

CHANTILLY MODEL UNITED NATIONS PRESENTS

WHO



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Committee Background

Established in 1948, the World Health Organization (WHO) is the United Nations' specialized agency for international public health. Its mandate is ambitious yet essential, which is to ensure the highest possible level of health for all people. Headquartered in Geneva, WHO operates in over 150 countries and includes 194 member states, making it one of the most globally represented UN bodies. It leads health campaigns, manages emergency responses, sets evidence-based international standards, and helps countries strengthen their healthcare systems.

Over the decades, WHO has led major global initiatives, including the eradication of smallpox, the near-elimination of polio, the expansion of vaccination programs, and the establishment of the International Health Regulations (IHR), which require member countries to report certain outbreaks. WHO also introduced the International Classification of Diseases (ICD), used by health professionals in over 100 countries. In addition, it coordinates responses to global pandemics such as H1N1, Ebola, and COVID-19. Specifically, it develops guidance, training, and resources for public health systems.

WHO works through a three-tier system: the World Health Assembly (WHA), which determines policies; the Executive Board, which ensures those policies are implemented; and the Secretariat, which carries out day-to-day operations globally. WHO also partners with academic institutions, private companies, and governments to drive innovation and knowledge-sharing.

Despite its reach, WHO faces structural limitations. It does not have enforcement power and must rely on diplomacy and cooperation. It also depends on voluntary donations for most of its budget, which are often earmarked, limiting flexibility. Political tension, misinformation, and uneven infrastructure across member states can also slow progress. Nevertheless, WHO's leadership in promoting universal health coverage, mental health services, and pandemic preparedness is more critical than ever.



Topic A: Combatting Colorism and the Skin Whitening Industry in South Asia

Colorism, the societal preference for lighter skin, remains deeply embedded in South Asia, influencing media, employment, marriage prospects, and even healthcare. Unlike racism, colorism operates within racial or ethnic groups and is often passed down across generations. It is amplified by colonial legacies, caste structures, globalized beauty standards, and relentless marketing by cosmetic companies.

The skin whitening industry is worth billions, with South Asia as one of its largest consumer markets. Products include creams, soaps, face masks, injections, and intravenous treatments. These items are marketed with slogans like “glow up” or “fair and lovely,” reinforcing the idea that lighter skin leads to success, confidence, and desirability.

Many of these products are not only ineffective but dangerous. Mercury, hydroquinone, and corticosteroids—found in popular products—can cause kidney failure, neurological damage, premature aging, skin infections, and even cancer. Despite bans in some countries, these products remain widespread due to weak regulation and enforcement. Additionally, social media and online markets allow banned products to be sold without oversight.

The mental health effects of colorism are severe. Young people especially are vulnerable to low self-esteem, anxiety, and internalized inferiority. Colorist narratives also disproportionately affect darker-skinned women, leading to lifelong psychological trauma. In some communities, infants are exposed to fairness creams within months of birth, reflecting how deeply ingrained these ideals are.

Efforts to counter this trend are growing. India’s Advertising Standards Council has started regulating fairness claims. Major companies like Unilever have renamed products to remove “fair” from branding. But these are surface-level shifts. What’s needed is a regional, health-focused approach that includes education, stronger labeling standards, and a mental health framework.



WHO can support South Asian governments by offering safety benchmarks for skincare, guiding mental health outreach, and fostering collaboration across ministries of health, education, and media. Delegates must examine not only public health risks, but also the cultural shifts required to dismantle colorism at its roots.

Additional Questions to Consider:

1. Should WHO advocate for a regional regulatory body to standardize labeling and ingredient bans in South Asia?
2. How can schools and youth programs be integrated into anti-colorism campaigns?
3. Can WHO develop partnerships with dermatologists and psychologists to support victims of harmful product use?
4. What strategies can stop multinational companies from pushing colorist messaging in developing nations?

Helpful Links

- [WHO – Cosmetics and Skin Lightening](#)
- [Human Rights Watch – Harmful Skin-Lightening Products](#)
- [The Conversation – Colourism as a Public Health Crisis](#)
- [NCBI – Skin Whitening and Public Health](#)
- [SAGE Journal – Skin Tone Stratification in South Asia](#)



Topic B: Removing Barriers to Mental Health Care in Marginalized Communities

Mental health is an often-overlooked crisis that intersects with poverty, discrimination, gender inequality, and disability. Marginalized groups, including refugees, indigenous communities, racial minorities, LGBTQ+ populations, and people in rural or underserved areas, face the dual burden of poor mental health and limited access to treatment. These challenges are rooted in stigma, underfunding, and structural exclusion.

In many parts of the world, mental illness is still treated as taboo. In low- and middle-income countries, there is often just one psychiatrist for every 100,000 people. People with schizophrenia, depression, PTSD, or anxiety often go undiagnosed and untreated, leading to worsening health, family instability, poverty, and in extreme cases, suicide. WHO reports that suicide is one of the leading causes of death among young people globally and marginalized youth are at the highest risk.

Access to culturally appropriate care is also lacking. For example, LGBTQ+ individuals may be afraid of being “corrected” or outed by providers, while refugees often face language and trauma barriers. Women in patriarchal societies may be denied treatment or support for postpartum depression or abuse-related trauma.

WHO’s Mental Health Action Plan calls for the integration of mental health into universal health coverage. It promotes training primary care workers, expanding mobile clinics, investing in digital mental health, and ensuring medications are available. Promising innovations include task-shifting (training lay people to deliver care), peer support networks, teletherapy platforms, and school-based screening tools.

Still, stigma, political will, and lack of funding remain major obstacles. Many countries spend less than 2% of their health budget on mental health. Marginalized voices are rarely included in national policy discussions. In humanitarian emergencies, mental health support is often excluded entirely from response plans.



Delegates must focus on building equitable, sustainable systems that leave no one behind. From legislation and financing to youth engagement and mental health literacy, addressing this crisis requires a multi-sectoral, culturally grounded approach.

Questions to Consider:

1. How can WHO help countries include mental health in emergency and refugee health responses?
2. What role can art, media, or storytelling play in reducing stigma across diverse cultures?
3. How can telehealth be adapted for regions with low internet or phone access?
4. How can national governments be incentivized to invest more in mental health services?

Helpful Links

- [WHO – Mental Health and Substance Use](#)
- [UN Chronicle – Investing in Mental Health](#)
- [WHO – Guidance on Community Mental Health Services](#)
- [NCBI – Global Mental Health Inequities](#)
- [Frontiers in Psychiatry – Peer-Led Mental Health Models](#)



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