

WHO

WHO	1
Letter from the Chairs	2
Introduction to Committee	4
Topic 1: Period Poverty	5
Topic 2:	12
Sources	16



Letter from the Chairs

Dear Esteemed Delegates,

Welcome to the World Health Organisation committee for WAMUNC 2026!

I'm your head chair, Chloe, and I'm so excited to be a part of WAMUNC this year.

I've been a part of Model UN since my freshman year of high school, and am currently a freshman student at the George Washington University, double-majoring in International Affairs and International Business on a pre-law track. My hometown is Cary, North Carolina, and I am looking forward to experiencing Model UN in DC.

Our WHO committee will have two topics covering Period Poverty and Mental Health in Post-Conflict Areas. Both are critical global public health and human rights issues that I hope brings interest to our delegates! Background guides are not required for WAMUNC, although delegates are welcome to write papers as an option. Please email position papers to both chairs' emails.

We look forward to thoughtful and stimulating debate, well-researched proposals, and creative solutions that uphold health, gender equality, and human rights.

Delegates are implored to look over committee procedures and decorum during debate, and do not hesitate to reach out with questions.

Best of luck,

Chloe Kim

Head Chair, World Health Organization

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Welcome to the World Health Organization committee for WAMUNC 2026!

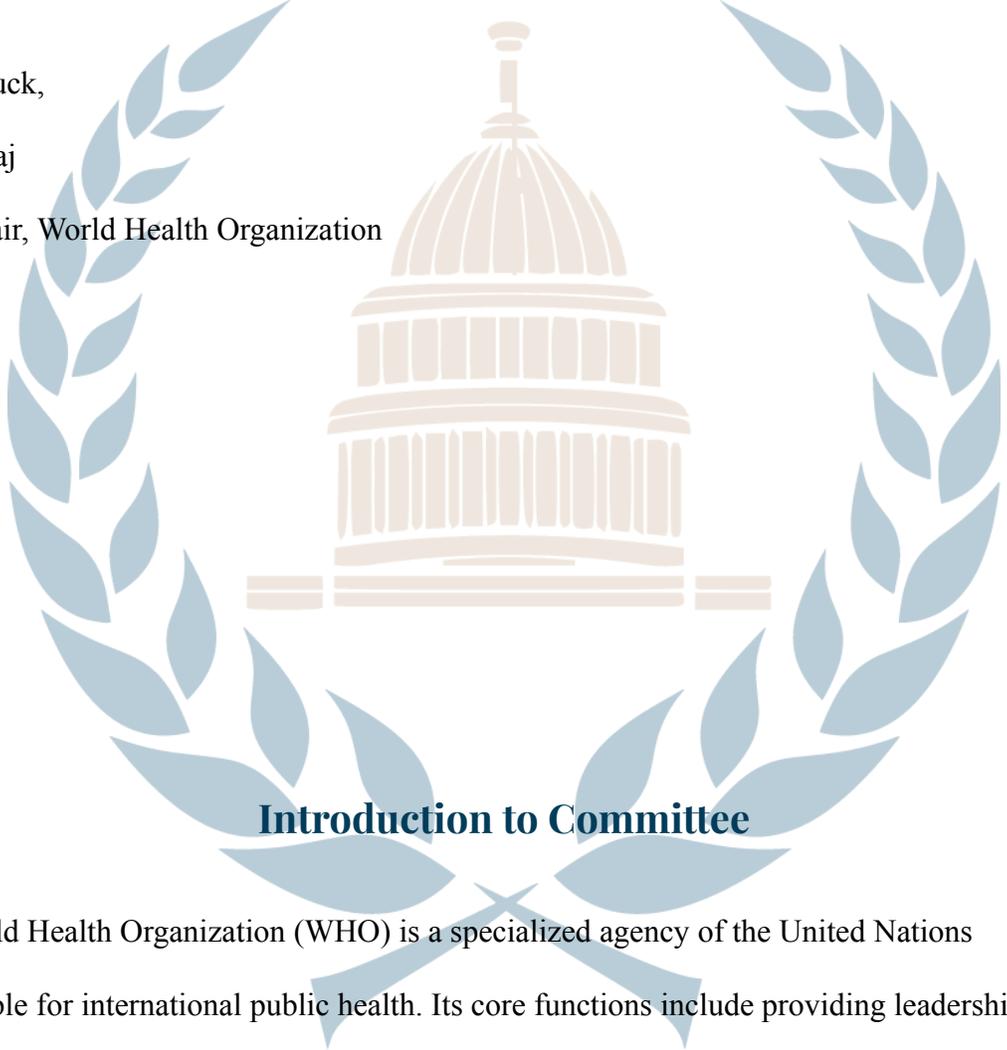
My name is Dea, and I am honored to welcome you to this year's WHO committee. I am currently a student at The George Washington University studying international affairs and economics on the prelaw track. I am thrilled to serve as a vice chair for WAMUNC and to guide you through one of the most pressing yet under-addressed global health challenges.

Background guides are not required for WAMUNC; however, they are intended to support your research and preparation. Delegates are encouraged, though not required, to submit position papers to the chairs' emails prior to the conference. We look forward to thoughtful debate, well-researched positions, and innovative solutions that uphold the principles of health equity, dignity, and human rights.

Best of luck,

Dea Rucaj

Vice-Chair, World Health Organization



Introduction to Committee

The World Health Organization (WHO) is a specialized agency of the United Nations responsible for international public health. Its core functions include providing leadership on global health matters, shaping research agendas, setting norms and standards, and supporting countries in strengthening health systems. The WHO operates on the principle that health is a fundamental human right and that achieving the highest attainable standard of health requires international cooperation.

In post-conflict and fragile settings, the WHO plays a vital role in coordinating emergency health responses, rebuilding national health systems, and integrating mental health and psychosocial support into primary health care. Through technical guidance, data collection, and partnerships with governments and humanitarian actors, WHO seeks to ensure that mental health is treated as an essential component of recovery rather than a secondary concern.

Committee Structure & Dynamics

This committee simulates a session of the World Health Organization in which delegates represent Member States and engage in consensus-driven deliberation. Unlike enforcement-based bodies, WHO operates primarily through technical guidance, norm-setting, and international cooperation. As such, delegates are expected to balance national interests with global health equity and evidence-based policymaking.

Throughout debate, delegates will articulate national perspectives on mental health challenges in post-conflict environments, drawing on country-specific data and institutional capacity. The committee will deliberate on global strategies related to health systems strengthening, humanitarian coordination, financing mechanisms, and minimum standards of care. Delegates are also encouraged to consider the roles of non-state actors, including non-governmental organizations, community health workers, and other UN agencies, in delivering mental health services where state capacity is limited. Resolutions should reflect WHO's mandate by emphasizing cooperation, feasibility, sustainability, and respect for national sovereignty.

Topic 1: Period Poverty

Background Information:

Menstruation is a natural biological process experienced by over half of the world's population. However, for hundreds of millions of people, the ability to manage menstruation safely, hygienically, and with sufficient products is scarce. The inability to access and lack of menstrual products, sanitation facilities, menstrual education, and social support is known as *period poverty*, and it represents one of the most under-recognised and under-funded issues to gender equality and public health. Although menstruation is universal, the social, economic, and political conditions surrounding it are not.

Period poverty is not just the absence of menstrual products. It includes a wide range of barriers, including the lack of clean water, private and safe toilets, disposal facilities, access to medical care, and education about reproductive health. When any of these elements are missing, individuals are forced to manage menstruation in unsafe or humiliating ways, often using unhygienic materials or avoiding school, work, or social life altogether. The World Health Organization (WHO) defines menstrual health as a state of complete physical, mental, and social well-being in relation to the menstrual cycle. Under this definition, period poverty is not merely a hygiene problem but a systemic public health and human rights issue.

Globally, an estimated 500 million people lack access to the resources necessary to manage menstruation safely. Period poverty exists in both developing and developed countries, though it takes different forms. In low- and middle-income countries, it is often driven by the high cost or unavailability of menstrual products, weak water and sanitation infrastructure, and limited health education. In high-income countries, the problem is more closely tied to income inequality, homelessness, and the rising cost of living, which forces many to choose between food, rent, and

menstrual supplies. Across all contexts, social stigma and silence surrounding menstruation further isolate those affected and prevent effective policy responses.

There are many consequences to period poverty that the WHO is concerned about. From a health perspective, the use of unhygienic materials such as rags, paper, or unsanitized materials increases the risk of urinary tract infections, reproductive tract infections, and other medical complications. Without access to clean water and soap, individuals cannot properly wash themselves or their reusable products, increasing exposure to bacteria and disease. Over time, these health issues can lead to chronic pain, infertility, or life-threatening conditions. Menstrual discomfort combined with fear of leaks or odour also creates psychological stress, anxiety, and embarrassment, undermining overall well-being.

Education is one of the most visibly affected areas. In many parts of the world, adolescent girls miss school during menstruation due to the lack of products, private toilets, or disposal facilities. In some regions, schools do not provide separate toilets for girls, and many lack doors, water, or bins, making it impossible to manage menstruation discreetly. Over time, repeated absences contribute to lower academic performance, higher dropout rates, and reduced access to future employment opportunities.

Geographically, period poverty is most widespread in regions facing persistent poverty and infrastructure gaps, particularly in Sub-Saharan Africa, South Asia, parts of the Middle East, and Latin America. In Sub-Saharan Africa, many schools lack the most basic sanitation facilities needed for menstrual management, and in rural areas, menstrual products may be unavailable or unaffordable. In South Asia, cultural taboos surrounding menstruation often compound material shortages, leading to practices that isolate menstruating individuals from family, school, and community life. Refugee camps and conflict-affected regions face even greater challenges, as

humanitarian aid systems may not prioritise menstrual supplies, and overcrowded or unsafe sanitation facilities make private menstrual care nearly impossible.

Period Poverty is not exempt from wealthier countries. In countries such as the United States and the United Kingdom, low-income individuals, homeless populations, and refugees frequently struggle to afford menstrual products, which are often excluded from social assistance programs.

Economic inequality limits the ability of individuals and families to purchase menstrual products, particularly in countries where they are heavily taxed or imported. Weak public health systems fail to provide education about menstruation, leaving young people unprepared and vulnerable to misinformation. Countries like Algeria have increasingly high rates of period poverty, where it costs almost 14.8% of a person's monthly income to purchase menstrual products. The lack of funding and economic crises are leading to rising prices for menstrual products, and the lack of education that pushes these products to be a human right are worsening conditions for millions of people.

Despite growing international attention, significant data gaps remain. Many countries do not collect or report detailed information on menstrual health, making it difficult to track progress or design effective interventions. Without reliable data on access to products, facilities, and education, menstrual health remains marginalised in national health strategies and development plans. This lack of visibility contributes to the continued neglect of period poverty at both national and international levels.

Period poverty is therefore not only a matter of hygiene but a reflection of broader inequalities in health, education, gender, and economic opportunity. It affects the ability of millions of people to live with dignity and to participate fully in society. For the World Health Organization and the international community, addressing period poverty is essential to

advancing universal health coverage, gender equality, and the Sustainable Development Goals. Without meaningful action to ensure that menstruation is managed safely, affordably, and without stigma, the promise of global health and human rights will remain incomplete.

Statistics and Data on the General Topic of Period Poverty

Every month, an estimated 1.8 to 2 billion people worldwide menstruate as a natural biological function, with nearly 800 million individuals menstruating on any given day. Despite its universality, data consistently show stark disparities in access to menstrual products, sanitation facilities, and education necessary to manage menstruation with dignity.

An estimated 500 million women and girls lack access to adequate menstrual hygiene facilities, including safe toilets, water, disposal systems, and menstrual products. These deficiencies have profound repercussions across multiple dimensions of life. For example, periodic school absenteeism remains a statistically documented consequence: in regions of sub-Saharan Africa, approximately 1 in 10 girls miss school during their menstruation due to inadequate facilities and cultural stigmas. UNICEF-led data from the Middle East and North Africa reveals that nearly 30 % of girls miss some or all of school during their period, while 20 % lack essential information about menstruation.

Sanitation infrastructure deficits are also in a crisis. According to a 2024 WHO/UNICEF report, an estimated 1 in 5 children globally lack basic drinking water or sanitation services in schools, and 1 in 3 lack access to basic hygiene services such as hand-washing facilities, which directly undermines safe menstrual management. Furthermore, nearly 1.5 billion people worldwide lack basic sanitation services, hindering the ability of many to manage menstruation privately and hygienically.

Although progress has been made in recent years, significant gaps remain in global monitoring of menstrual health, particularly in low-resource areas, limiting policymakers' ability to design targeted interventions and measure their impact effectively.

Past Actions by the United Nations, WHO, and Relevant Actors

The World Health Organization has recognised menstrual health as a core public health and human rights concern. In its 2022 statement to the United Nations Human Rights Council, the WHO emphasised that menstruation must be addressed through a comprehensive framework that includes health services, education, water and sanitation, and gender equality. WHO has warned that failing to provide adequate menstrual health support violates fundamental rights, including the right to health, education, work, and non-discrimination.

In June 2022, WHO issued a statement on menstrual health and rights at the Human Rights Council, emphasising that menstrual health must be integrated into health systems, education settings, water and sanitation planning, and gender equality strategies. WHO has continued to advocate for multisectoral action. In 2023, WHO partnered with UNICEF, UNFPA, UNESCO, the Global Menstrual Health Collective, and research institutions to advance menstrual health commitments within the Water Action Agenda at the UN Water Summit. These commitments call on countries to integrate menstrual health into universal health coverage policies and national sanitation strategies, acknowledging that access to menstrual products, water, sanitation, and hygiene education is essential to health and gender equity.

At the policy level, the 56th session of the UN Human Rights Council in 2024 adopted a landmark resolution recognising menstrual health as a fundamental human right. This resolution calls for universal access to affordable, safe menstrual hygiene products and adequate water and

sanitation facilities, particularly in rural and underserved areas, and urges states to improve infrastructure in public spaces, including schools.

National and regional actions further illustrate progress at the country level. For example, Scotland became the first jurisdiction to legally mandate free access to menstrual products, requiring local authorities and educational institutions to make products available at no cost, a policy now regarded as a model of menstrual equity. In Spain, the Catalonia region implemented a pioneering program that distributes free reusable menstrual products through pharmacies to millions of people.

However, menstrual health and education are falling behind in providing sufficient aid and action to low-resource countries and are a growing issue today. Data gaps persist, and implementation of national menstrual health strategies varies widely with uncertain global standards for menstrual health.

Questions to Consider:

- How will funding be managed to solve period poverty? Who provides and receives funding?
- Which countries and demographics are most in need of menstrual products?
- How should the World Health Organization define minimum global standards for menstrual health and hygiene?
- Is menstrual health primarily a public health issue, a human rights issue, or both?

- Do cultural taboos and practices interfere with WHO regulations and standards for menstrual rights?
- How does sustainability come to play when producing/providing menstrual products.
- How can period poverty be addressed in humanitarian and refugee settings?

Topic 2:

Background Information

Armed conflict leaves profound psychological scars that persist long after physical violence subsides. Post-conflict areas are regions emerging from war, civil unrest, or prolonged instability, where populations have been exposed to displacement, loss of life, sexual violence, forced recruitment, and chronic insecurity. These experiences significantly elevate the risk of mental health conditions such as post-traumatic stress disorder (PTSD), depression, anxiety disorders, and substance abuse.

Mental health systems in post-conflict states are often severely weakened. Hospitals and clinics may be destroyed, trained professionals displaced or killed, and government capacity eroded. In many cases, mental health services were limited even prior to conflict, leaving countries ill-equipped to address the surge in psychological needs that follows violence. As a result, mental health care is frequently inaccessible, underfunded, or centralized in urban areas, excluding rural and displaced populations.

Beyond individual suffering, widespread untreated trauma can undermine societal recovery.

Communities affected by collective trauma may struggle with social cohesion, trust in institutions, and reconciliation processes. Former combatants and survivors alike may face barriers to reintegration, perpetuating cycles of violence, poverty, and instability. Mental health

in post-conflict settings is therefore not only a medical issue but a foundational component of peacebuilding and development.

Why This Issue Matters

Mental health is a critical yet often neglected pillar of post-conflict recovery. Failure to address psychological trauma can slow economic reconstruction, weaken governance, and increase the likelihood of renewed violence. Individuals living with untreated mental health conditions may face stigma, unemployment, social isolation, and increased vulnerability to exploitation.

From a global perspective, prioritizing mental health aligns with multiple United Nations objectives, including Sustainable Development Goal 3 (Good Health and Well-Being) and Sustainable Development Goal 16 (Peace, Justice, and Strong Institutions). Addressing mental health in post-conflict areas is essential to ensuring that peace is durable and inclusive, rather than fragile and temporary.

Statistics and Data on Mental Health in Post-Conflict Areas

Exposure to armed conflict significantly increases the prevalence of mental health conditions among affected populations. Research consistently shows that rates of post-traumatic stress disorder, depression, and anxiety in conflict-affected populations are multiple times higher than global averages. In many post-conflict countries, the availability of trained mental health professionals is extremely limited, with fewer than one psychiatrist or psychologist per 100,000 people, compared to more than ten per 100,000 in high-income countries.

The treatment gap remains severe. In some post-conflict and humanitarian settings, up to ninety percent of individuals living with mental health conditions receive no formal care. Despite the scale of need, mental health and psychosocial support programs receive only a small share of

overall humanitarian health funding. Data collection and monitoring also remain limited, as fragile health systems often lack the institutional capacity to track mental health outcomes. This lack of reliable data further obscures the true scale of the crisis and complicates the design of effective, targeted interventions.

High-Focus Post-Conflict Areas

Delegates are encouraged to ground their research and policy proposals in specific national and regional contexts. Several post-conflict and conflict-affected countries illustrate the scale and diversity of mental health challenges faced globally. South Sudan continues to experience widespread displacement and insecurity, paired with minimal mental health infrastructure. The Democratic Republic of the Congo has endured decades of conflict marked by sexual violence and mass trauma, while possessing only a severely limited mental health workforce. Syria's prolonged civil war has resulted in extensive civilian trauma and one of the largest displacement crises in modern history. Afghanistan's population has experienced decades of violence alongside increasing barriers to accessing health services. Iraq faces ongoing challenges related to post-ISIS recovery and the reintegration of displaced populations. Ukraine continues to experience active conflict, producing large-scale civilian trauma and internal displacement. Colombia, while formally post-conflict following its peace agreement, continues to confront mental health disparities, particularly in rural areas and among formerly displaced communities.

Past Actions by the United Nations, WHO, and Relevant Actors

The United Nations and WHO have increasingly recognized mental health as an essential component of humanitarian response and post-conflict recovery. WHO's Mental Health Gap Action Programme (mhGAP) seeks to scale up services for mental, neurological, and substance use disorders, particularly in low-resource and conflict-affected settings. Through mhGAP,

non-specialist health workers are trained to deliver basic mental health care within primary health systems.

The Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings provide a framework for coordinating responses across humanitarian actors, emphasizing community-based support, protection, and the integration of mental health into broader health and social services. WHO also collaborates closely with UNICEF, UNHCR, and NGOs to deliver mental health services in refugee and internally displaced person (IDP) camps.

Despite these initiatives, implementation remains uneven due to funding constraints, stigma, insecurity, and weak governance. The gap between policy commitments and on-the-ground delivery continues to challenge effective mental health responses in post-conflict contexts.

Questions to Consider

As delegates prepare for debate, they should reflect on several guiding questions:

- What are the most pressing mental health challenges facing post-conflict populations in your assigned country, and how do these challenges differ across demographic groups?
- How can the World Health Organization support Member States in rebuilding mental health systems while respecting national sovereignty and cultural context?
- Should WHO advocate for global minimum standards for mental health and psychosocial support in post-conflict settings, and if so, what should those standards include?
- How can mental health services be integrated into primary health care and humanitarian aid?
- How can sustainable financing be secured beyond emergency response?

- How mental health initiatives can contribute to reconciliation, reintegration, and long-term peace?

Sources

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