

Forum: World Health Assembly

Issue: Addressing the mental health crisis among refugees in post-conflict zones

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Introduction

In the past decade, there has been an unprecedented surge in the number of displaced individuals worldwide, with more than 123 million individuals globally displaced by war, armed conflict or persecution. 43.7 million of the 123 million displaced are classified as refugees. These individuals face severe psychological strain prompted by prolonged experiences of violence, displacement, and squalid conditions of livelihood. Such psychological strains stemming deep in the refugee population increase the risk of developing detrimental mental health conditions, including post-traumatic stress disorder (PTSD), anxiety, or depression. Despite recognition of this notion of refugee vulnerability, humanitarian awareness of refugee mental health conditions is significantly lacking compared to other forms of healthcare systems, particularly in post-conflict zones where healthcare systems are critically fragile and disrupted.

In a 2024 National Library of Medicine mandated meta-analysis, a prevalence estimate of 24% for PTSD symptoms and 26% for depressive features was discovered among war-affiliated civilians, which is 5 times that of aforementioned symptoms in regular populations, illustrating acute necessities for mental healthcare accessibility. Exacerbating this crisis, post-conflict zones often lack the legal status, resources, and culturally appropriate services to acquire fundamental mental healthcare. The limited mental-healthcare accessibility is not confined to purely conflict-affiliated regions, but also in high-income and non-conflict states, particularly the United States, only 3% of US resettled refugees have been referred to legitimized mental health treatment (Figure 1).

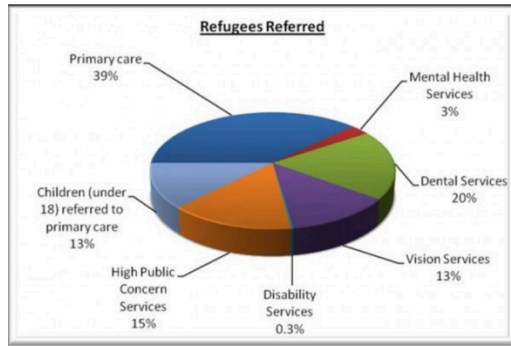


Figure 1 – ORR Refugee Health Newsletter, 2013(Office for Refugee Resettlement)

This chair report will exemplify the primary fuel and history for the crisis of refugee mental health, along with significant actors, current efforts and potential avenues for further solutions.

Key Terminology

Refugees

Refugees are individuals who are forced to exit their home countries due to conflict, violence, or prosecution in the interest of a safer and stabler life in another nation. Refugees often seek asylum status in order to receive protection and recognition under international law.

Internally-Displaced Person(IDP)

Unlike refugees, an internally-displaced person is an individual who is forced to exit their homes due to extensive conflict, violence, or disasters, but remain in their home country's territory.

Post-Conflict Zones

Post-Conflict Zones are regions in the phase of emerging out of armed conflict and violence, transitioning towards a more stable and peaceful region. Post-Conflict Zones' transition to a stable and peaceful region often require particular interventions to address or assist its emerging challenges.

Post-Traumatic Stress Disorder(PTSD)

Post-Traumatic Stress Disorder or PTSD is a mental health condition prompted by inhumane and unethical trauma such as disasters, war, or extensive assault. Symptoms of PTSD include intensive flashbacks, nightmares, and anxiety. People with PTSD experience critical ripples across their daily lives, often rivaled with isolation, mistrust and elevated probabilities of other mental health conditions.

Secondary Traumatic Stress(STS)

Secondary Traumatic Stress, or STS, is a distress compelled by indirect exposure to trauma that can span from the emotional to physical level. Examples of indirect exposure include heeding graphic accounts of trauma, viewing distressing images, or caring for traumatized victims.

Culturally-Appropriate Services

Culturally-Appropriate Services are humanitarian services that are tailored to respect a victim's culture, linguistics, and unique beliefs or rituals. Culturally-appropriate services ensure the reduction of disparities within humanitarian aid, improvising the quality of care among individuals in need of support.

Post-Migration Stressors

Post-Migration Stressors are persisting challenges immigrant refugees face after entering another nation. Examples of such stressors include financial strain, discrimination, and social isolation. Post-Migration Stressors can also include fears of being deported and uncertain legal status, especially for refugees who have not pursued asylum status.

Structural Barriers

Structural barriers are systematic obstacles that disadvantage particular groups, limiting equal accessibility towards pivotal resources, services or opportunity. Such obstacles are often stemmed deep from societal structures; for example, racism, economic inequality, or remnants of a patriarchy.

Evidence-Based Therapy(EBT)

Evidence-Based Therapies are scientifically researched therapeutic treatments for mental health conditions, aiming to improve specific behaviors, emotions and patient-specific fears.

Background

The Impacts of Escalating Numbers of Conflicts

Since 1990, the protracted complexities of conflicts, disputes, and violence have severely deteriorated the global security environment. By 2024, a historic high of 61 active conflicts were officiated by the Uniform Collateral Data Portal (UCDP), an increase from 59 in the previous year and the highest number since 1946. On the other hand, through exponentially growing spending targets on conflict-related technology, state-centered war has multiplied, and fighting has intensified both in its magnitude and systemic destruction of infrastructure. Russia's invasion of Ukraine has marked Europe's first interstate war since 1945, culminating in 40,000 civilian casualties and 800,000 military casualties from both parties in 2025 alone. The heavily intertwined situation in Gaza further exemplifies this pattern, with 83% of all casualties classified as civilian. The pattern of protracted conflict not only brews tragic amounts of lives lost, but also unforeseen levels of forced displacement, civilian exposure to violence, persecution, and instability. The aforementioned issues resemble the primary fuel of trauma-related mental health conditions, particularly regarding the population of refugees.

As conflict intensifies, secondary impacts increase substantially. Organized conflicts prompt higher probabilities of life-threatening experiences, particularly bombardment, torture, the loss of family members, and sexual violence. Via recurring exposure to such traumatic stressors, the risk of mental health conditions substantially increases. In 1994, during the 100-day length of the Rwandan Genocide, an estimated 500,000 to over 600,000 Tutsi people were killed, and 250,000 to 500,000 women faced unrestricted sexual violence. Figures 2 and 3 below are visualizations published on BioMed Central (BMC Public Health) of traumatic events experienced by the Rwandan people during the Genocide.

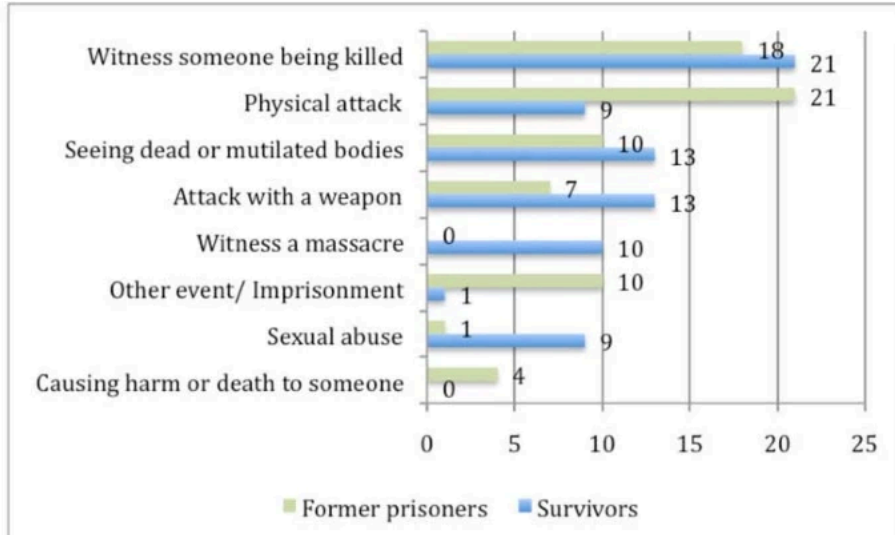


Figure 2: Bar graph of the percentages of the worst traumatic event types reported by the group of survivors and former prisoners during the Rwandan Genocide

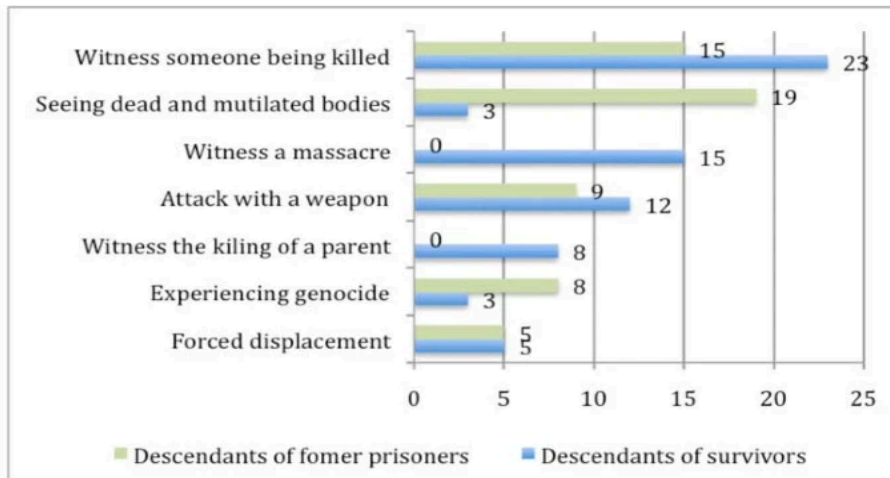


Figure 3: Bar graph of the percentages of the worst traumatic event types reported by the group of descendants of survivors and descendants of former prisoners during the Rwandan Genocide

Alongside these horrific instances of cumulative trauma, the genocide has also decimated the Rwandan population, infrastructure, and destabilized government systems.

Destruction led by the Hutu militias left the Rwandan post-conflict zone in multiple dimensions of disarray. Figure 4 below is a linear graph published by The Guardian of

Rwanda's GDP per capita, illustrating a sharp decline during the 1994 Genocide.

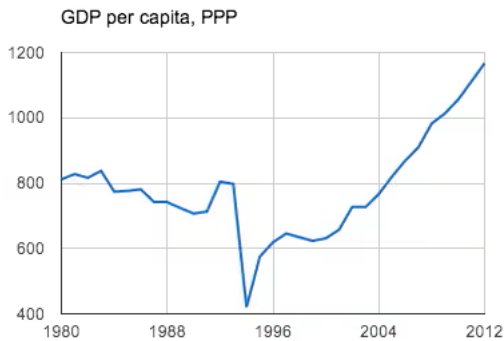


Figure 4: Linear progression graph publicized by The Guardian (2014) of the GDP per capita of Rwanda

Beyond the catastrophic loss of lives and the dismantling of the country's socioeconomic fabric was the internal displacement of approximately 2,000,000 Rwandans, compelling an urgent humanitarian crisis. Many who lacked sufficient opportunities to exit the shattered Rwanda became internally-displaced persons trapped in the overcrowded and squalid post-conflict zone, challenged with inadequate life necessities and medical care. Simultaneously, over 550,000 Rwandan refugees exited across international borders into neighboring countries, including Zaire(now Democratic Republic of Congo) and Tanzania, facing similar turmoil in refugee camps set up by host nations and international bodies.



Figure 5: Artifact of Rwandan refugees in Zaire, 1997



Figure 6: Artifact of Internally Displaced Persons of Rwanda, 1994

Intensified fighting, war technologies, and disputes only leave a legacy of more dilapidated aftermaths, with unsanitary and precarious conditions magnifying the vulnerabilities of developing PTSD, depression, and anxiety among conflict-affiliated populations.

Flaws of Systemic Humanitarian Aid

Currently, the global humanitarian system is centralized under the anchor of the United Nations and its Office for the Coordination of Humanitarian Affairs(OCHA), a UN secretariat body responsible for responding to crises and coordinating international relief efforts. Although the OCHA, along with its affiliated organizations, including but not limited to the UNHCR, UNICEF, and the WHO, already possess the capacities for fundamental support(food, water, shelter, and medical aid), aid still struggles to reach an estimated 300 million people in need of urgent assistance, particularly the demands of the forcibly displaced. According to the UNHCR, the number of refugees has surged to over 43.7 million, and the forcibly displaced population has surged to over 117 million individuals due to conflict, persecution, and violence, pressuring the already overburdened humanitarian response. In addition to chronic funding gaps, according to the WHO and the Mental Health Atlas, today, only 43% of all countries are prepared for mental health and psychological support (MHPSS) during emergencies. Despite sturdy growth since its last documented 28% in 2019, the limited resources of mental health care are still treated as optional and are often overlooked during a crisis. The WHO claims that 1 in 5 people who live in emergencies bear with a mental health condition. Other than the pre-existing funding gaps, the global humanitarian system is reliant on the coherence of all contributing states, specifically, in 2024, the United States held a 43% share of international humanitarian assistance due to its active humanitarian aid in Ukraine and other emergency regions. In early 2025, influenced by the foreign policy decisions of the US, sudden withdrawals of international funding resulted in a 96% decline in country requests for essential psychotropic medicines. Consequently, MPHSS services will

continue to fall short of needs.

Figure 1.1: CVA volumes, people in need and USG funding reduction

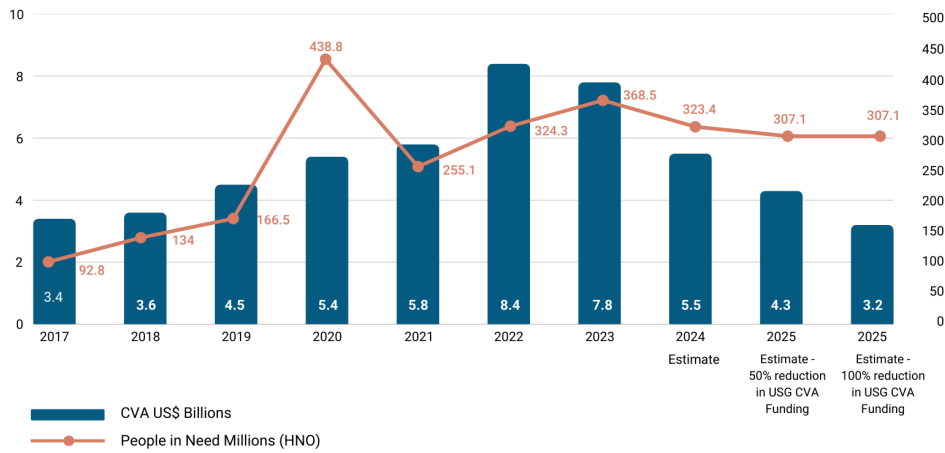


Figure 7: Bar graph by CALP Network, illustrating the plummet of global humanitarian cash and voucher assistance(CVA) in 2025, contributed by the US Government funding reduction

The global humanitarian system’s flawed nature of its structural reliance, chronic resource shortages, and inconsistent funding results in mental health and psychosocial support becoming a secondary concern, leaving MHPSS as severely underfunded and unequipped to comply with escalating demands in crisis settings.

Major Parties Involved

World Health Organization(WHO)

The WHO is a UN agency dedicated to responding to international public health crises and issues. Within its responsibilities, the WHO has long emphasized mental health among refugees through co-chairing the Inter-Agency Standing Committee(IASC) reference group on MHPSS in emergencies, as well as its leadership roles in pivotal mental health initiatives such as the Comprehensive Mental Health Action plan adopted in 2013, and pursued until 2030, which urges the integration of refugee health into national health notions. The WHO has also issued a range of guidelines, including the Mental Health Gap Action Programme (mhGAP) human resource guidelines and

factsheets on migrant mental health, which encourage community efforts, social acceptance, and the integration of mental health care into primary healthcare policies. The WHO consistently partners with the UNHCR, UNICEF, and OCHA to respond critically to conflict- and disaster-driven crises by deploying essential life necessities and mental health care professionals and by emphasizing its mental health care principles in support of post-conflict regions.

United States of America

Historically, the US has been both a major donor and a refugee host, with localized agencies such as the Office of Refugee Resettlement (ORR) overseeing and screening refugee health in the US. Refugees arriving in the US are all obliged to receive a health assessment covering mental health; however, implementation after preliminary screening assessments remains lacking. In a 2018 data-driven report by the American Psychiatric Association, it is claimed that “only about 3% of refugees are referred to mental health services following screening.” The US is the largest humanitarian donor and remains so despite major cuts influenced by its foreign affairs. Historically, the US has provided over 40% of global humanitarian funds, enabling US funding priorities to heavily influence refugee aid services, including MHPSS. Furthermore, alongside major NGOs such as the International Rescue Committee, Hebrew Immigrant Aid Society, and Global Refuge, the US continually develops culturally appropriate systems that increasingly emphasize mental health referrals.

United Nations Office for the Coordination of Humanitarian Affairs (OCHA)

OCHA is the UN Secretariat body responsible for coordinating the global humanitarian response. OCHA directs appeals and plans that revolve around the mandatory funding of MHPSS. In line with the IASC guidelines, OCHA enables partnerships with other UN agencies to integrate psychosocial assistance into emergency response mechanisms. In November 2024, OCHA co-hosted a UN-level gathering with the WHO, UNICEF, and the UNHCR to launch new initiatives to elevate and expand humanitarian responses to mental health in crises, notably the Greentree Acceleration Plan. OCHA’s coordinative role on mental health advocacy and resource allocation is undoubtedly pivotal to both

pre-existing and future fixating efforts on mental healthcare among individuals in post-conflict zones.

United Nations High Commissioner for Refugees

The UNHCR is the main UN refugee agency, providing humanitarian assistance to refugees worldwide. UNHCR's strategic assistance, aimed at integrating MHPSS programs, enables mental healthcare services to extend into refugee camps and post-conflict settings. UNHCR's efforts on building local capacity through refugee community counselor training and MHPSS integration into health clinics enable the development of more holistic health services in post-conflict zones. The UNHCR also advocates for host governments to actively integrate refugees into state mental health systems, which further calls upon psychosocial support services.

United Nations Children's Fund (UNICEF)

The United Nations Children's Fund magnifies the mental health issue among child refugees. As of 2024, child refugees make up roughly 40% of all refugees worldwide, which emphasizes the need for child-friendly psychosocial welfare. UNICEF's efforts to improve child psychosocial health include its Child-Friendly Spaces and the UNHCR and UNICEF jointly mandated Blue Dot Centers in Ukraine. UNICEF's efforts, along with the partnerships with other agencies worldwide, illustrate its intent to mainstream mental health towards child protection, education, and welfare services.

Non-Governmental Organizations(NGOs)

In the global humanitarian context, NGOs often fill gaps left by the system's lack of localization. Since the overstretched systems of both government and state services struggle to meet all needs, NGOs become the main providers of counselling and psychosocial aid, especially when state or UN infrastructure is absent or weak. Large NGOs such as Doctors Without Borders, the International Rescue Committee, the Norwegian Refugee Council, Save the Children, the Global Compact on Refugees, and others all commit to vast-scale, crucial outreach across multiple post-conflict zones. In 2024, Doctors Without Borders reported offering 506,000 individual mental health

consultations through its global psychosocial clinics. Furthermore, NGO partnerships with agencies enable the implementation of community-based models, particularly for MHPSS training. Through NGOs' autonomy, they become pivotal in enhancing cultural appropriation, eliminating linguistic barriers, and improving sustainability in post-conflict settings. In Lebanon, the UNHCR and Save the Children co-led a community-based MHPSS pilot for Syrian refugees from 2021 to 2023. This programme, funded by the UNHCR, implemented Save the Children-coordinated outreach volunteer training and youth life-skills sessions, underscoring the role of NGOs in delivering humanitarian efforts on peer support, psychosocial first aid, and localized mental health care.

Timeline of Events

Date	Description/Note
May 27th, 2013	During the 66th World Health Assembly, the WHA adopted the WHO Comprehensive Mental Health Action Plan 2013–2020, which called for more effective governance, the integration of mental health and social care services in community-centered settings, and the implementation of promotion and prevention strategies, with strengthened information, evidence, and research mechanisms.
May 28th, 2019	During the 72nd World Health Assembly, the WHO Comprehensive Mental Health Action Plan 2013–2020 was extended for ratification until 2030, with long-term commitments to elevate global mental health responses.
November, 2024	Co-hosted by the Chair of Wellcome Trust, OCHA, WHO, UNHCR, and UNICEF, the UN Deputy-Secretary General establishes a UN-level meeting on “Mental Health in Humanitarian Settings”, with gatherings of donors, experts, and related professionals, initiating the planning stage of the Greentree Acceleration Plan.
September 23rd, 2025	The Greentree Acceleration Plan officially launches with supportive funding from the Wellcome Trust (\$13.2 Million); the initiative pledges to embed mental and psychosocial healthcare in humanitarian settings.

Previous Attempts/Solutions

Although a number of previous efforts and solutions have aimed to address refugee mental health in humanitarian backgrounds, all have produced complex outcomes. The WHO and its partner agencies have culminated in a multitude of global frameworks, including the Mental Health Action Plan and the IASC emergency guidelines, to facilitate policymakers in post-conflict zones. In line with national execution, Turkey, Lebanon, and Jordan are exemplary governments that have expanded community MHPSS through alignment and partnership with the WHO and have trained staff to manage conflict-related trauma. UNICEF's efforts through establishing secure, child-friendly spaces and trained child counselors, offering fundamental psychosocial support to child refugees in migrant states. Furthermore, NGOs of the Hebrew Immigrant Aid Society, the International Rescue Committee, and Doctors Without Borders also operate similar mental healthcare projects in camps and post-conflict zones.

Nonetheless, solutions mostly fall short in meeting needs. Global screening data from the American Psychiatric Association reveals that only 43% of all countries have the planned capacity to address mental health emergencies, which translates to MHPSS demands remaining to be marginalized and insufficient in logistics. Few isolated programs have illustrated success; for example, trauma therapy groups in Sri Lanka following the Sri Lankan Civil War, lasting from 1983-2009, and culturally appropriate social worker models in East Africa (Rwanda, Uganda, and Kenya) to combat the impact of widespread conflict. However, the lack of sustainable pathways, funding, and cultural barriers emphasizes the scaling stigmas of similar projects. As of 2022, Jordan hosts over 650,000 Syrian refugees, where numerous studies have discovered multiple barriers to accessing mental health care. In a qualitative study conducted by the East Mediterranean Health Journal in 2022, it was discovered that Syrian refugees in Jordan lack mental health literacy, which translates to the lack of recognition and acknowledgement of MHPSS among the refugee population. Low mental health literacy among the refugee population is primarily compounded by the critically short supply of Arab-speaking clinicians, costly treatment stemming from inadequate funding, and looming social stigma, in which many Syrians fear being distanced, labeled, or discriminated against due to their mental illness.

The emerging three themes of the lack of MHPSS awareness, affordability, and social discrimination keep most mentally-ill refugees peripherally engaged with care, weakening sustained treatment demand and adherence, inhibiting the scalability of MHPSS initiatives beyond temporary, individual-oriented services.

Despite most being in short supply, it is still crucial to acknowledge the pilot and awareness frameworks and projects that have addressed this, as they will only pave the way for a more robust pipeline for future efforts and solutions.

Potential Solutions

Given the chronic underfunding and structural barriers to concurrent healthcare in post-conflict zones, delegates should pursue solutions that address both long-term capacity development and short-term emergency-specific interventions. Delegates should also reference current solutions from the Greentree Acceleration Plan, the Comprehensive Mental Health Action Plan 2013–2030, and the WHO, IASC, and mhGAP guidelines on integrating mental healthcare as primary healthcare priorities while upscaling community-centered approaches. Community-centered approaches translate into sensitive care that requires culturally appropriate services and yields measurable outcomes.

Delegates are encouraged to allocate a fixed percentage of humanitarian aid, funds, or deployment to mental health and psychosocial support within the context of initiatives such as the Greentree Acceleration Project, with a policy focus on mobilizing additional funds and resources. Such solutions should address and dismantle the current structural barriers in the global humanitarian system. Member states and parties can enter this effort, committing contributions for MHPSS in local refugee crises.

Delegates are recommended to reference UNICEF approaches to capture solutions that facilitate young refugee-specific psychosocial care, including school-based counseling, trained, trauma-informed teachers, and designated play therapies, leveraging modern

technologies such as AI. Delegates should advocate for child education and protection policies in refugee camps and schools.

Cross-sectoral policies are another way to address the determinants of post-conflict zones, particularly by advocating for refugee access to housing, legal aid, and education. Delegates could propose methods such as work permits or offering cash assistance to eliminate barriers that elevate asylum seekers' or IDPs' anxiety in reforming post-conflict zones, indirectly resolving sources of further trauma.

The WHO and multiple partners specifically note that social aid workers themselves are exposed to traumatic recounts, experiences, and visualizations that may compel secondary traumatic stress. Solutions should include evidence-based therapies and training for first responders on coping mechanisms to prevent burnout or STS among humanitarian staff.

When lobbying and facilitating viable solutions, the feasibility of solutions is an area often overlooked. Delegates must balance humanitarian ambition with complex political, logistical and fiscal landscapes. Sustainable reform demands ascending implementation, measurable outcomes, and strong adherence to already existing framework realities to secure both ratification and impact.

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