GLCMUN

COMMITTEE GUIDE

World Health Organisation

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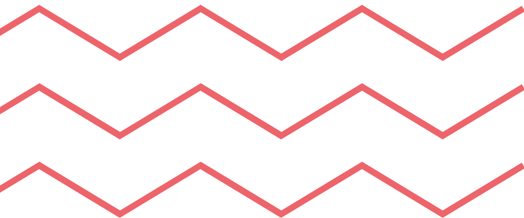

PRESIDENT'S WELCOME LETTER

Dear delegates,

we extend our warmest greetings to you. We are Arianna Cárdenas and Sophie Caus, eleventh graders at Gimnasio la Colina School. We would like to welcome you to the XI edition of the GLCMUN Model UN. It is an honor for us to lead the World Health Organization (WHO) committee and to be part of this wonderful experience for you as delegates and for us as presidents.

Throughout our journey with the United Nations, we have had the opportunity to acquire a wealth of knowledge and experience. We have had fun and learned a lot. As your presidents, we want you to have an unforgettable Model UN and an unforgettable committee. We want you to shine with all your diplomatic and leadership skills, as well as to reach your potential and represent your nation, but above all, we want you to enjoy this rewarding experience. We want you to appreciate the United Nations as much as we do so that you can put into practice all your skills and abilities, which will make you citizens of the future.

To conclude, delegates, we want to wish you the best, we know you will do very well. Please, if you need anything, clarifications, resolving doubts, tips, or anything at all, do not doubt that we are here to guide you and solve whatever you need. We know that during the days of the model nerves can interfere, and although this is normal, we want you to be sure of yourselves and your interventions. Remember at all times that quality exceeds quantity and that punctuality is very important. We are honored to be your presidents. See you at the XI edition of GLCMUN.

And remember, "Education is the most powerful weapon which you can use to change the world." Nelson Mandela (1918-2013)

Sincerely,

Arianna Cardenas

Arianna Cárdenas | President WHO

Sophie Caus

Sophie Caus | President WHO

INTRODUCTION TO THE COMMITTEE

The World Health Organization (WHO) is the specialized agency of the United Nations responsible for leading and coordinating international health action. Founded on April 7, 1948, the WHO's main objective is to achieve for all people the highest attainable standard of health, defined as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

HISTORY

The creation of the WHO dates back to the international health conferences held between 1851 and 1938, which laid the foundations for cooperation in public health at a global level. Following World War II and the founding of the United Nations (UN), international public health gained greater importance, leading to the creation of the WHO in 1948.

MISSION AND VISION

The mission of the WHO is to promote health, keep the world safe, and serve the vulnerable. Its vision includes implementing the International Health Regulations and addressing urgent threats such as antimicrobial resistance, climate change, and noncommunicable diseases.

ORGANIZATIONAL STRUCTURE

WHO is composed of the World Health Assembly, the Executive Board, and the Secretariat. The World Health Assembly is the supreme decision-making body and is composed of delegations from all Member States. The Executive Board, composed of 34 technically qualified health professionals, implements the decisions and policies of the Assembly. The Secretariat, headed by the Director-General, implements the approved policies and programs.

REGULATIONS

WHO sets health-based norms and standards, monitors and assesses global health trends, and provides support during emergencies. It also implements the International Health Regulations and addresses urgent threats such as antimicrobial resistance and climate change.

AREAS OF WORK

The WHO's main areas of work include:

· **Universal Health Coverage:** Promotes equitable access to quality essential health services without financial hardship.

• **Health Emergencies:** Leads and coordinates the global response to health emergencies, including epidemic outbreaks and natural disasters.
• **Health Promotion and Disease Prevention:** Encourages healthy lifestyles and addresses risk factors associated with noncommunicable diseases.
• **Health and Environment:** Addresses the impacts of climate change and other environmental factors on human health.

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TOPIC 1:

The Role Of The WHO In Combating Inequality In Health Care Accessibility

CONTEXT

Inequality in healthcare accessibility is one of the most persistent and complex challenges faced by the global health system. Although modern medicine has advanced rapidly, with improvements in diagnostics, pharmaceuticals, digital health, and disease surveillance, the benefits of these advancements remain very uneven. Across the world, entire populations continue to face barriers that prevent them from receiving even the most basic forms of medical attention. These inequalities are not aimless; they are shaped by socioeconomic conditions, political instability, historical disadvantages, and major differences in national health system capacities.

At the core of this issue is the fact that access to healthcare is not distributed according to need, but according to opportunity. Individuals with lower incomes, people living in rural or conflict-affected regions, and those belonging to marginalized communities often encounter obstacles such as unaffordable services, long distances to clinics, shortages of trained medical workers, lack of medicines, limited insurance coverage, and systemic discrimination. Because these barriers pile up, they create a cycle where the most vulnerable groups receive the poorest quality of care, or none at all.

Figure 1: Access to healthcare is global equity issue (Global Scan, 2022).

Figure 2: 6 in 10 nigerians lack access to primary health care services (Onyedinelu, G. 2022).

Global studies highlight the scale of the situation. Research shows that millions of deaths every year could be prevented with timely and effective healthcare services, and worldwide, a significant share of mortality is considered “amenable to healthcare,” meaning these deaths should not occur in functioning health systems (Kruk et al., 2018).

Poor-quality care has become a major contributor to mortality, showing that inequality is not only about whether someone can reach a hospital but also whether that hospital provides safe, competent, and respectful treatment. This distinction shows a double challenge: improving accessibility and improving quality, both of which depend on fair distribution of resources, workforce capacity, and strong health system management.

These disparities become even clearer during global crises. Pandemics, natural disasters, armed conflicts, and economic instability affect badly in regions where health systems are already weak. When emergencies strike, communities with limited infrastructure or fragile primary healthcare systems cannot absorb the shock, leading to higher mortality, interruptions in essential services, and long-lasting setbacks in public health. The COVID-19 pandemic, for instance, revealed how deeply structural inequalities shape a population's ability to receive testing, treatment, and vaccines, reminding the world of the importance of strong and fair health systems everywhere.

Within this global landscape, the World Health Organization (WHO) plays a key technical and coordinating role. Since 1948, the WHO has defined health as a basic human right, stating that all individuals, regardless of income, gender, ethnicity, or demographics, are entitled to accessible, safe, and good-quality health services. The organization supports Member States by offering technical guidance, creating standards and recommendations, strengthening health workforce training, and promoting frameworks such as Universal Health Coverage (UHC) that should ensure that all people have access to the full range of health services, from prevention to treatment and palliative care, whenever and wherever they need them, without suffering from financial problems. It also monitors global inequalities, identifies at-risk populations, and advises governments on targeted strategies.

The WHO's mandate goes beyond emergency response. It works to strengthen long-term system resilience by improving primary healthcare networks, supporting national plans for quality and safety, guiding essential medicines policies, and helping ensure that health services reach marginalized populations. This requires collaboration with governments, NGOs, research centers, and international donors to reduce disparities caused by poverty, conflict, geography, and global market forces. The WHO also promotes cooperation between countries so they can share experiences, coordinate responses, and support one another across borders.

Still, the WHO faces limitations. It depends on Member States choosing to follow its recommendations, and its influence can be affected by political will, national priorities, funding constraints, and differences in state capacity.

Inequality in global health is deeply tied to wider trends such as economic instability, unequal distribution of global wealth, brain drain, rural and urban gaps, and weaknesses in governance. This means that reducing healthcare inequality requires not only technical strategies but also political commitment, global cooperation, and sustained investment from countries at all income levels.

Understanding this context is essential for delegates because it sets the stage for the central question of the debate: How can the WHO strengthen its role in supporting countries and addressing the deep inequalities that prevent millions from accessing quality healthcare? The issue goes beyond isolated problems, it pushes the international community to rethink how health care systems are built, financed, and managed, and how global institutions can work together to ensure no population is consistently left behind.

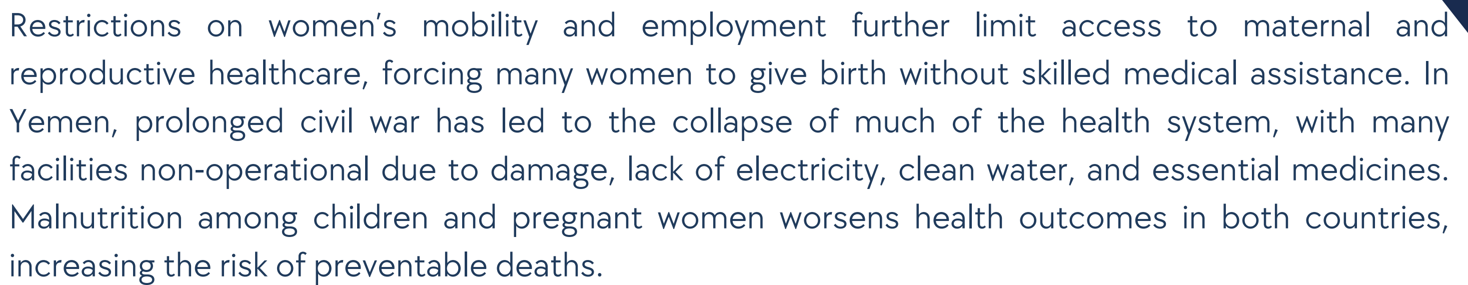
CURRENT SITUATION

The current global situation shows a world where healthcare access and quality vary dramatically from one country to another. Even though major medical advancements have been made in recent decades, millions of people still struggle to obtain basic, safe, and timely healthcare services. In many regions, health systems remain underfunded, understaffed, or unable to meet the needs of rapidly growing populations. The difference between countries is so significant that, in some of them, healthcare is readily available and well-funded, while in others, even the most essential services remain out of reach.

According to recent global studies, between 5.7 and 8.4 million people in low- and middle-income countries die each year because of poor-quality healthcare, while another 2.9 to 3.6 million die because they cannot access healthcare at all (National Academies of Sciences, Engineering, and Medicine, 2018; Kruk et al., 2018). Many of the countries in this committee fall directly into those categories and are facing immense pressure on their health system

Countries affected by conflict and instability, including Afghanistan, Yemen, Iraq, and Ukraine, face extreme challenges in accessing healthcare. Ongoing violence and political instability have damaged hospitals and clinics, disrupted supply chains, and reduced the availability of trained healthcare workers. Many communities are completely cut off from medical services due to insecurity, destroyed infrastructure, or long travel distances. As a result, preventable illnesses and deaths remain common, particularly where people cannot reach functioning health facilities in time.

In Afghanistan and Yemen, these challenges are especially severe and have had devastating effects on maternal and child health. In Afghanistan, decades of conflict and economic collapse have left many healthcare facilities underfunded, understaffed, or closed, particularly in rural areas.

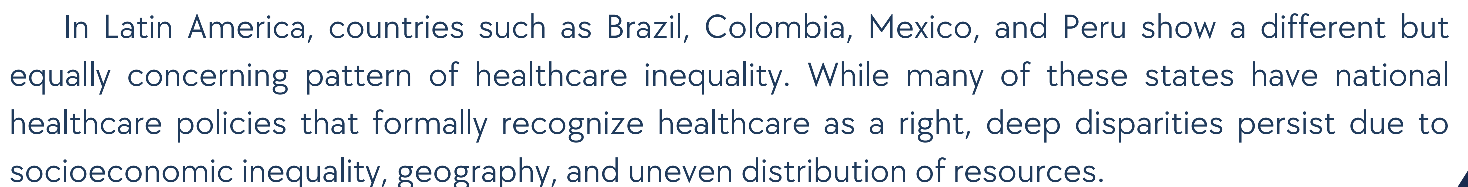


Restrictions on women's mobility and employment further limit access to maternal and reproductive healthcare, forcing many women to give birth without skilled medical assistance. In Yemen, prolonged civil war has led to the collapse of much of the health system, with many facilities non-operational due to damage, lack of electricity, clean water, and essential medicines. Malnutrition among children and pregnant women worsens health outcomes in both countries, increasing the risk of preventable deaths.

Although large-scale violence has declined in Iraq, the healthcare system continues to suffer from the long-term effects of conflict and displacement. Many hospitals and clinics were damaged during years of violence, and access to healthcare remains uneven across the country. Rural areas and previously conflict-affected regions face shortages of trained medical staff and essential resources. Internally displaced people often struggle to access consistent care, while mental health services and treatment for chronic diseases remain limited due to strained infrastructure and insufficient funding.

In Ukraine, the ongoing conflict has placed immense strain on the healthcare system. Hospitals and clinics have been damaged or destroyed, particularly near frontline areas, while power outages and medicine shortages disrupt service delivery. Mass displacement has interrupted regular healthcare for millions of people, especially the elderly, individuals with chronic conditions, and pregnant women. Access to care remains particularly limited in rural and conflict-affected regions, where security risks and damaged infrastructure restrict movement.

Beyond conflict zones, countries such as Ethiopia, Nigeria, India, Bangladesh, and the Philippines also experience significant barriers to healthcare access driven by population size, workforce shortages, poverty, and geographic challenges. In Ethiopia and Nigeria, long travel distances and severe shortages of healthcare workers contribute to high numbers of deaths linked to lack of healthcare utilization. In India, Bangladesh, and the Philippines, healthcare systems are heavily strained by large populations and regional inequalities, with rural and remote communities facing overcrowded facilities, high out-of-pocket costs, limited transportation, and shortages of trained personnel. Across these settings, inequality in healthcare access remains closely tied to income, location, and infrastructure, leading to delayed treatment and preventable health outcomes.



In Latin America, countries such as Brazil, Colombia, Mexico, and Peru show a different but equally concerning pattern of healthcare inequality. While many of these states have national healthcare policies that formally recognize healthcare as a right, deep disparities persist due to socioeconomic inequality, geography, and uneven distribution of resources.

Urban areas generally receive the majority of healthcare investment and infrastructure, while rural, remote, and marginalized regions continue to experience limited access to essential medical services.

Brazil is a notable example, as it has the Sistema Único de Saúde (SUS), a universal and free public healthcare system that guarantees access to healthcare for all citizens. In major cities, SUS operates alongside private healthcare and provides access to advanced hospitals and specialized treatment. However, significant inequalities remain within the system. Remote Amazonian regions, rural communities, and Indigenous populations often lack nearby facilities, sufficient medical staff, and emergency or maternal care, making access to healthcare far more difficult despite the system being free at the point of use. Colombia, Mexico, and Peru face similar internal inequalities: although Colombia has universal coverage laws, regions such as Chocó and La Guajira report some of the lowest access levels due to poverty and geographic isolation. In Mexico and Peru, healthcare services are heavily concentrated in urban centers, while rural and mountainous areas struggle with shortages of doctors, underfunded facilities, and limited availability of essential medicines.

Furthermore countries such as Egypt and Morocco have taken steps to expand healthcare coverage, yet strong inequalities persist between urban and rural areas. In Egypt, improvements in healthcare access and infrastructure have been made in recent years, particularly in major cities, but overcrowding, limited funding, and uneven resource distribution continue to place heavy pressure on public hospitals. Rural and low-income communities often face difficulties accessing timely and quality care. Similarly, Morocco has achieved progress in maternal healthcare and basic services; however, many rural regions still lack access to specialists, emergency care, and well-equipped medical facilities, leaving populations vulnerable despite national reforms.

High-income countries represented in this committee, including Canada, France, Germany, Italy, Japan, Switzerland, the United Kingdom, and the United States, generally have the resources to provide universal or near-universal healthcare. Despite this, inequality persists within these systems, particularly affecting marginalized groups and remote regions. In the United States, lack of insurance remains a major barrier, contributing to tens of thousands of preventable deaths each year and leaving large portions of the population living in healthcare deserts. In the United Kingdom, long waiting times and regional disparities limit access, especially in rural areas. Other high-income countries, such as Canada, France, Germany, and Italy, face increasing pressure from aging populations, rising healthcare costs, and shortages of healthcare workers, which challenge the sustainability and equity of their healthcare systems.

Global Overview

Across all delegation countries in this committee, several patterns emerge:

- Conflict-affected countries face collapsing health infrastructure.
- Large LMICs (Low and middle-income countries) struggle with high demand and limited resources.
- Middle-income countries face strong inequalities between wealthy urban centers and neglected rural regions.
- High-income countries still experience access gaps, workforce shortages, and affordability issues.

Despite some progress, more than 4.5 billion people worldwide still lack full access to essential health services. A significant portion of these people live in the countries represented in this committee. The current situation shows a world where access to care and the quality of that care still depend heavily on where someone is born, how much they earn, and how strong their national health system is.

KEY POINTS OF THE DEBATE

- The balance between WHO responsibilities and national government responsibilities.
- Expanding access to healthcare vs. improving the quality of care.
- Strengthening healthcare systems in conflict-affected states (Afghanistan, Yemen, Iraq, Ukraine).
- Addressing severe healthcare workforce shortages in countries like Ethiopia, Nigeria, South Africa, and Egypt.
- Financing Universal Health Coverage for low- and middle-income countries.
- Reducing internal inequalities in large countries (India, Brazil, Mexico, Philippines, Colombia).
- Improving healthcare access in rural and remote regions.
- Supporting digital health, telemedicine, and mobile clinics in countries with limited infrastructure.
- Enhancing data collection, transparency, and inequality monitoring across all member states.
- Addressing the growing problem of poor-quality healthcare in addition to lack of access.

GUIDING QUESTIONS

1. What role should the WHO play in reducing healthcare inequalities globally, and what challenges does your country face in providing equitable healthcare, especially in low-income or conflict-affected regions?
2. Should the WHO focus more on expanding access or improving the quality of healthcare, and how does your country balance these two priorities within its own healthcare system?
3. How does your government address healthcare inequalities between urban and rural or remote communities, and what additional support could the WHO provide?
4. What funding mechanisms could help countries implement Universal Health Coverage, and how is your country currently financing equitable healthcare services?
5. What challenges does your country face regarding shortages or uneven distribution of healthcare workers, and how could the WHO support workforce development?
6. To what extent should wealthier member states contribute financially to reducing global health inequalities, and what is your country's position on international health funding?
7. What innovative solutions (such as telemedicine or mobile clinics) has your country adopted to reduce healthcare inequalities, and how could the WHO support further innovation?
8. How does your country address not only access to healthcare but also the quality of services, and what strategies could the WHO recommend to improve both?
9. How does your country collect and use health data to measure inequalities, and what improvements in transparency or data systems are needed?
10. For countries affected by conflict or crises, what long-term strategies should be prioritized to reduce healthcare inequalities, and what lessons can your country share from its own experiences or internal challenges?

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TOPIC 2:

Improving Global Access to Mental Health Services in Low and Middle income Countries

GLOSSARY

- **Mental Health Disorder:** A condition that affects thoughts, emotions, or behavior (e.g., depression, anxiety).
- **Treatment Gap:** The large difference between people who need mental health care and those who receive it.
- **LMICs (Low- and Middle-Income Countries):** Countries with low resources and limited access to mental health services.
- **HICs (High-Income Countries):** Wealthier countries with stronger health systems and higher mental health funding.
- **Stigma:** Negative attitudes or discrimination toward mental illness that prevents people from seeking help.

CONTEXT

The issue of inequality in global mental health is a serious problem characterized by significant variations in funding, workforce availability, and access to treatment, particularly between countries of different income levels. This disparity has its roots in historical colonial psychiatric systems that focused on institutional control rather than caring for individuals in colonized areas; after World War II, global health efforts prioritized infectious diseases, neglecting mental health; structural adjustment initiatives during the 1980s and 1990s led to budget cuts that severely impacted services in low- and middle-income countries (LMICs); and important milestones from the World Health Organization (WHO)—including the 1978 Alma-Ata Declaration and the 2001 World Health Report—promoted integration but experienced slow progress in implementation.

Figure 1: Global Development Funding for Health in Low and Middle Income Countries in 2016 (StrongMinds, 2017).

The WHO has highlighted the persistent lack of financial resources for mental health services, noting that, on average, countries dedicate less than 2% of their total healthcare budgets to mental health (Santos, 2022). This figure has remained mostly static, with the median portion of government health budgets assigned to mental health in LMICs remaining low at merely 2.1% (WHO Mental Health Atlas, 2020, as cited in United GMH, 2023).

In sharp contrast, high-income countries (HICs) usually allocate more than double that amount, achieving a median expenditure of 5.4% (WHO Mental Health Atlas, 2020, as cited in United GMH, 2023).

Such limited investment contributes to the considerable treatment gap evident in LMICs. Globally, approximately 71% of people experiencing psychosis do not receive mental health care (Santos, 2022). In low-income areas, fewer than 10% of individuals facing common mental health challenges, like anxiety and depression, can access treatment (Patel et al., 2025). When services are accessible, they are often poorly managed; over 70% of mental health expenditures in middle-income countries continue to be directed toward psychiatric hospitals instead of being redirected towards more efficient community-based and preventive approaches (Santos, 2022).

CURRENT SITUATION

Around the world, mental health disorders are rising faster than ever, and while awareness has grown, the real issue remains painfully clear: most people still can't get the help they need. Imagine the global mental health system as a smoke alarm blaring nonstop, yet there are barely any firefighters available. The danger grows, but the response is slow and unequal. Today, more than 1 billion people are experiencing a mental health condition. And this number isn't steady, it's expanding, especially in countries where healthcare systems already struggle to keep up. In many low-income areas, less than 10% of people with mental illnesses receive support (WHO, 2025). Meaning that millions of individuals who are dealing with depression, anxiety trauma, or other conditions are left completely alone. The consequences go far beyond emotional suffering. Suicide, often preventable when support exists, caused 727,000 deaths in 2021, and 73% of those happened in low- and middle-income countries. The message is clear: lack of access to mental healthcare may have life-threatening consequences.

Figure 2: Representation of the compelx burden of various mental health disorders (All Day, 2025).

A major obstacle is the absence of political and financial dedication. Worldwide, governments allocate merely 2% of their overall health expenditures to mental health, a figure that has seen little change since 2017. To provide context: High-Income Countries spend around US$65 per individual, whereas Low-Income Countries allocate merely US$0.04 (WHO, 2025).

This funding shortfall results directly in a human resource emergency. Typically, there are merely 13 mental health practitioners for each 100,000 individuals, with nearly half of the global population residing in areas that have fewer than one psychiatrist per 100,000 people (United GMH, 2024).

This indicates that the majority of specialists stay in major city hospitals, whereas rural and isolated areas depend on general healthcare providers who frequently do not have the necessary training to properly diagnose and manage mental health issues. The lack of investment results in a global funding shortfall of US$200–350 billion required each year to establish robust, community-oriented services (McKinsey, 2025). While this disparity continues, effective mental health care will stay inaccessible to most of the global population.

Even though 71 nations indicate that they satisfy a minimum of three of the WHO's criteria for incorporating mental health into primary care, execution tends to be inadequate. Only 45% of countries have mental health legislation that completely aligns with international human rights standards, indicating that stigma and neglect still affect policy-making. At the same time, worldwide crises worsen the issue. Climate change, involuntary relocation, and armed conflict—all having a greater impact on LMICs—greatly elevate occurrences of depression, anxiety, and trauma. Groups residing in conflict areas, for instance, exhibit notably elevated rates of psychological distress compared to the worldwide average (Statista, 2025)

The most concerning fact is that 50% of all mental health disorders in adults start before the age of 14, with 75% emerging by the mid-20s. However, assistance for young individuals is still alarmingly inadequate. Worldwide, 1 in 7 teenagers (approximately 13%) suffers from a mental health issue (WHO, 2025; UNICEF, 2022). However, in numerous regions globally, particularly in LMICs, access to healthcare is highly restricted. Self-injury and suicide currently stand as leading causes of mortality among teenagers, with the highest prevalence observed in resource-poor environments. Kids experiencing ongoing poverty, violence, or abuse, elements largely prevalent in LMICs, are significantly

Figure 3: Visual Synthesis of Global Mental Health Inequity (Gemini, 2025).

more vulnerable to developing conditions such as anxiety or depression. Even when treatment exists, only a few young individuals access it. In nations like Kenya, Indonesia, and Vietnam, merely 4.7% to 11.9% of teenagers with a diagnosable condition receive services. This is highly alarming given that 90% of the 1.2 billion adolescents globally reside in LMICs (Zhou et al., 2020). In addition, The Yale School of Management states that the COVID-19 pandemic inflicted a profound and enduring impact on mental health in Low- and Middle-Income Countries, greatly heightening symptoms of depression. A significant study spanning eight LMICs showed that these adverse effects continued long after the initial lockdowns, not managing to "fully recover" to pre-pandemic levels even after 15 months. This ongoing crisis was intensified in LMICs by existing vulnerabilities, such as prevalent economic hardship and food scarcity, along with an already insufficient healthcare infrastructure (with some nations allocating only $0.25 per person each year for mental health). To tackle this ongoing treatment gap, the study emphasizes the pressing necessity for innovative and cost-effective solutions, like task-sharing and educating community-based lay health workers. Incorporating this affordable, accessible support into universal healthcare coverage is essential for reaching the large population in LMICs who still lack access to adequate mental health care resources.

Figure 4: COVID-19 patient taken to a hospital in Dhaka, Bangladesh (Yale, 2023.)

The disregard becomes clearer when examining resources:

- In certain areas, there is one psychiatrist for every 4–5 million teenagers.
- Fewer than 1% of inpatient mental health beds are designated for children and adolescents.
- Less than 1% of schools have mental health professionals on staff.
- Numerous nations are without up-to-date, trustworthy data, complicating the process of policy formulation.

Based on recent studies comparing health systems across different income groups, the following countries are demonstrated to be among the most affected by the systemic lack of access to mental health care:

- India: The large population means that even a lower prevalence rate can result in a huge number of people with mental illness. For example, one district in India had more people with schizophrenia than all of North America.
- Egypt and Ghana: Both countries were identified as facing mental health challenges during the COVID-19 pandemic, with particularly limited support for vulnerable populations like the elderly.

- Middle East: Regions experiencing ongoing conflict and violence have a high burden of mental health issues due to a combination of trauma, lack of access to services, and significant stigma.
- Malawi: is frequently cited as a tragic example of extreme resource limitation. The country of 20 million people has historically reported as few as four psychiatrists for the entire population, dramatically illustrating the depth of the treatment gap in Sub-Saharan Africa

KEY POINTS OF THE DEBATE

- Clarifying the balance between WHO responsibilities and national government responsibilities in expanding mental-health services in LMICs.
- Whether LMICs should prioritize expanding access to basic mental-health services or improving the quality of existing care.
- Addressing severe shortages of mental-health professionals in countries like Ethiopia, Nigeria, South Africa, and Egypt through task-shifting and international support.
- Expanding mental-health access in rural, remote, and Indigenous regions where specialists are almost entirely absent.
- The role of schools in LMICs as the primary entry point for early mental-health detection and support.
- Prioritizing child and adolescent mental-health care in LMICs, where suicide and self-harm are rising sharply.

GUIDING QUESTIONS

1. What are the main barriers to mental health services in your country (such as funding, stigma, workforce shortages, or conflict)?
2. How much does your country invest in mental health services, and is this funding sufficient to meet the needs of the population?
3. How accessible are mental health services in rural or low-income areas of your country compared to urban areas?
4. What role should the World Health Organization play in helping countries improve access to mental health services?
5. How can your country integrate mental health services into primary healthcare systems more effectively?
6. What strategies can be used in your country to reduce stigma and discrimination related to mental health?
7. How can your country improve mental health support for children and adolescents, considering that most disorders begin at a young age?
8. What solutions could help address the shortage of mental health professionals in your country (for example, community health workers or task-sharing)?
9. How have recent crises (such as COVID-19, economic difficulties, climate change, or conflict) affected mental health in your country?
10. What innovative and low-cost solutions (such as telemedicine or community-based programs) could help improve mental health services in your country?

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With the purpose of accompanying and advising the delegates in their process of formation for this UN model and this upper school committee, we, as your presidents, have some key recommendations for preparing your portfolios, intervention and overall performance in GLCMUN:

IMPORTANCE OF YOUR PREPARATION PROCESS

As you should know, during the model, it is not allowed to use electronic devices to read during your interventions, therefore it's important to have a conscious research with clarity on the topic and your position, for being able to speak with confidence with just your bullet points.

SPEECH

The way you communicate your ideas to other delegates is sometimes just as important as what you have to say. We highly recommend practicing your oratory and speech-making abilities to ensure that everyone listens.

PORTFOLIO

This is not only a tool to get to know your topic and position, it is an opportunity to prepare your interventions in advance. It is important that you include arguments and possible counter arguments for your position in your research paper.

USE DIPLOMACY

It is important to uphold the spirit of diplomacy that defines the Model United Nations. Debate with passion, but also with respect. Challenge ideas, not individuals. Listen as much as you speak, and recognize that consensus is not weakness, but strength.

MAKE USE OF THE SPACE

When doing an intervention, making use of the space allows you to impact other delegates easier and it makes your arguments stand out more.

Finally, remember to not be afraid to talk to your fellow delegates or to ask anything to us, your presidents, as MUN is based on cooperation and improvement, not perfection.