/1 and 1/2 were adopted by acclamation, while draft resolution 1/3 was considered through a roll call vote. It was then approved with 21 votes in favor, 0 against, and 2 abstentions.

After adoption of these resolutions, the committee promptly moved to work on the second topic. A couple of working groups were formed, and a short working paper was submitted. However, the meeting adjourned before the working paper could be recognized as a draft resolution.



**Code:** WHO/RES/1/1

**Committee:** World Health Organization

**Topic:** Improving Access to Mental Health Resources in Developing Countries

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1 *The World Health Organization,*  
2  
3 *Acknowledging* the sovereignty of all Member States as stated by Article 2 Section 1 of the United Nations Charter,  
4  
5 *Guided by* Article 25 of the *Universal Declaration of Human Rights*, reaffirming that everyone has the right to a  
6 standard of living adequate for the well-being of himself and his family, and the *International Covenant of Social,*  
7 *Economic, and Cultural Rights*, reaffirming that all people have the right to health,  
8  
9 *Cognizant of* the World Health Organization Constitution which states that the extension to all peoples of the  
10 benefits of medical, psychological, and related knowledge is essential to the fullest attainment of health,  
11  
12 *Recognizing* mental illness is an ongoing concern that is not bound by borders,  
13  
14 *Drawing attention to* the omission of mental health in the Millennium Development Goals,  
15  
16 *Emphasizing* that mental health and physical health require equal consideration,  
17  
18 *Affirming* the work of the *WHO/World Bank Ministerial-level Meeting on Universal Health Coverage* of 2013,  
19  
20 *Alarmed by* the insufficient proportion of mental health professionals in respect of population sizes, in developing  
21 states, especially in regards to rural and urban areas,  
22  
23 *Recalling* the policy recommendations of the *Mental Health Policy and Service Guidance Package on Child and*  
24 *Adolescent Mental Health Policies and Plans* of 2005,  
25  
26 *Recognizing* the progress made through development of the *Convention of the Rights of Persons with Disabilities,*  
27 *the Comprehensive Mental Health Action Plan 2013-2020,* and WHA65.4, The global burden of mental disorders  
28 and the need for a comprehensive, coordinated response from health and social sectors at the country level,  
29  
30 *Commending* the progress of the WHO Mental Health Gap Action Programme (mhGAP) in increasing mental health  
31 services for industrializing countries and lowering the mental health care treatment gap,  
32  
33 *Acknowledging* the critical information provided by the *Mental Health Atlas 2011* and *Investing in Mental Health*  
34 (2003),  
35  
36 *Conscious of* the political and economic stressors that can increase mental illnesses, the long-term nature of mental  
37 illnesses and their appropriate treatment, and the inaccessibility to resources in industrializing nations,  
38  
39 *Further recognizing* the efforts of NGOs to collaborate with the United Nations and the WHO in using the World  
40 Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS),  
41  
42 *Noting with appreciation* the work of the World Federation of Mental Health,  
43  
44 *Recalling* United Nations General Assembly resolution 46/119 which states that every patient shall have the right to  
45 receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in  
46 accordance with the same standards as other ill persons,  
47  
48 *Reaffirming* the *Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental*  
49 *Health*, as stated in United Nations General Assembly resolution 58/173,  
50  
51 *Further believing* that WHA58.33 holds a strong foundation for the sustainable financing of universal coverage and  
52 social health insurance,  
53

- 54 *Noting with satisfaction* the success of national mental health care training programs, such as the *Swiss Mental*  
55 *Health Actions Programme*, and advocacy programs such as the *Malaysian Social Workers Association*,  
56
- 57 1. *Supports* continued collaboration with the World Bank to create a comprehensive international framework to  
58 assist developing Member States in the promotion of universal access to basic healthcare;  
59
  - 60 2. *Calls for* the inclusion of mental health into the post-2015 Development Agenda for the purposes of  
61 encouraging Member States to take up mental health as an integral part of their development agendas, as well as  
62 raising awareness among the general population;  
63
  - 64 3. *Endorses* the involvement of non-governmental organizations that respect national sovereignty and cultural  
65 customs and values in the expansion and improvement of mental health care networks as well as in the raising  
66 of awareness;  
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  - 68 4. *Asks* the Director-General to convene a high-level summit for the creation of a framework which facilitates  
69 intersectoral collaborative efforts focused on mental health care issues between relevant international actors  
70 including pharmacology corporations, governmental programs, community representatives, and non-  
71 governmental organizations;  
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  - 73 5. *Further requests* the agenda of the convention contain topics including, but not limited to, providing developing  
74 nations with access to adequate supply of psychiatric and psychotropic products;  
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  - 76 6. *Further endorses* the creation of local support groups to provide a personalized and community-based approach;  
77
  - 78 7. *Encourages* Member States that currently lack a record keeping system to implement such practices and  
79 Member States that do keep records to improve upon their systems in order to see the evolution of the illnesses  
80 and treatment for the purpose of gaining a better understanding of mental illnesses;  
81
  - 82 8. *Implores* Member States to institute or strengthen existing national legislation which provides for universal  
83 access to basic healthcare, emphasizing mental healthcare resources which provide training to primary care  
84 providers in detecting symptoms of mental illness, including but not limited to:  
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    - 86 a. Alzheimer's disease;
    - 87
    - 88 b. Dementia;
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    - 90 c. Depression;
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    - 92 d. Addiction;
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  - 94 9. *Invites* Member States to set incentives for mental health specialists to practice within their home territories by:  
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    - 96 a. Promoting educational opportunities;  
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    - 98 b. Supporting university cooperation between industrialized and industrializing countries for the  
99 purpose of sharing best practices such as but not limited to:  
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      - 101 i. Awareness campaigns regarding mental health;
      - 102 ii. Efficient methods of addressing mental health care and improving access in the  
103 communities;
      - 104 iii. Visiting professor programs to introduce different perspectives;
      - 105 iv. Exchange of curriculum, published research, scientific theories and other relevant  
106 materials in the field of mental health;
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    - 108 c. Establishing a link between students and the workforce in order to provide them with work  
109 experience and ease their transition into the local workforce;

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- d. Providing assistance for the creation and integration of community-based rural psychosocial facilities within preexisting community-based primary healthcare settings, which will be preferably staffed by:
  - i. Local individuals trained by the Member State;
  - ii. NGO personnel as appropriate;
- e. Encouraging specific programs for the care of children and adolescents which:
  - i. Include comprehensive assessment and treatment through a multidisciplinary team approach;
  - ii. Are evidence based;
  - iii. Are multimodal and may include:
    - 1. Psycho-education;
    - 2. Psychosocial therapies, including but not limited to:
      - a. Cognitive behavioral therapy;
      - b. Supportive therapy;
      - c. Parental therapy;
      - d. Pharmacotherapy;
      - e. Traditional and cultural therapy;
- f. Continuing development of human resources at all levels of care to address the need of additional comprehensive treatment of community members;

10. *Recommends* Member States work toward relieving social stigma by the following means:

- a. Avoiding the seclusion of mentally ill patients from other patients;
- b. Offering early childhood education programs in order to tackle misconceptions about mental illness and its implications;
- c. Inviting the lengthening of the World Mental Health Day to a week-long awareness campaign from October 10<sup>th</sup> through October 16<sup>th</sup>, as well as the expansion of its reach by the World Federation of Mental Health;

11. *Further recommends* Member States collaborate with the office of the Director-General to implement national programs for the expedited training of non-specialized personnel and mental healthcare workers which:

- a. Have a six to eight month training duration;
- b. Require a one year residency working under a licensed professional;
- c. Include a contractual obligation to work in the national program for a period of a minimum of three years, unless the individual is pursuing further mental health care related education;

12. *Intends* to collaborate with UN bodies and specialized agencies including but not limited to Economic and Social Council and *United Nations Development Programme* (UNDP) to act as advisors and lend assistance on viable alternative sources of funding;

13. *Encourages* collaboration with the UNDP, specifically utilizing the *United Nations Information Technology Service* to provide a communication link between primary care providers and community-based mental healthcare workers:

- a. This communication will be used to enhance cooperation and information sharing;

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- b. Expanding patient outreach;
- c. Increasing mental healthcare efficiency, this may also be developed for physical healthcare as well.

**Code:** WHO/RES/1/2

**Committee:** The World Health Organization

**Topic:** Improving Access to Mental Health Resources in Industrializing Countries

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1 *The World Health Organization,*

2  
3 *Affirming* the language of the *Comprehensive Mental Health Action Plan 2013-2020* (WHA66.8), which defines  
4 mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the  
5 normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her  
6 community,” and further states that “health is a state of complete physical, mental and social well-being and not  
7 merely the absence of disease or infirmity,”

8  
9 *Recognizing* the financial strain which donor-dependent countries face when asked to implement plans on the  
10 national level which do not take into account their dependence on foreign aid and non-governmental organizations  
11 for the funding of a significant portion of health care expenditures, thus exacerbating their dependence on outside  
12 sources to provide basic care for their citizens,

13  
14 *Emphasizing* that it is systematically advantageous for industrialized Member States to prevent the poverty, regional  
15 instability, and loss of human capita associated with widespread mental health issues in industrializing countries  
16 which interrupts the economic flow of raw goods,

17  
18 *Considering* the importance of exchanging perspectives, best practices and sharing experiences on equal terms by  
19 the means of south-south, trilateral cooperation to bridge developed and developing world together in international  
20 norms,

21  
22 *Fully aware* that the social and economic impact of mental disability is diverse and far-reaching as stated by the  
23 Secretariat report A65/10,

24  
25 *Recalling* the guidance document *Building back better: sustainable mental health care after emergencies* and  
26 drawing attention to the utmost urgency and importance of mental health and psychosocial care in industrializing  
27 countries that have recently faced war, widespread poverty, environmental disasters, and other situations that create  
28 instability and therefore a special vulnerability for these Member States who need mental health and psychosocial  
29 support in emergencies and unstable situations,

30  
31 *Expressing appreciation* for existing community groups, nongovernmental and international organizations, and  
32 state-sponsored programs which take a community-based approach to basic and emergency health services, and  
33 which often serve rural, isolated, and vulnerable populations,

34  
35 *Noting* that community groups, nongovernmental and international organizations, and state-sponsored programs  
36 which take a community-based approach to basic and emergency health services empower individuals to come  
37 forward to health care providers already integrated into their community about mental health issues they may be  
38 facing without fear of stigmatization,

39  
40 1. *Encourages* Member States to adopt the following proposed norms and benchmarks when engaged in global  
41 advocacy or policy creation, and when considering means for funding for mental health programs or solutions  
42 in industrializing countries;

43  
44 2. *Recommends* industrializing Member States to:

45  
46 a. Integrate and unify mental health services into preexisting frameworks for primary health care to  
47 ensure better access to mental health resources;

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49 b. Consider reallocation of any additional financial resources Member States may have to the  
50 expansion of mental health care capacity and accessibility;

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- 52 c. Facilitate and maintain cooperation with nongovernmental and international organizations and  
53 community groups that work to provide community-based, decentralized health care to their  
54 citizens, especially those that specialize in providing mental health care;  
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- 56 3. *Asks* industrialized Member States who are already financially contributing to industrializing countries to  
57 maintain or increase their support to their global neighbors by continuing to provide multilateral financial  
58 support and volunteer aid from governmental organizations and industrialized states in order to foster a sense of  
59 international community;  
60
- 61 4. *Supports* the efforts of community groups, nongovernmental and international organizations, and Member  
62 States in establishing training programs which encourage the development of education in mental health care,  
63 help recognize signs of mental health issues, and can provide basic treatment and management within  
64 industrializing Member States by:  
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- 66 a. Making training and training materials available to countries who request assistance from the  
67 World Health Organization;  
68
- 69 b. Similarly making these materials available to nongovernmental organizations and community  
70 groups which are acting in cooperation with national governments and/or providing response to a  
71 given emergency situation;  
72
- 73 c. Designing the training and training materials for use by all levels of human resources, in order for  
74 the materials to be understood and implemented by all levels of human resources in the case of  
75 limited healthcare personnel;  
76
- 77 5. *Encourages* all Member States to acknowledge the influence of socio-economic factors in the development of  
78 mental health illnesses amongst its population and to react accordingly by improving communication between  
79 mental health facilities, governmental and nongovernmental organizations, and social support groups;  
80
- 81 6. *Reaffirms* the necessity for all Member States to join the efforts to improve mental health in industrializing  
82 nations through international community standards which are informed by cultural contexts and respect state  
83 sovereignty.



**Code:** WHO/RES/1/3

**Committee:** World Health Organization

**Topic:** Improving Access to Mental Health Resources in Industrializing Countries

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1 *The World Health Organization,*  
2  
3 *Acknowledging* the sovereignty of all Member States as expressed by Article 2.1 of the United Nations Charter,  
4  
5 *Reiterating* that equal human rights guarantees must be incorporated for people with mental disorders as stated in the  
6 Caracas Declaration as well as in United Nations General Assembly resolution 46/119 concerning the protection of  
7 persons with mental illness and the improvement of mental health care,  
8  
9 *Guided* by the *Comprehensive Mental Health Action Plan 2013-2020*, which calls for improved coordination of  
10 mental health services,  
11  
12 *Reaffirming* the *Rio Political Declaration on Social Determinants of Health*, which emphasizes the engagement of  
13 all sectors of government and society, as well as all members of the international community, in a “health for all”  
14 global action in order to address the issue of mental health in a profound manner,  
15  
16 *Acknowledging* that South-South and Trilateral Cooperation play a central part in the achievement of the  
17 internationally agreed development goals, including those contained in the health-related United Nations  
18 Millennium Development Goals,  
19  
20 *Recognizing* that there are two central problems regarding the issue of mental health in developing countries, which  
21 are unequal regional access to mental health resources between rural and urban areas within countries, as well as the  
22 mental health treatment gap,  
23  
24 *Emphasizing* the Brasilia Principles of the World Psychiatric Association, which further endorse the restructuring of  
25 local health-system models in order to improve accessibility, efficacy, and efficiency of mental health care through  
26 decentralization and network-building,  
27  
28 *Keeping in mind* the Secretariat report A65/10 regarding the global burden of mental disorders and the need for a  
29 comprehensive, coordinated response from health and social sectors at the country level,  
30  
31 *Fully aware* of the complexities of mental health and mental illness and their potential to be a destructive force  
32 extending not only to the physical being of an individual but also to the development of nations and economic  
33 productivity for at-risk populations,  
34  
35 *Recalling* resolution WHA55.10 that focuses on promoting mental health as well as urges member states to take  
36 strong actions towards the promotion and protection of the human rights of socially disadvantaged groups,  
37  
38 *Noting with deep concern* that access to mental health facilities, resources, and specialists are still a prevalent issue  
39 in developing nations that hinders at-risk populations from receiving treatment and support,  
40  
41 *Deeply concerned* that there is an estimated shortage of 1.18 million healthcare workers in 144 developing countries,  
42 as mentioned in *Mental Health Atlas 2011*, this lack of workers being mostly due to outmigration of mental  
43 healthcare specialists from these low and middle income countries,  
44  
45 *Recognizing* that many suffer unfair persecution and discrimination due to state inaction or cultural isolation in  
46 regards to mental health and the stigma surrounding the issue,  
47  
48 *Fully believing* that mental health education increases awareness and eliminates stigma surrounding those with  
49 mental health disorders, which creates a community more sensitive to mental illness and an environment more  
50 conducive to recovery, rehabilitation, and individual empowerment,  
51  
52 *Believing* that the family and the community surrounding the afflicted individual are a crucial and integral part of the  
53 recovery, support, empowerment, and well-being of mental health patients,

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*Deeply regretting* the omission of mental health during the establishment of the Millennium Development Goals in General Assembly resolution 55/2,

1. *Recommends* the expansion of the existing Community Psychosocial Centres (CAPS), of which the composition, structure, budget, and breadth of reach will be defined according to domestic and location-specific needs that would:
  - a. Serve as a common meeting point for patients and families;
  - b. Provide day hospital care;
  - c. Train locals for first-response mental health treatment;
  - d. Provide training for NGO workers for mental health;
  - e. Raise awareness;
  - f. Eventually, contingent upon Member State's approval, establish themselves in the area in which they operate;
2. Encouraging psychosocial therapy and counselling measures to support those battling with post-traumatic stress disorder as well as therapeutic support and empowerment counselling to help integrate them back into society;
3. *Endorses* new means of access to mental health care for rural areas such as:
  - a. Multidisciplinary mobile clinics, if possible, consisting of psychologically and medically trained professionals serving as an extension of CAPs that would:
    - i. Provide comprehensive mental health care services to communities on a frequent basis;
    - ii. Collect and upload data to mental health databases;
    - iii. Refer those needing in-patient care to the proper facilities;
    - iv. Train locals caring for mentally ill patients;
    - v. Also make use of already existing traditional health practices that are culturally rooted through exchange of best practices;
  - b. Encouraging free sharing and dissemination of knowledge and tools via the Internet when possible;
  - c. Ensuring access to care in rural and remote areas by encouraging the creation within regions of the member states of public, toll-free phone service that would focus on providing professional mental health counseling to individuals in need;
  - d. Increasing access to printed and other more accessible materials on mental illness through partnerships with NGOs to assist communities that lack technological infrastructure;
4. *Invites* Member States to raise awareness about the possible use of cell phones to connect patients and unspecialized workers with urban doctors;
5. *Recommends* Member States establish programs aimed at educating the community, the family, and the patient about mental illness, coping, and rehabilitation techniques by:
  - a. Providing an adequate standard of living for those with mental health impairments to promote the empowerment and functionality of the afflicted individual;

- 109           b. Establishing education programs geared towards children, adolescents, young adults and the elderly to  
110           ensure the equity of mental health support for all citizens in the community, and increase awareness  
111           of mental illness in all age groups;  
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- 113           c. Establishing family education programs to teach coping skills and rehabilitation techniques to family  
114           members of those living with mental illnesses, in order to aid in the recovery process and decrease  
115           chances of relapse, or to help the individual reach their highest potential;  
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- 117           d. Establishing comprehensive and nurturing support groups for both the individuals and families  
118           affected by mental illness;  
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- 120       6. *Invites* Member States and NGOs to utilize the WHO MiNDbank database which would encourage mental  
121       health professionals in their respective states to collaborate and share information with trained non-specialist  
122       professionals in other States on the causes and treatment of mental illness;  
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- 124       7. *Encourages* the creation of a Mental Health Indicator Program (MHIP), an international indicator based on  
125       tracking mental health issues for the purpose of:  
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- 127           a. Identifying at-risk populations by highlighting the most pertinent medical mental health disabilities  
128           and the socio-economic factors that facilitate their development;  
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- 130           b. Eliminating the stigma surrounding mental health by identifying the source of mental illness;  
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- 132           c. Encouraging knowledge sharing from every country to eradicate discrimination towards victims of  
133           mental health disabilities;  
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- 135           d. The exclusive use of data for the better understanding of mental health issues among communities to  
136           foster solutions, identify non-communicable disease trends and create adaptable intervention  
137           programs;  
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- 139           e. Developing community-based solutions with respect to specific socio-economic needs, including but  
140           not limited to:  
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- 142               i. Utilizing the MHIP to adapt and implement interventions by mental health workers;  
143               ii. Developing education programs that promote healthy lifestyles;  
144               iii. Identifying the main types of mental illness within each Member State, and providing clearly  
145               defined definitions of these illnesses as well as their symptoms in order to achieve early detection  
146               and prevention of these diseases;  
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- 148       8. *Encourages* Member States to find new ways of educating professionals and non-specialists in the mental  
149       health sector through:  
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- 151           a. Exchanging mental health professionals between and within countries to enhance their knowledge in  
152           specific types of mental health techniques through partnership with organizations such as Village  
153           Volunteers (VV) to support the health and welfare of the communities they serve;  
154
- 155           b. Encouraging post-graduate programs to specialize in field work in remote areas;  
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- 157           c. Employing counsellors who are able to work with mental health issues stemming from civil war, rape,  
158           human trafficking, and sexual violence, while keeping in mind the source of mental health care issues in  
159           their community as determined by MHIP;  
160
- 161           d. Creating contract-based scholarship programs that may require a minimum time period of commitment  
162           in a remote area as each Member State sees fit;  
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- 164 e. The provision of financial support for post-graduate education programs specializing in mental health  
165 plans;  
166
- 167 f. Collaboration with NGOs such as the International Mental Health Research Organisation that provide  
168 specific research-scholarships in the field of mental diseases;  
169
- 170 9. *Urges* the international community to create innovative solutions, such as the existing Return Home  
171 Program that aims at the deinstitutionalization of acute patients who are appropriate for community based  
172 health care to tackle social stigma connected with mental health problems;  
173
- 174 10. *Further requests* that Member States work to raise awareness for mental health on a multi-dimensional level  
175 by:  
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- 177 a. Encouraging NGO members to learn about cultural norms and state polices in order to provide  
178 services within Member States while remaining sensitive to their national sovereignty and cultural  
179 needs;  
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- 181 b. Providing education on mental health disorders associated with physical ailments, illnesses, and life-  
182 threatening diseases such as depression caused by a terminal cancer diagnosis;
- 183 11. *Suggests* Member States raise awareness of mental health on a regional level by:  
184
- 185 a. Partnering with NGOs such as Bring Change 2 Mind to promote awareness of mental health in order  
186 to eliminate social stigma;  
187
- 188 b. Working with health care professionals to provide and disseminate research-based information about  
189 mental health, including its causes and effects;  
190
- 191 12. *Encourages* Member States to establish protective services for those affected by mental illness from  
192 persecution, discrimination, and violence by:  
193
- 194 a. Engaging in active participation and cooperation with MHIP;  
195
- 196 b. Creating legislation pertaining to mental health rights and advancement;  
197
- 198 c. Providing protection against unjust imprisonment due to mental illness;  
199
- 200 13. *Recommends* gradually raising the median percentage of mental health expenditures within the general and  
201 respective Health budget of each Member State by 2% over the next six years in order to fund new  
202 initiatives to build capacity for mental health resources;  
203
- 204 14. *Proposes* the reallocation of funds, the amount of which will be determined by each Member State,  
205 concerning possible licensure agreements that they may have with pharmaceutical and other corporations  
206 within their State towards the funding of mental health resources;  
207
- 208 15. *Suggests* that NGO staff members collaborate with policy makers within each Member State and utilize the  
209 WHO-CHOICE program in order to:  
210
- 211 a. Ensure the cost-effectiveness of projects to be implemented by analyzing data from sources such as:  
212
- 213 i. Mobile clinics and other services mentioned above;  
214
- 215 ii. Non-governmental organizations (NGOs), as well as the 58 existing funding and grant  
216 organizations focused on mental health;  
217
- 217 iii. Current Member State government surveys;  
218
- 218 iv. Universities;

- 219            b. Collect, analyze, and use health data as a prerequisite for making investment decisions and for  
220            enhancing efficiency and accountability of mental health programs;  
221
- 222        16. *Recommends* that other relevant international bodies prioritize the establishment of mental health care as a  
223        primary health goal within the Post-2015 Development Agenda, which would allow more funding for the  
224        aforementioned as well as similar initiatives.