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UNICEF

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Fortifying support systems for the mental health of children and adolescents in post- war zones.

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UNICEF STUDY GUIDE

INTRODUCTION TO THE COMMITTEE- UNICEF

The United Nations International Children's Emergency Fund (UNICEF), is a special program of the United Nations (UN) devoted to aiding national efforts to improve the health, nutrition, education, and general welfare of children.

UNICEF was created in 1946 to provide relief to children in countries devastated by World War II. After 1950 the fund directed its efforts toward general programs for the improvement of children's welfare, particularly in less-developed countries and in various emergency situations. The organization's broader mission was reflected in the name it adopted in 1953, the United Nations Children's Fund. UNICEF was awarded the Nobel Prize for Peace in 1965. It is headquartered in New York City.

UNICEF has concentrated much of its effort in areas in which relatively small expenditures can have a significant impact on the lives of the most disadvantaged children, such as the prevention and treatment of disease. In keeping with this strategy, UNICEF supports immunization programs for childhood diseases and programs to prevent the spread of HIV/AIDS; it also provides funding for health services, educational facilities, and other welfare services. Since 1996 UNICEF programs have been guided by the Convention on the Rights of the Child (1989), which affirms the right of all children to "the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health." UNICEF's activities are financed by both government and private contributions.

The story of UNICEF is that of every child we reach. It is also reflected in the people who have relentlessly served and supported our organization. This is the story of

committed people who have provided critical resources, time and encouragement to build an environment where children can grow up protected, healthy and educated. Be they our employees, our directors or international personalities, UNICEF has never been wanting for ambassadors of goodwill.

For 75 years, UNICEF has collected records, items and leading research that document our story as well as that of the world. The UNICEF Archives, located in our New York Headquarters, houses material that captures UNICEF's global field operations – from our founding in the aftermath of World War II through today. From biographies to landmark policy documents, posters and greeting cards, explore a collection of UNICEF memorabilia from the UNICEF Archives.

INTRODUCTION TO THE AGENDA

Fortifying support systems for the mental health of children and adolescents in post-war zone.

Post-war zones are areas severely impacted by the devastation of violence, displacement, and social instability that follow armed conflicts. These are regions where the effects of warfare persist long after hostilities have ended, and they are defined by the psychological and physical wounds caused by war. Beyond the actual borders of battlegrounds, post-war zones comprise entire communities dealing with the devastation, trauma, and disintegration of social systems. In this scenario, children's and teenagers' mental health becomes a pressing concern as they deal with the difficulties of starting again in the wake of violence. A more complex definition of post-war zones is needed, one that goes beyond the immediate cessation of conflict. It includes realising the long-lasting effects of conflict on societies, appreciating the intricate interactions between historical, political, and social factors, and understanding the lingering effects that influence people's daily lives—particularly those of the youngest members of society. Children and teenagers in post-war areas endure a variety of traumas. It may result from being in close proximity to violent events, such as watching bombs go off, armed conflicts, or family members being killed. In addition, their trauma may be greatly exacerbated by the turmoil brought on by forced migration, relocation, and the loss of their home and community. Psychological anguish arises from these experiences that upset their sense of security, stability, and faith in the outside world. Flashbacks, nightmares, hypervigilance, avoidance behaviours, and emotional numbness are possible symptoms. These symptoms can develop chronic and significantly hinder day-to-day functioning in post-war areas where the threat of violence and instability is still present. Furthermore, PTSD and other mental health conditions frequently co-occur, which increases the overall load on young people. In addition to PTSD, children and teenagers who grow up in former combat zones

are more likely to experience anxiety and sadness. These diseases are facilitated in part by ongoing stressors, future uncertainties, and inadequate support networks. Excessive worrying, restlessness, and trouble focusing are some of the symptoms of anxiety, whereas persistent sadness, disinterest in activities, and hopelessness are indications of depression. If left untreated, these illnesses may have a lasting impact on a person's general well-being and mental health. Children and adolescents may experience developmental delays in their normal course due to trauma and related mental health issues. The effects can be particularly severe in post-war areas where access to healthcare, education, and other important services may be restricted. Trauma impairs social, emotional, and cognitive development, which has an adverse effect on future prospects, interpersonal connections, and academic achievement. In addition to other forms of care, comprehensive programmes that prioritise mental health support are necessary to address these developmental issues. Identifying the mental health requirements of kids and teenagers in areas that have experienced conflict is crucial to creating successful interventions. For support to be respectful and tailored to each person's distinctive experience, culturally aware methods incorporating trauma-informed care concepts are essential. This may include psychosocial support programmes designed to foster resilience and coping mechanisms in addition to psychotherapy, including cognitive-behavioural therapy and trauma-focused therapies. In post-war areas, addressing the mental health needs of children and teenagers necessitates concerted community and policy-level action. Important strategies include bolstering mental health services, incorporating psychosocial assistance into humanitarian relief efforts, and advocating for laws that put youth welfare first. Additionally, building social cohesiveness and community resilience can help to establish a supportive atmosphere that lessens the effects of trauma and aids in rehabilitation.

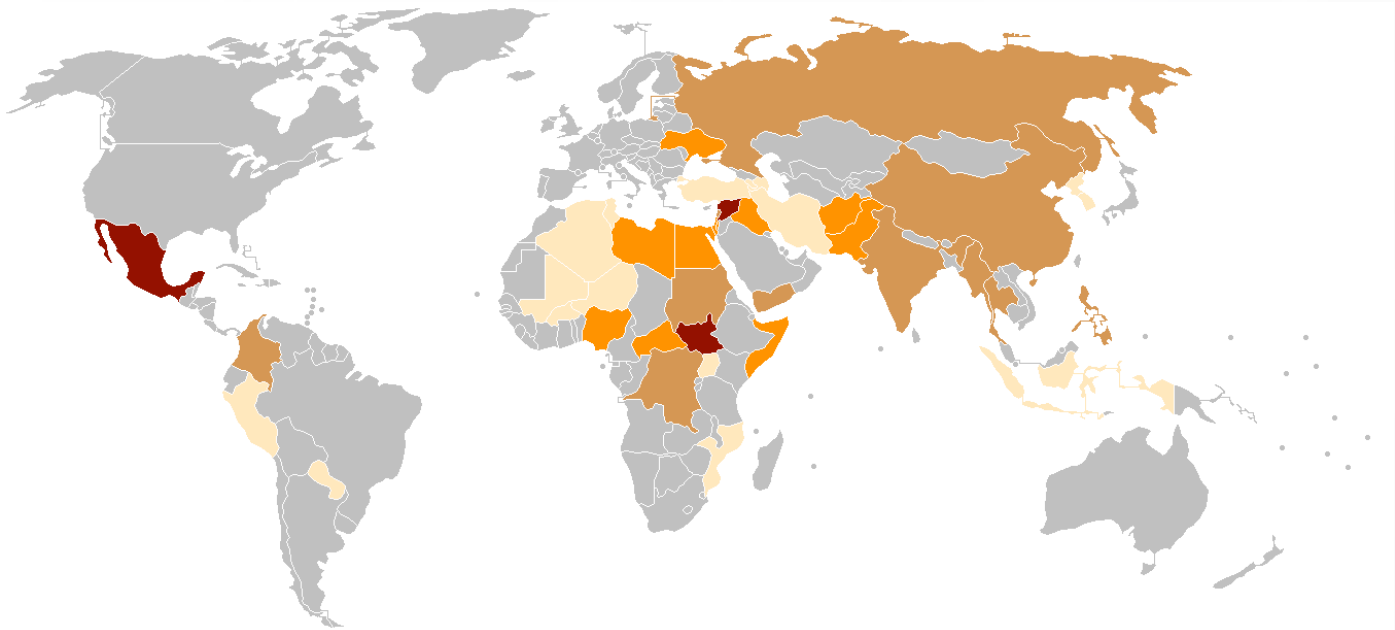
POST-WAR ZONES:

Any territory that has recently seen armed conflict or warfare and is presently going through the healing and reconstruction process is referred to as a post-war zone. It is distinguished by the conflict's aftermath, which consists of the following elements: Physical destruction: This includes harm to vital infrastructure, including schools, hospitals, roads, bridges, and buildings. There might be extensive damage, leaving communities in need of essential resources and services.

Social dislocation: Social structures and community cohesion are frequently severely disrupted in post-war areas. Population displacement, family breakup, the disintegration of established support systems, and modifications to social norms and interpersonal dynamics are a few examples of this.

Psychological trauma: During the conflict, people in post-war areas are frequently subjected to high levels of stress, terror, and violence. Widespread psychological distress, including mental health disorders including anxiety, sadness, and post-traumatic stress disorder (PTSD), may result from this. Not only can witnesses—including kids and teenagers—experience the trauma, but so can the actual victims of the abuse.

WAR ZONES-



MENTAL HEALTH ISSUES:

In post-war zones, children and adolescents face a myriad of mental health challenges stemming from their experiences during conflict and the subsequent conditions they endure. Some prevalent mental health issues in this population include:

Post-Traumatic Stress Disorder (PTSD): After experiencing traumatic experiences, PTSD is a prevalent mental health illness marked by intrusive memories, flashbacks, hypervigilance, and avoidance behaviours. After enduring direct exposure to violence, witnessing tragic events, or losing loved ones, children and adolescents living in post-war zones may develop post-traumatic stress disorder (PTSD).

Anxiety-Disorders: In post-war areas, children and adolescents frequently suffer from social anxiety disorder, panic disorder, and generalised anxiety disorder. They might have ongoing anxiety, future-focused fear, and elevated arousal, all of which can negatively impact their day-to-day activities and quality of life.

Depression: Young people in post-war environments have a notably high prevalence of depression. Depressing, gloomy, and hopeless feelings might be brought on by family member deaths, relocation, not being able to get necessities, and persistent stressors associated with thepost-war environment.

Behavioural and Conduct Disorders: Adolescents and children in post-conflict environments may have behavioural issues like oppositional defiant disorder, conduct disorders, and violence. These behaviours may result from familial upheavals, exposure to violence, and a lack of suitable role models and support networks.

Factors contributing to these mental health challenges include:

Direct exposure to violence: During the battle, children and teenagers may have witnessed or experienced violent acts, which can cause traumatic stress reactions and psychological suffering.

Grief and loss: A large number of youths in post-conflict areas have lost friends, family, or carers. Feelings of loneliness and hopelessness can be aggravated by the pain and sadness brought on by these losses, as well as mental health conditions.

Displacement and insecurity: In post-war zones, children and adolescents have elevated levels of stress and anxiety due to forced displacement, homelessness, and uncertainty about the future. Mental health issues are made worse by uncertainty regarding housing, access to basic necessities, and the possibility of going back to school.

Lack of access to mental health services: In many post-conflict areas, there are insufficient facilities and resources to offer quality mental health treatment. Many children and adolescents are unable to get the help they require to address their mental health difficulties because they do not have access to programmes.

The right to mental health and wellbeing is guaranteed to all children. It is against their rights and jeopardises their capacity to flourish and realise their full potential to ignore their mental health requirements. For children and adolescents to recover and successfully reintegrate into their communities and society at large, mental health support is crucial. Meeting their mental health needs enables individuals to mend their lives, deal with trauma, and make valuable contributions to their communities. Disregarding the psychological requirements of kids and teenagers can have long-term effects, such as persistent mental illnesses, substance misuse, and compromised social interactions. These repercussions may affect not just the individuals involved but also the generations to come, perpetuating cycles of poverty, violence, and societal instability.

Investing in mental health care enables kids and teenagers to become more resilient, which in turn helps them manage stress, overcome adversity, and form positive connections. People that possess resilience are more capable of overcoming obstacles and making positive contributions to the harmony and stability of their communities.

STIGMA RELATED TO MENTAL HEALTH

In many cultures, including those in post-war situations, stigma surrounding mental illness is deeply ingrained and influenced by various attitudes, beliefs, and societal norms. These cultural factors can significantly impact help-seeking behaviours and the provision of mental health support. For instance, people with mental illness frequently feel ashamed and guilty because they believe that their illness is a moral failing or weakness rather than a medical issue. Because of this belief, many are deterred from asking for assistance for fear of being rejected by their communities or judged. Furthermore, in some cultures, mental health issues are also linked to supernatural or spiritual origins, such as demonic possession or divine retribution. As a result, people may seek out alternative treatments from conventional healers or religious authorities. A person's fear of social rejection and discrimination can exacerbate the stigma around mental illness. This is because people may experience social isolation and be reluctant to talk about their issues because they fear being called "crazy" or "unstable." Gender stereotypes are also relevant; men are under pressure to uphold traditional ideas of masculinity that inhibit emotional openness, while women may experience shame because of their perceived incapacity to provide care for others or keep the peace in the home. Help-seeking behaviours can also be influenced by cultural views regarding the acceptability and effectiveness of mental health treatments. For example, some cultures place a higher value on traditional healing methods or religious interventions than on Western medical approaches, which can cause people to put off or completely avoid seeking professional help. Access to adequate care and support is significantly hampered in post-war contexts by the widespread stigma associated with mental illness, which is a result of these cultural attitudes and beliefs.

These cultural attitudes and beliefs in post-war settings are frequently exacerbated by the pain and turmoil endured during hostilities. Social network collapse, uprooting, losing one's job, and being in violent situations can all aggravate mental health problems while also escalating stigma and impediments to receiving treatment. People may put off getting treatment or giving their mental health needs priority because they believe that more pressing issues including food insecurity, physical safety, and life reconstruction are more important than mental health issues. A multimodal strategy is needed to address the stigma associated with mental illness in post-war

settings. This strategy should involve community education, awareness-raising initiatives, culturally appropriate mental health treatments, and attempts to incorporate mental health into larger health systems and humanitarian measures. It is feasible to lessen stigma and increase help-seeking behaviours by dispelling myths and fostering acceptance and understanding of mental health issues. This will ultimately improve access to care and assist the wellbeing of those who are impacted by conflict.

EXISTING SUPPORT SYSTEMS-

Numerous organizations and programs are dedicated to addressing the mental health needs of affected populations, particularly children and adolescents. These initiatives often involve collaboration between governments, non-governmental organizations (NGOs), community-based organizations, and international agencies.

United Nations Children's Fund (UNICEF): UNICEF is a major player in helping children and adolescents in post-war areas with mental health and psychosocial support (MHPSS). They create and carry out programmes aimed at trauma recovery, resilience building, and reintegration into communities and schools in collaboration with local partners and governments.

World Health Organisation (WHO): To improve mental health care in post-war environments, WHO offers governments and health systems technical support and advice. They promote the creation of guidelines, medical professional education initiatives, and the inclusion of mental health services in primary care.

The International Committee of the Red Cross (ICRC) provides psychological and mental health support services to victims of violence and armed conflict. They provide community-based activities, counselling, and assistance to families of missing persons.

Médecins Sans Frontières (MSF): MSF runs mental health programmes in conflict-affected areas, concentrating on offering children, adolescents, and adults psychiatric care, counselling, and psychological support. They also push for better access to mental health treatments and seek to lessen the stigma associated with mental illness.

Save the Children: In post-conflict areas, Save the Children offers children and adolescents a range of mental health and psychosocial support services. Community-based interventions, kid-friendly environments, and educator and carer training on promoting children's mental health are some of their projects.

Community-Based Organisations and Local NGOs: A large number of community-based organisations and local NGOs run mental health programmes that are customised to meet the unique requirements of their local communities. These organisations frequently possess a profound comprehension of the local context and culture, which allows them to provide culturally aware and contextually appropriate support services.

Government Initiatives: In post-war environments, numerous governments have launched programmes to offer assistance in recognition of the critical nature of tackling mental health concerns. These could involve opening mental health clinics, incorporating mental health services into primary healthcare systems, and putting in place mental health initiatives centred in schools.

International Organisations and Donors: Funding and technical support are frequently provided to help mental health programmes in post-war areas by international organisations including the World Bank, the United Nations, and bilateral donors. They are essential in organising initiatives, developing resources, and promoting greater funding for mental health services.

Successful mental health interventions in post-war zones, along with challenges encountered in providing support-

Healing Classrooms Program in Liberia

Intervention: The International Rescue Committee (IRC) in Liberia carried out the Healing Classrooms programme, which aimed to support the psychosocial wellbeing of students impacted by the nation's civil war. In order to facilitate social cohesiveness, trauma processing, and emotional expression, the programme incorporated structured activities within the academic curriculum. The program's success can be ascribed to its integration with the educational system, which uses schools as a venue for interacting with kids and to train instructors in meeting the emotional needs of their students. Through the use of participative and culturally appropriate methods like art therapy and storytelling, the programme successfully involved kids in the healing process.

Obstacles: The provision of assistance faced obstacles due to a lack of resources, notably licenced mental health practitioners, and the requirement for continuous financing to maintain the programme after it was first put into place. The stigma associated with mental health issues also created obstacles to accepting and using support services.

Child and Adolescent Mental Health Program in Bosnia and Herzegovina

Intervention: To improve mental health services for children and adolescents impacted by the Bosnian War, the World Health Organisation (WHO) and local partners conducted the Child and Adolescent Mental Health Programme in Bosnia and Herzegovina. The program's main objectives were increasing mental health awareness, developing community-based support systems, and strengthening the ability of healthcare professionals. The program's all-encompassing strategy, which tackled several facets of mental health treatment, such as advocacy, capacity-building, and service delivery, was credited with its success. Through partnerships with regional stakeholders and the incorporation of mental health into pre-existing healthcare frameworks, the initiative enhanced service accessibility and mitigated the stigma associated with mental illness.

Obstacles: Difficulties included the scarcity of money and resources for mental health treatment, especially in underprivileged and rural areas. Additionally, persistent efforts in community participation and awareness-raising were needed to overcome cultural obstacles and treat the aftermath of war trauma.

War Child Holland's Can't Wait to Learn Program in Uganda

Intervention: To provide psychosocial support and educational materials to children afflicted by conflict in northern Uganda, War Child Holland's Can't Wait to Learn programme in Uganda made use of cutting-edge technology. The programme made use of tablets that were already loaded with interactive exercises and games meant to support academic learning, coping mechanisms, and emotional resilience. The program's ability to leverage technology to remove obstacles to participation and access—especially in remote, hard-to-reach locations with inadequate infrastructure—was key to its success. Through the integration of psychological care and education, the programme met the emotional and academic requirements of the kids, enabling them to grow in resilience and skill.

Obstacles: Concerns regarding the appropriateness and cultural relevance of digital interventions were among the challenges, as were logistical issues with distributing and maintaining technological devices in remote places. Sustaining the programme after its initial phase also required continuous funding and assistance.

Comprehensive, community-based strategies that cater to the unique requirements of impacted communities are frequently used in post-war areas to achieve successful mental health interventions. Limited resources, the stigma associated with mental health, administrative difficulties, and the requirement for ongoing financing and involvement are some of the difficulties in delivering help. To surmount these obstacles, cooperation, creative thinking, and a dedication to sustained funding for mental health

services are necessary.

CHALLENGES FACED IN PROVIDING SUPPORT-

Financial Challenges:

Financial limitations are a major barrier to providing mental health care in post-war areas. A constant problem is a lack of funds, which is made worse by the urgent need for resources to meet basic humanitarian requirements including food, shelter, and healthcare. As a result, mental health services are frequently given less priority, which leaves little money for essential elements like employee pay, training initiatives, and service delivery. Furthermore, the issue is made more difficult by the need on outside assistance, since many post-conflict nations mostly rely on foreign financing to maintain their healthcare systems. But establishing and sustaining long-term mental health programmes is difficult since donor priorities, short-term funding, and unpredictability are common features of this assistance. Furthermore, the substantial expenses linked to delivering all-encompassing mental health services in post-war environments where resources are limited and conflicting objectives are common, investments in skilled personnel, drugs, infrastructure, and continuous support services, among other things, provide daunting obstacles.

Human Resource Challenges:

A major barrier to meeting the complicated mental health requirements of affected communities in post-war zones is the lack of qualified mental health specialists. There

is frequently a shortage of psychiatrists, psychologists, counsellors, and social workers since many of these highly qualified individuals choose to relocate away from areas of conflict in search of safety or better prospects. This migration leaves a knowledge vacuum that exacerbates the already inadequate ability to offer quality mental health care. In post-war situations, mental health professionals may not have had specialised training in trauma-informed care, culturally sensitive techniques, or dealing with children and adolescents. Therefore, capacity-building initiatives are crucial to providing local healthcare professionals with the abilities and information needed to handle the complex mental health issues that arise. Additionally, because of the difficult work environment, the traumatic stories they are exposed to, and the personal risks involved in working in conflict-affected areas, healthcare professionals who provide mental health treatment in post-war zones endure significant stress, burnout, and secondary trauma. Ensuring the viability and efficacy of mental health services in post-war settings requires prioritising the support of the mental health of these frontline workers.

Infrastructural Challenges:

The difficulties in providing mental health treatment in post-war areas are exacerbated by severe infrastructure constraints. Hospitals, clinics, and mental health centres are among the healthcare facilities that are frequently badly damaged or destroyed during conflicts, requiring massive reconstruction operations. The time and money required to rebuild infrastructure cause delays in providing impacted communities with critical mental health care. Furthermore, it can be difficult to reach isolated people in conflict-affected areas due to inadequate road systems, physical obstacles, and security worries. Outreach initiatives are further hampered by inadequate logistical assistance and transportation infrastructure, which makes it challenging to reach those in need. Strong information systems are also necessary for patient management, data gathering, monitoring, and assessment in order to provide successful mental health care. Unfortunately, post-war areas frequently lack the internet connectivity, dependable electricity, and technological infrastructure needed to enable digital health solutions. The lack of adequate infrastructure makes it more difficult to provide timely, comprehensive mental health care to people impacted by conflict and its aftermath.

SAFETY ISSUES:

Providing crucial humanitarian assistance and mental health support to affected communities poses major hurdles for aid workers operating in post-war zones due to the numerous and varied safety concerns involved. These dangers stem from the generalised insecurity and intricate dynamics of conflict that characterise such settings. Direct threats to the personal safety of aid workers are a common occurrence. These

threats can take the form of imminent violence, kidnapping, or attacks by armed organisations. Their apparent affinities or perceived meddling in local power dynamics frequently give birth to this vulnerability, making them targets in tumultuous and uncertain environments. Additionally, the prevalence of armed players, lax governance, and widespread lawlessness in post-war areas create an environment where aid workers are susceptible to a variety of criminal acts like robbery, extortion and assault. These difficulties are made worse by the continuous violence and instability, which makes it difficult to reach the most remote and impacted parts of the conflict and where the greatest need for humanitarian aid lies. The imposition of roadblocks, checkpoints, and restricted movement by armed groups or government forces pose significant challenges that impede the supply of important services, such as mental health support, and cause delays for humanitarian relief efforts. Aid workers also struggle with perceptions of bias or favouritism among various political, religious, or ethnic groups, as well as the ambiguity of their duties. Humanitarian workers may encounter mistrust or hostility in situations where aid is politicised or used as a tool by opposing groups, which jeopardises their safety and efficacy even more. Moreover, operating capacities are severely hampered by the absence of basic infrastructure, which includes essential elements like roads, telecommunications, and medical facilities. Aid workers' difficulties are made worse by restricted access to emergency medical care, transportation, and communication networks, which makes it more difficult for them to quickly and efficiently address the needs of impacted communities. Aid agencies and humanitarian actors show incredible tenacity and dedication to their work in spite of these severe safety risks and obstacles. They use strict security procedures, carry out in-depth risk assessments, and promote close collaboration with local law enforcement and armed groups in order to protect staff and reduce hazards. To protect the safety and security of relief workers working in post-war areas, stakeholders must constantly exercise caution, flexibility, and teamwork due to the unstable and unpredictable nature of conflict contexts.

STRATEGIES FOR FORTIFYING SUPPORT SYSTEMS

Integration of mental health services into existing healthcare systems

In order to meet the urgent mental health needs of impacted communities, it is imperative that mental health services be integrated into the current healthcare systems in post-war areas. Accessibility may be greatly increased by integrating mental health services into primary healthcare frameworks, guaranteeing that people have quicker and easier access to critical support. Since people are more likely to seek assistance from known and reliable healthcare practitioners, integrating mental health services within primary care settings facilitates the early detection and intervention of mental health concerns. This method also lessens the stigma attached to getting mental health treatment by normalising it as a standard component of medical care. The

ability to address mental health issues can be increased by teaching primary care physicians in the fundamentals of mental health assessment and treatment. This is especially useful in settings with limited resources where specialised mental health doctors might be hard to come by. Furthermore, incorporating mental health services into the current healthcare framework encourages a holistic approach to treatment, acknowledging the connection between mental and physical health. Through collaboration amongst many healthcare professions, this integration makes it possible to provide complete and coordinated care that meets the demands of both physical and mental health. In post-conflict areas, promoting the inclusion of mental health services in primary healthcare systems is crucial to improving accessibility, lowering stigma, and guaranteeing that patients receive the comprehensive care they require to rehabilitate from the trauma of fighting.

Training and capacity-building

Enabling healthcare practitioners with the requisite skills and knowledge to effectively serve impacted people is a crucial function of training and capacity-building projects aimed at addressing mental health needs in post-war zones. Putting money into training programmes guarantees that medical professionals—such as physicians, nurses, psychologists, and social workers—have the skills necessary to identify, evaluate, and manage mental health issues. These courses ought to cover a wide range of subjects, such as cultural sensitivity, psychological first aid, trauma-informed treatment, and counselling strategies, to empower medical professionals to offer suitable and situationally appropriate assistance to various populations. Furthermore, community-based strategies should be included in capacity-building initiatives in order to enable local leaders, volunteers, and organisations to support initiatives for mental health promotion and psychosocial support. These approaches should go beyond clinical expertise. Training initiatives support sustainability and resilience in addressing mental health issues in post-war situations by enhancing the ability of healthcare systems and community networks. Moreover, it is imperative to provide constant supervision, mentorship, and professional development opportunities to the healthcare personnel to guarantee lifelong learning and quality improvement. In the end, funding training and capacity-building programmes is crucial to developing a knowledgeable and adaptable workforce that can provide successful mental health services and support to people and communities impacted by violence and its aftermath.

Collaborative efforts

The importance of cooperation amongst governments, NGOs, and international organisations must be emphasised in order to properly treat mental health issues in areas that have experienced conflict. When these organisations work together, re-

sources, knowledge, and networks may be combined to maximise the effectiveness of programmes and guarantee that all mental health needs are met. Governments are essential in supporting mental health programmes with funding, infrastructure, and policy support; on the other hand, non-governmental organisations (NGOs) offer community connections, grassroots expertise, and flexibility in tailoring interventions to specific settings. To coordinate efforts and prevent service duplication, international organisations provide financial opportunities, coordination channels, and technical assistance. Stakeholders can overcome obstacles like scarce funds, a labour shortage, and logistical difficulties by cooperating and utilising their unique capabilities. In addition, cooperative initiatives facilitate the exchange of knowledge, the dissemination of best practices, and the development of cross-sector competence, creating an environment for collective learning that is supportive of sustainability and innovation. In addition, collaborations among governments, non-governmental organisations, and global organisations improve openness and accountability in mental health services, guaranteeing that funds are distributed fairly and effectively to assist the most disadvantaged groups. Ultimately, collaborative activities are critical to making significant and long-lasting gains in mental health outcomes in post-war zones because they promote cooperation and synergy among diverse stakeholders.

Utilization of technology

Technology has the ability to greatly reduce distances and reach rural populations in post-war areas, especially when it comes to telemedicine and online counselling services. People who reside in places with inadequate healthcare infrastructure or security concerns can receive mental health services more easily because to telemedicine platforms, which allow mental health specialists to give services remotely. People no longer have to travel great distances for prompt evaluation, counselling, and psychiatric consultations thanks to telemedicine, which also lessens the financial and practical strain of travel. Additionally, people can obtain treatment from qualified mental health specialists in a discreet and easily accessible manner through online counselling services, which helps people overcome obstacles like social isolation and stigma that would prevent them from seeking help in more traditional face-to-face settings. Furthermore, by utilising mobile technology and internet access, telemedicine and online counselling services can expand the reach of mental health interventions, especially in areas with high smartphone prevalence. Mental health professionals can reach neglected and rural people by utilising technology to deliver evidence-based, culturally sensitive treatments that are specifically designed to meet the requirements of post-war communities. To guarantee fair access to telemedicine and online counselling services, it is crucial to address issues like digital literacy, data privacy, and internet connectivity. However, by utilising technology, individuals and organisations can take advantage of creative ways to overcome distances and provide accessibility

to essential mental health care in areas that have been affected by conflict.

Advocacy and awareness campaigns

In post-war areas, advocacy and awareness initiatives are essential for de-stigmatizing mental illness and advancing mental health literacy. These efforts assist in lowering stigma and discrimination by dispelling myths about mental health concerns and increasing public knowledge of them, which in turn encourages people to get support and assistance. Focused advocacy initiatives can dispel myths and cultural preconceptions that support stigma by educating communities about the scientific and psychological causes of mental illness. In addition to bringing attention to the prevalence of mental health issues and their effects on people, families, and communities, these initiatives also aim to increase public empathy and understanding. In addition, advocacy programmes support the rights of those who suffer from mental illness by encouraging fair and culturally appropriate mental health treatments and assistance. Advocacy campaigns can raise awareness and gather resources to give mental health a higher priority on the post-war agenda by interacting with a variety of stakeholders, including as legislators, media outlets, community leaders, and healthcare professionals. Furthermore, promoting mental health literacy enables people to identify warning signs and symptoms of mental illness, get the help they need, and assist loved ones who are struggling with mental health issues. Advocacy efforts, by raising awareness and educating people, foster an atmosphere that is helpful for candid communication, inclusion, and acceptance. This helps to improve mental health outcomes and bring about good social change in post-war areas.

CONCLUSION

Owing to its significant influence on both individuals and societies, addressing mental health issues in post-war areas is vital. Following a battle, communities are frequently faced with a wide range of mental health issues, such as trauma, depression, anxiety, and post-traumatic stress disorder (PTSD). If these issues are not properly addressed, the results can be disastrous. People can get the support and treatment they require to get past their traumas and start over by giving mental health care first priority. Moreover, funding mental health programmes encourages social cohesiveness and resilience in local communities, enabling people to actively engage in the process of restoration and growth. Furthermore, attending to mental health issues supports efforts to establish stability and promote peace since people who get enough care are less likely to use violence or participate in activities associated to conflicts. Additionally, through increasing productivity, lowering healthcare expenses, and fortifying social ties, enhanced mental health outcomes support societal advancement and economic growth. In the end, post-war communities may foster healing, resilience, and sustain-

able growth by identifying and addressing mental health needs, opening the door to a more promising future for all. It is critical and urgent to give mental health interventions top priority in post-war rehabilitation initiatives and to allocate funds for the development of strong support networks for kids and teenagers. The mental health needs of impacted communities need to be addressed as urgently as physical restoration efforts as civilizations recover from the wreckage of violence. In addition to being a humanitarian necessity, funding mental health interventions is a calculated investment in long-term security, prosperity, and peace. Stakeholders can lessen the long-term effects of trauma, lower the likelihood of violent intergenerational cycles, and foster future generations' resilience and well-being by placing a high priority on mental health. It is especially important to concentrate on children and adolescents since they are especially susceptible to the psychological impacts of war and displacement. Giving kids access to comprehensive psychosocial care and mental health assistance can help them cope better with the effects of trauma, perform better in school, and have more hope for a better future. Consequently, in order to give mental health interventions top priority in post-war rebuilding efforts, governments, non-governmental organisations, international organisations, and community partners must band together. Collaboratively, we can invest in creating robust support networks for children and young adults, laying the groundwork for long-term peace, resilience, and prosperity in post-war communities. Stressing the long-term advantages of funding mental health initiatives now highlights the significant influence that these treatments can have on the peace, stability, and prosperity that post-war nations will experience in the future. Prioritising mental health care now can help stakeholders create a foundation for long-term benefits that go well beyond short-term relief operations. Investing in mental health therapies helps communities become resilient and cohesive, enabling them to overcome hardship in the long run, in addition to short-term pain relief and healing. Individuals' mental health needs, especially those of children and adolescents, should be attended to in order to break the cycle of trauma and violence and promote a culture of peace and reconciliation. Better mental health outcomes also boost societal progress and economic growth by lowering healthcare expenses, increasing productivity, and fortifying social ties. Societies may create a solid basis for long-term peace and prosperity by making investments in the mental health of the next generation, guaranteeing a more promising and resilient future for everybody. Consequently, it is critical to understand the role that mental health investments play in post-conflict areas as a means of achieving long-term peace, stability, and prosperity.

Roll Call

A committee meeting begins with a roll call, without which quorum cannot be established. A debate cannot begin without a quorum being established. A delegate may change his/her roll call in the next session. For example, if Delegate answers the Present in the First session, he can answer the Present and vote in the next session when the roll call occurs.

During the roll call, the country names are recalled out of alphabetical order, and delegates can answer either by saying Present or Present and voting. Following are the ways a roll call can be responded in -

Present - Delegates can vote Yes, no, or abstain for a Draft Resolution when

they answer the Roll Call with Present;

Present and voting - An delegate is required to vote decisively, i.e., Yes/No only if they have answered the Roll Call with a Present and voting. A Delegate cannot abstain in this case.

Abstention - The Delegate may abstain from voting if they are in doubt, or if their country supports some points but opposes others. Abstention can also be used if a delegate believes that the passage of the resolution will harm the world, even though it is unlikely to be highly specific. A delegate who responded with present and voting is not allowed to abstain during a substantive vote. An abstention counts as neither “yes” nor “no vote”,and his or her vote is not included in the total vote tally.

Quorum

In order for the proceedings of a committee to proceed, quorum (also known as a minimum number of members) must be set which is one-third of the members of the committee must be present. Quorum will be assumed to be established unless a delegate’s presence is specifically challenged and shown to be absent during the roll call. The Executive Board may suspend committee sessions if a quorum is not reached.

General Speakers List

After the agenda for the session has been established, a motion israised to open the General Speaker's List or GSL. The GSL is where all types of debates take place throughout the conference, and the list remains open throughout the duration of the agenda's discussion. If a delegate wishes to speak in the GSL, he or she must notify the Executive Board by raising his or her placard when the Executive asks for Delegates desiring to speak in the GSL. Each country's name will be listed in the order in which it will deliver its speech. A GSL can have an individual speaker time of anywhere from 60-120 seconds. Following their GSL speech, a Delegate has the option of yielding his/her time to a specific Delegate, Information Points (questions) or to the Executive Board.

Speakers List will be followed for all debate on the Topic Area, except when superseded by procedural motions, amendments, or the introduction of a draft resolution. Speakers may speak generally on the Topic Area being considered and may address any draft resolution currently on the floor. Debate automatically closes when the Speakers List is exhausted.

Yield

A delegate granted the right to speak on a substantive issue may yield in one of three ways at the conclusion of his/her speech: to another delegate, to questions, or to the Director. Please note that only one yield is allowed. A delegate must declare any yield at the conclusion of his or her speech.

- Yield to another delegate. When a delegate has some time left to speak, and he/ she doesn't wish to utilize it, that delegate may elect to yield the remaining speaking time to another delegate. This can only be done with the prior consent of another delegate (taken either verbally or through chits).The delegate who has been granted the other's time may use it to make a substantive speech, but cannot further yield it.

- Yield to questions. Follow-up questions will be allowed only at the discretion of the Director. The Director will have the right to call to order any delegate whose question is, in the opinion of the Director, rhetorical and leading and not designed to

elicit information. Only the speaker's answers to questions will be deducted from the speaker's remaining time.

- Yield to the EB. Such a yield should be made if the delegate does not wish his/her speech

to be subject to questions. The moderator will then move to the next speaker.

Motions

Motions are the formal term used for when one initiates an action. Motions cover a wide variety of things.

Once the floor is open, the Chairs will ask for any points or motions. If you wish to bring one to the Floor, this is what you should do:

- Raise your placard in a way that the chair can read it
- Wait until the Chair recognizes you
- Stand up and after properly addressing the Chair(":hank you, honourable Chair" or something along these lines), state what motion you wish to propose
- Chairs will generally repeat the motions and may also ask for clarification. Chairs may do this if they do not understand and may also ask for or suggest modifications to the motion that they feel might benefit the debate.

Every motion is subject to seconds, if not otherwise stated. To pass a motion at least one other nation has to second the motion brought forward. A nation cannot second its own motion. If there are no seconds, the motion automatically fails.

If a motion has a second, the Chair will ask for objections. If no objections are raised, the motion will pass without discussion or a procedural vote. In case of objections, a procedural vote will be held. The vote on a motion requires a simple majority, if not otherwise stated.

While voting upon motions, there are no abstentions. If a vote is required, everyone must vote either “Yes” or “No”. If there is a draw on any vote, the vote will be retaken once. In case there are multiple motions on the Floor, the vote will be casted by their Order of Precedence. If one motion passes, the others will not be voted upon anymore. However, they may be reintroduced once the Floor is open again.

During a moderated caucus, there will be no speakers’ list. The moderator will call upon speakers in the order in which the signal their desire to speak. If you want to bring in a motion for a moderated caucus, you will have to specify the duration, a speakers’ time, a moderator, and the purpose of the caucus. This motion is subject to seconds and objections but is not debatable.

In an unmoderated caucus, proceedings are not bound by the Rules of Procedure. Delegates may move around the room freely and converse with other delegates. This is also the time to create blocks, develop ideas, and formulate working papers, draft resolutions, and amendments. Remember that you are required to stay in your room unless given permission to leave by a Chair.

During the course of debate, the following points are in order:

- Point of Personal Privilege: Whenever a delegate experiences personal discomfort which impairs his or her ability to participate in the proceedings, he or she may rise to a Point of Personal Privilege to request that the discomfort be corrected. While a Point of Personal Privilege in extreme case may interrupt a speaker, delegates should use this power with the utmost discretion.

- Point of Order: During the discussion of any matter, a delegate may rise to a Point of Order to indicate an instance of improper parliamentary procedure. The Director may rule out of order those points that are improper. A representative rising to a Point of Order may not speak on the substance of the matter under discussion. A Point of Order may only interrupt a speaker if the speech is not following proper parliamentary procedure.

- Point of Enquiry: When the floor is open, a delegate may rise to a Point of Parliamentary Inquiry to ask the EB a question regarding the rules of procedure. A Point of Parliamentary Inquiry may never interrupt a speaker. Delegates with substan-

tive questions should not rise to this Point, but should rather approach the committee staff during caucus or send a note to the dais.

- Point of information: After a delegate gives a speech, and if the delegate yields their time to Points of Information, one Point of Information (a question) can be raised by delegates from the floor. The speaker will be allotted the remainder of his or her speaking time to address Points of Information. Points of Information are directed to the speaker and allow other delegations to ask questions in relation to speeches and resolutions.

- Right to Reply: A delegate whose personal or national integrity has been impugned by another delegate may submit a Right of Reply only in writing to the committee staff. The Director will grant the Right of Reply and his or her discretion and a delegate granted a Right of Reply will not address the committee except at the request of the Director.

Draft Resolution

Once a draft resolution has been approved as stipulated above and has been copied and distributed, a delegate(s) may motion to introduce the draft resolution. The Director, time permitting, shall read the operative clauses of the draft resolution. A procedural vote is then taken to determine whether the resolution shall be introduced. Should the motion receive the simple majority required to pass, the draft resolution will be considered introduced and on the floor. The Director, at his or her discretion, may answer any clarificatory points on the draft resolution. Any substantive points will be ruled out of order during this period, and the Director may end this clarificatory question-answer period' for any reason, including time constraints. More than one draft resolution may be on the floor at any one time, but at most one draft resolution may be passed per Topic Area. A draft resolution will remain on the floor until debate on that specific draft resolution is postponed or closed or a draft resolution on that Topic Area has been passed. Debate on draft resolutions proceeds according to the general Speakers List for that topic area and delegates may then refer to the draft resolution by its designated number. No delegate may refer to a draft resolution until it is formally introduced.

Amendments

All amendments need to be written and submitted to the executive board. The format for this is authors, signatories and the clause with mentioning the add, delete and replace. There are two forms of amendment, which can be raised by raising a motion for amendment and approval of the chair

Friendly Amendments: Amendment,which is agreed upon by all the author's does not require any kind of voting

Unfriendly Amendments: Amendments that are introduced by any other need not be voted upon by the council and are directly incorporated in the resolution. You need a simple majority in order to introduce a normal amendment.

BODY of Draft Resolution

The draft resolution is written in the format of a long sentence, with the following rules:

- Draft resolution consists of clauses with the first word of each clause underlined.
- The next section, consisting of Preambulatory Clauses, describes the problem being addressed, recalls past actions taken, explains the purpose of the draft resolution, and offers support for the operative clauses that follow. Each clause in the preamble begins with an underlined word and ends with a comma.
- Operative Clauses are numbered and state the action to be taken by the body. These clauses are all with the present tense active verbs and are generally stronger words than those used in the Preamble. Each operative clause is followed by a semi-colon except the last, which ends with a period.