Surf City XVIII

Huntington Beach High School

United Nations High Commissioner for Refugees

Topic A Communicable Diseases in Refugee Camps

Topic B Rohingya Refugee Crisis

Mohini Chatterjee

Jacqie Gordon

Emily Smith

Welcome Letter

Dear Delegates,

On behalf of the Huntington Beach High School Model United Nations Program, we would like to welcome you to our Surf City XVIII advanced conference!

Our annual Surf City conference upholds the principles and intended purpose of the United Nations. Delegates can expect to partake in a professional, well-run debate that simulates the very issues that those at the United Nations discuss every day. Both novel and traditional ideas will be shared, challenged, and improved.

It is our hope that all delegates will receive the opportunity to enhance their research, public speaking, and communication skills as they explore the intricacies of global concerns through various perspectives, some of which may be very different from their own. We hope their experiences here give them new insight and values that they can apply outside of the realm of Model UN for the betterment of the world community.

Although we will be entertaining a new style of a virtual conference, we hope all delegates will experience a fruitful and enhancing debate. Please do not hesitate to approach our Secretariat or Staff Members with any questions or concerns that you may have throughout the day. We wish the best to all our participants and hope that they may share a fulfilling experience with us! Enjoy the conference.

Sincerely,

Summer Balentine
Secretary-General

Jenna Ali
Secretary-General

Kayla Hayashi
Secretary-General

Hailey Holcomb
Secretary-General

Meet the Dias

Mohini Chatterjee

Hey delegates! My name is Mohini Chatterjee and I am so excited to be one of your chairs for this year's Surf City conference! I am currently a senior at Huntington Beach High School and this is my fourth year in the MUN program. MUN is one of my favorite classes and has taught me so much about global issues, while also sharpening my speaking and researching skills. Outside of MUN, I love playing tennis, traveling, hanging out with my friends, and painting. I am also a part of the National Honors Society, California Scholarship Federation, and love volunteering at Beachside nursing home to pursue a future career in medicine. Even though this year's format is different than usual being online, I am positive that you will all bring innovative solutions, collaborate with other delegates, and carry on committee as we normally would. I am super excited to meet you guys, and am looking forward to a great round of debate, Good Luck!

Jacqie Gordon

Hi delegates! My name is Jacqie Gordon, and I am beyond excited to be co-chairing UNHCR at this year's Surf City conference! I am currently a senior at Huntington Beach High School, and this is my fourth year participating in Model United Nations. This class has always been immensely important to me because it has allowed me to expand my horizons regarding current events in our world, and it has inspired me to formulate my own opinions based on my knowledge and research regarding global politics. Not only that, but it has granted me the opportunity to meet and collaborate with delegates from schools not just in surrounding areas, but in other states and countries! Outside of MUN, I play softball for HBHS, and I spend whatever free time I have with my friends, going to the movies, and hyper fixating on Marvel, Star Wars, and a ton of other franchises. I am sure you will all be able to bring some excellent solutions to the table to make for an exciting committee session, and I cannot wait to see all of you in action! Delegates… Assemble!

Emily Smith

Hey delegates! My name is Emily Smith, and I am so happy to have the opportunity to be one of your chairs for this year's Surf City conference! I am currently a junior at Huntington Beach High School, and this is my third year in the HBHS Model United Nations program. Throughout my MUN experience, I have learned to love this program and all it has done for me. It has not only improved my public speaking abilities but has also helped me to learn more about pressing issues in today's society and how to properly research and have educated opinions on them. When I'm not doing MUN, I costume design for the APA program at HBHS, cook and bake, and hang out with my friends. I also volunteer for the National Honors Society and am a member of Peer Ministry at my church. I can't wait to hear all of your unique ideas and solutions for our pressing topics! I'm confident that all of you will do great in committee even though the online setup may be a little bit different. Have fun and good luck!!

All Papers are due on January 2, 2020 by 11:59pm to surfcitymun.unhcr@gmail.com

TOPIC 1: Communicable Diseases in Refugee Camps

BACKGROUND

According to the World Health Organization, Communicable Diseases (CDs) are any disease which passes between people or from animals to people through contaminated surfaces, bodily fluids, blood, or through the air.[1] These include HIV, tuberculosis, malaria, cholera, viral hepatitis, and most recently, COVID 19.[2] CDs cause more than 4 million deaths each year and are extremely prominent in refugee camps due to a variety of factors.[3] Overcrowding, poor water and sanitation, a lack of immunizations, and a shortage of healthcare professionals make refugee populations extremely vulnerable to CDs, and although access to healthcare services has steadily increased over the past few decades, there are still 30.9 million refugees facing barriers to treatment.

Public health programs have been crucial in assessing refugee populations for infectious diseases. In its early stages, authorities monitored ships on arrival to conduct screening and quarantine programs before entrance into camps. With the exponential growth in the migrant population, however, these screenings have become less effective and difficult to enforce. Each refugee population is unique to its regional factors, which makes it impossible to create general healthcare guidelines and policies across the board.[4] However, studies done by the World Health Organization (WHO) indicates that refugee populations disproportionately affected by communicable diseases acquire low levels of vaccinations due to frail healthcare systems in their origin countries, exposure to communicable diseases while traveling overseas and previous discriminations in health care services. [5]The most prevalent communicable diseases in refugee camps and migrants have been Latent Tuberculosis Infection (LTBI) (9-45%), Hepatitis B (12%), and Human Immunodeficiency Virus (HIV) (7%).[6] Some refugee camps in Iraq, Somalia, and Finland have begun to provide single blood tests that detect LBI, HIV, and Hepatitis B to provide early diagnosis upon entry to the camp and start treatment/ prevention methods. These countries have been 18 % more successful in diagnosing HIV and Hepatitis B, but LBI was often undetected as it is better diagnosed through a Chest X-ray. [7]

Latent Tuberculosis Infection is particularly high among refugee children aged 0-14, which marks them as a prominent group to be targeted for preventative measures. If LTBI is left untreated, patients are susceptible to a 5-10% chance of reactivation later in their lifetime, with the majority of cases emerging within 5 years of its initial infection. [8]LTBI is often more prevalent in refugee populations because they are susceptible to psychosocial distress, which makes them more prone to immune deficiency.[9] In addition, Hepatitis B has infected approximately 3.5 million refugees with rates significantly higher among men than women, and most prevalent in refugees from Albania and Asia. The crowded living conditions of sheltering facilitate the spread of the disease, as it is highly transmissible in settings that expose contaminated blood and other bodily fluids.[10] Although transmission is particularly linked with needle-stick injuries, it has also been reported in other settings, such as areas with aftermaths of explosions or violence based injuries. [11] For example, an outbreak of Hepatitis occurred in September 2019, when a massive explosion in Kabul left Afghanistan refugees with extensive burns, large areas of exposed skin, and fluid loss. Furthermore, 14% of the refugee population is

infected with Human Immunodeficiency Virus (HIV) and is especially prevalent in refugee populations because of their vulnerability to physical and sexual violence, human trafficking, army contact, stigma against the disease, and a lack of sexual education in refugee camps.[12] Another serious danger to the spread of HIV in refugee camps lies in the transfusion of HIV-infected blood, which are common practices often conducted in large numbers within camps due to situations of war and poor nutritional status in women and children.

According to UNHCR, the most effective method of preventing Communicable diseases is through the WASH system, which includes proper water sanitation, ensuring hygienic shelter and treatment conditions, and promoting vaccinations to mobile populations. [13]However, several humanitarian organizations have failed to provide these resources over sustained periods and more innovative and cost-effective solutions are needed. Furthermore, refugees face several socioeconomic and cultural barriers to accessing healthcare because of disease-related stigma and fear of discrimination by health services.[14] A study done by the BMC HealthNet association indicated that 22 percent of refugees reported experiences of discrimination and a lack of trust in foreign medical professionals providing treatment within camps.[15] Language barriers and a lack of culturally responsive care often hinder refugee treatment access and contribute to undiagnosed diseases and therefore a lack of treatment. Discrimination within the healthcare system is most prevalent for refugees that are socially disadvantaged due to gender, race/ethnicity, or religion.[16]

In addition to pre-existing communicable diseases, the emergence of the worldwide Coronavirus pandemic has placed a huge threat to refugee health. While most communities are staying home and practicing social distancing, refugees are unable to follow standard CDC guidelines due to frail healthcare infrastructures, insufficient sanitary conditions, and cramped living conditions. [17]According to John Hopkins Center for Humanitarian health, only 20 percent of refugee camps have hospital infrastructures and under 3 percent acquire ICUs/ ventilators necessary for severe cases of COVID19.[18] Additionally, several host countries have closed off their borders to prevent the spread of the virus, leaving refugees in the dark in regards to treatment and access to permanent residence. [19]The United Nations High Commissioner for Refugees has been forced to temporarily suspend refugee resettlement travels, which limits their access to basic necessities, and of course puts a hold on their education, resettlement, careers, and hope for a new life[20]. On top of this, underlying conditions such as malnutrition and stress make the effects of COVID 19 even more severe on refugee populations and overpopulated camps are insufficient in containing the virus. [21] For example, there are currently around 700,000 migrants living in Libyan refugee camps holding tents just 5 feet away, about a foot shorter than what's recommended by CDC experts. [22] On March 24, 2020, Libya reported their first case of COVID 19, with more than 50,000 confirmed cases in May 2020, and with a lack of testing kits, the true numbers of cases may be even greater[23]. Although several UN bodies and organizations such as the Red Cross and the International Rescue Committee have been active in preparing medical facilities to keep up with the healthcare guidelines, it is imperative for host countries to emphasize prevention and continue to provide support to these vulnerable populations regardless of citizenship status- because this is a disease that does not respect borders or nationality.

UNITED NATIONS INVOLVEMENT

The United Nations Refugee Agency has developed the Emergency Handbook to establish effective responses to humanitarian emergencies within refugee camps, the most notable being disease outbreaks. Sphere standards 2.1.1-2.1.4 within this Emergency Handbook

encompass information regarding communicable diseases, including strategies concerning prevention, surveillance, diagnosis, management, and outbreak preparedness for these diseases.[24] The Sphere Project, which first introduced such standards for humanitarian response, was established in 1997 and effectively implemented into frameworks across UN agencies with the help of the Humanitarian Charter and Minimum Standards.[25]

The World Health Organization also works hands-on to prevent the spread of communicable diseases amongst refugees and displaced persons. The drafting of the 2019-2023 Global Action Plan promoting the health of refugees and migrants was developed to enhance current strategies regarding the reduction of outbreaks within refugee camps while working in direct coordination with the 2030 Sustainable Development Goals.[26] SDG 3, Good Health and Wellbeing, has emphasized the recent spikes in communicable diseases, with both widespread pandemics like COVID-19 and recurring outbreaks like Malaria, highly prevalent within refugee camps. As a result, Regional Offices of the World Health Organization, as seen with the European Office, have published updated reports regarding the spread of communicable diseases amongst refugees and the measures that can be implemented to promote health for all migrants.[27] Such measures include the New York Declaration for Refugees and Migrants, which commits all member states to successfully integrate refugee camps into programs regarding public health and communicable disease prevention.[28] Additionally, in response to the COVID-19 outbreak, the World Health Organization requested an updated budget with $675 million designated to accommodate at-risk refugee camps and provide them aid.[29]

Because of their vulnerability to the spread of communicable diseases, refugee camps receive extra attention from the international community. For example, A/RES/S-26/2, known as the Declaration of Commitment on HIV/AIDS, emphasizes the importance of promoting development within high-risk populations and emphasizes that such groups should be closely connected to healthcare systems so they can be provided with essential resources if the pandemic spreads.[30] As a result, refugee camps received more hands-on support from the international community in the fight against AIDS. Furthermore, in response to the Ebola outbreak in 2014, the UN Refugee Agency developed partnerships with groups such as Care International to promote prevention methods as well as provide essentials within hygiene kits and necessary education on how to use such resources effectively.[31]

Regarding COVID-19 specifically, A/RES/74/307 was passed in September of 2020 to establish a united global response to the threat of the coronavirus. Operative 6 acknowledges that groups at high risk for the virus, including refugees within developing regions and camps, should be prioritized in the distribution of information and technologies that can contribute to the mitigation of the coronavirus to stay on track for the achievement of the SDGs.[32] UNHCR has worked to scale up their response to COVID-19 by providing essentials to refugee camps including hygiene materials and medical resources. The organization utilizes the already existing modes of communication amongst refugee camps to distribute information regarding prevention such as social distancing measures and isolation for infected persons.[33] Refugee camps that are struggling to accommodate the virus because of their concentrated populations, including those in Greece, Iran, and Bangladesh, have been receiving hands-on intervention from organizations like the International Committee of the Red Cross so they can further develop their medical facilities to better handle the pandemic.

CASE STUDY: Cholera Outbreak in Dadaab Refugee Camp

Dadaab Refugee Camp is located in the city of Dadaab in Kenya. The site is run by the United Nations High Commissioner for Refugees and currently houses over 340,000 refugees.[34] Unfortunately, due to small living quarters and poor sanitation due to the massive number of people at the camp, communicable diseases are spread very easily from person to person. Cholera is a communicable disease that takes control of one's bodily fluids with symptoms such as vomiting and diarrhea.[35] When someone contracts even a mild form of the disease, symptoms can become extremely uncomfortable. The risk of contracting cholera is especially high with poor sanitation and hygiene, as well as contaminated or unsanitary drinking water.[36]

At the Dadaab Refugee Camp, there are five subcamps called Dagahaley, Kambioos, Ifo, Ifo2, and Hagadera. Cholera spread throughout all five of these subcamps after a national outbreak in Kenya reached the camp. The outbreak began in November 2015 when two residents of the Dadaab camp were evaluated following the national cholera outbreak as a precaution, and observations of acute watery diarrhea were reported from both of the residents.[37] Only a week after the confirmation of both of these cases of cholera, over 45 more residents of the camp were reported to have the same symptoms as the others. Almost 1,800 cases of cholera were suspected or confirmed, and there were fourteen reported deaths from the disease. Only twenty of the essentially 1,800 residents who contracted cholera received professional medical care. Even out of those with symptoms, there were only 249 confirmed cases. The other cases were just "suspected," however, many more people plausibly had the virus but did not show symptoms, seeing that cholera only shows noticeable symptoms in 1/10 people that contract it.[38]

Later on, when scientists began to study the demographics of the outbreak, it was discovered that the disease affected both men and women at almost an equal rate. The studies also uncovered that cholera affects very young children the most by far out of any other age demographic.

The most unfortunate part of this outbreak was that it was for the most part easily preventable. Simply cleaning living areas, public spaces, and latrines would have stopped the majority of cases from being transmitted. The swimming in dirty rainwater pools is the only source of transmission that could not have been easily stopped, other than educating the people on why they should not swim in the pools because they are not sanitary. Providing clean and sanitary living conditions as well as the tools necessary for proper hygiene for the refugees are simple steps that could have been taken that could have eliminated the chances of cholera breaking out in the camp, as well as limited the number of residents that were affected by it.

As an immediate response to the cholera outbreak, the United Nations High Commissioner for Refugees created a cholera response program as well as sent community outreach volunteers to help out with the situation. There was another program specifically designed for the cholera outbreak called water, sanitation, and hygiene, otherwise known as WASH, to combat the issues that can create cholera cases and increase the chances of infected people passing it on to others. In a smaller-scale case study performed by the Kenya Ministry of Health to research how cholera can most easily be contracted, the highest risk factors for cholera transmission included human feces in living spaces, unsanitary latrines, defecation in public spaces, swimming in rainwater pools, food sharing, and using the same latrine as a person with diarrhea. This is why the WASH program was created. Having clean and sanitary living conditions might have originally stopped the disease from coming into the camp to begin with,

and now that cholera had already infected so many people, the best option was to provide the tools the residents needed for proper clean water, sanitation, and hygiene. The WASH program helped to eliminate cholera from the camp and the disease was eventually stopped completely in about a year from the initial cases being announced.

After the cholera outbreak had been eliminated, there were still measures to be taken as to what should be done to prevent something like this from happening again. The principals of the WASH Program were kept even after the outbreak was eliminated, keeping up with proper chlorination of not only drinking water but also local swimming holes and latrines. The WASH Program also properly sanitized latrines and living spaces to ensure that transmission of the disease will be eliminated through the way of public defecation in living and public spaces throughout the Dadaab Refugee Camp. Additionally, cholera treatment centers were built following the outbreak because of the significant impact it had on the community. The organizations Médecins Sans Frontiéres and the International Rescue Committee were the ones who took the initiative to fund and establish these treatment centers. Through these treatment centers, more active surveillance for cholera symptoms including acute watery diarrhea was instituted to ensure that the United Nations High Commissioner for Refugees could catch an outbreak more early on so that history doesn't repeat itself, having another large cholera plague in the refugee camp.

QUESTIONS

1. Have your country's immigration and asylum policies changed as a result of the COVID-19 pandemic? How could this impact the topic at hand?
2. Has your country had any outbreaks of Communicable Diseases? How did your country limit the spread of the disease/virus?
3. Does your country have universal healthcare? Does your country provide healthcare to those seeking asylum in your nation?
4. What are some ways to provide sustainable healthcare in refugee camps outside of short term humanitarian assistance programs?
5. What are the principal causes of communicable disease outbreaks in refugee camps and what unique solutions does your country have to prevent each one?
6. Think about the UN Global Action Plan promoting the health of refugees and migrants. Which parts of this plan have been successful and in what ways? Are there any changes your country would like to make to parts of the plan that have been unsuccessful? Why?

TOPIC 2: Rohingya Refugee Crisis

BACKGROUND

Beginning in the 1970s, the Rohingya people have repeatedly faced massive discrimination due to outbreaks of violence and religious conflict, and as a result, consistently migrate in large numbers from Myanmar to Bangladesh and surrounding areas within the Southeast Asian region. Known as one of the most persecuted groups on the planet, Rohingya Muslims are an ethnic group severely in the minority within the nation of Myanmar, a Buddhist country.[39] As a result of this cultural difference, the Rohingya, who are estimated to have a population of approximately 850,000 are not acknowledged as legal citizens, limiting them in employment opportunities and political involvement as well as making them more prone to abuse from security officials and citizens of the country.

This ethnic minority has been mostly isolated within Myanmar to the Rakhine State, a poor region of the nation with a population made up of majority Rakhine Buddhists and Rohingya Muslims.[40] This has bred numerous conflicts, one being the 2012 Rakhine State Riots. These riots began in June after a Rohingya protest turned violent and resulted in over twelve civilian casualties. Once a state of emergency was declared in the region, military intervention from the Burmese Army was authorized, and by August the conflict was mostly diminished; however, there ended up being a total of 88 citizens killed, with over 90,000 displaced and over 2,500 homes destroyed as a result.[41] When fighting sparked again in October, another 20,000 individuals were forced from the country and over 80 more civilians were killed. The Rohingya faced the majority blame for such atrocities, subjecting them to even more restrictions on their citizenship status and place within the nation of Myanmar.

On August 25, 2017, a group of Rohingya militants, known as the Arakan Rohingya Salvation Army (ARSA), launched a series of over 30 attacks against police forces within Myanmar. As reported in September of the same year by Amnesty International, an estimated 6,700 innocent Rohingya were killed, with an influx in rape and sexual abuse cases of young women and girls by the Myanmar military launched as a response to the attacks.[42] Such immediate and violent response from the military and enraged Buddhists within the country has resulted in the largest exodus of Rohingya Muslims seen in modern history.

Over 870,000 Rohingya have migrated to Bangladesh alone out of fear they will suffer the same fate as the almost 7,000 that were killed due to the ARSA's actions. Bangladesh has been the most involved in the fallout of this conflict, with their National Commission of Human Rights proposing the idea of formally charging Myanmar and its military for unlawful discrimination against the Rohingya and evidence of genocide. Though the government of Bangladesh has rightfully labeled the cruelties against the Rohingya people as nearing genocidal proportions, they have been particular about the numbers of Rohingya refugees they are letting into their country, and as of March 2019 halted their acceptance of Rohingya Muslims that are fleeing Myanmar.[43] As a result, there is a massive number of unregistered refugees within Bangladesh's borders, which they label as illegal infiltrators, who do not belong to refugee camps. Both unregistered migrants and those that are stationed within refugee camps are facing pressure to return to Myanmar, especially after the nation announced they would be reaccepting refugees in 2018, but none will return unless they are granted full citizenship and rights.[44]

Excluding those that are residing in Bangladesh as unregistered refugees, displaced Rohingya Muslims are forced to endure harsh overcrowding and a lack of resources within refugee camps. There are a total of 34 displacement camps containing Rohingya settlers, most of which do not even grant these individuals official refugee status. This comes as a result of the massive population of refugees within Bangladesh and across the rest of Southeast Asia, as well as the urgency from the government to relocate them back to Myanmar.[45] One such camp is Kutupalong, which has been reported by the United Nations High Commissioner for Refugees as being the largest refugee camp in the world. This settlement is currently housing over 630,000 migrants originating from the Rohingya crisis in Myanmar alone.[46] On average, over sixteen refugees are housed together in a single, small room without any sort of privacy, and with lacking access to resources like medicine and nutrition, illnesses and mortality are common.

A majority of these migrants are found in Cox's Bazar, an incredibly impoverished region of Bangladesh which has been known to provide hospitality to the Rohingya but cannot sustainably keep such efforts up.[47] Without substantial support from the international community, the Bangladeshi people are suffering alongside the refugees within this region, with a total of over 330,000 being subject to the same overcrowding problem and lacking resources as the Rohingya refugees. The villages are also unfit to survive the rainy season, which leads to massive flooding and combined with surrounding deforestation, landslides.[48] The instability of this region allows for it to become a hub for human trafficking and labor exploitation, with the organization Fortify Rights reporting an influx in not only trafficking rates but unlawful detainment and arrest.[49] These refugees are unable to support themselves, making them completely dependent on humanitarian aid from hands-on groups like Doctors Without Borders, who have been able to provide one million medical evaluations so far for the Rohingya people in Bangladesh. The COVID-19 virus, however, has posed an even greater challenge for the refugee crisis, as the first confirmed case within Kutupalong was reported in May. Considering the mass concentration of refugees within the camp and close proximity between persons, the resulting health crisis of the virus could be catastrophic.[50]

The Convention Relating to the Status of Displaced Persons, conducted in 1954, officially defines being stateless as individuals that are not viewed as legitimate citizens or nationals under any single country's legislation.[51] Considering not only the halt on acceptance of refugees in Bangladesh and surrounding countries but the inability of Rohingya Muslims to be considered legal citizens under Burmese law, the Rohingya are the largest population of stateless individuals on the planet. Even those with conventional qualifications of statehood, including housing and employment, are often forcibly evicted from their homes without proper cause.[52] Myanmar has established methods of integrating Rohingya as citizens, including National Verification Cards, but frequent revocation of documents and ignorance of rights declared under these cards proves them to be obsolete in the eyes of the Myanmar government and the Rohingya people.[53]

Though the Rohingya Refugee Crisis is ever prevalent, the government of Myanmar has not taken any substantial steps to promote a fair and safe return for those displaced by the conflict. Refusal to amend the 1982 Citizenship Law to include Rohingya Muslims has been mostly ignored, and humanitarian aid access has been frequently denied to the Rakhine State, despite pressure from the international community.[54] Furthermore, the government has refused to acknowledge the actions of the Myanmar military, which has continued to carry out acts of violence against the Rohingya people without any sort of punishment. Even outdated

occurrences of mass discrimination, including the 1978 Operation Dragon King, have been ignored though they have consisted of massive rates of murder, rape, and destruction. There is no current method of holding the Myanmar military accountable, and as a result, the Rohingya people are forced to endure continued persecution.[55]

UNITED NATIONS INVOLVEMENT

The United Nations has been extremely active in providing humanitarian aid and passing resolutions to assist the Rohingya people in Myanmar with an emphasis on the protection of human rights. The Rohingya Refugee crisis was first addressed by the United Nations on June 27, 2013, through A/HRC/PRST/23/1 which recognized a deep concern over the gross violation of human rights in Myanmar, especially against Rohingya Muslims in the Rakhine State.[56] The presidential statement brought global attention to the issue and urged the government of Myanmar to end all acts of violence based on religion, reaffirming the Universal Declaration of Human Rights. In 2015, The United Nations Humans Rights Council passed A/HRC/RES/29/21 called upon the government of Myanmar to address the spread of discrimination, conduct transparent investigations of all violations of human rights, and implement humanitarian assistance to affected communities in the Rakhine state. [57]

Simultaneously, the World Food Programme and UN High Commissioner for Refugees provided food assistance, malnutrition treatment, health care, safe drinking water, shelter, emergency telecommunications, and income-earning opportunities to refugees in Rohingya crisis camps.[58] Through the UN migration agency, UNHCR has built 660 pit latrines and 100 mobile restrooms in the Kutupalong settlement district, to accommodate for an influx of 1200 refugees. In addition to basic amenities, they have recently created “safe zones” for women and girls to receive counseling and psychiatric support for gender-based discrimination and single mothers facing barriers to camp resources.[59] Furthermore, the UN refugee agency hopes to move 6,000 refugees to a 3,000-acre piece of land, known as the Kutupalong Extension, to improve cramped living conditions. In 2018, the Human Rights Council (UNHRC) passed A/HRC/RES/S-27/1 to receive authorization from Myanmar to assist in the rehabilitation of the country. [60]

As makeshift camps have turned into long term residence for several Rohingya refugees, the Rohingya Children’s Educational Programme (RCEP) created 45 classrooms with mud walls, to provide quality education and schooling services to 3,5000 children. This program has also distributed learning materials and implemented a refugee-teach training program to also provide job security to adult refugees in the camp. [61]On December 27, 2019, the United Nations General Assembly approved A/RES/74/246 which condemned rights abuses against minority groups in Myanmar, especially Rohingya Muslim populations.[62] The resolution called upon the Myanmar government to take urgent measures against infringement of human rights and called for an immediate cessation of fighting and hostilities. [63] Recently, the United Nations have been passing a series of resolutions regarding ethnic cleaning occurring in Myanmar. UNHRC passed A/HRC/RES/37/32 condemning human rights violations that have been occurring in this region, including the mass exodus of the Rohingya people, although the government of Myanmar continues to deny allegations placed upon them and have recently been limiting outside humanitarian programs from entering their borders. Although the United Nations has helped millions of Rohingya refugees, as Antonio Guttierez states, the future calls for “long term reconciliation and solutions beyond immediate humanitarian assistance”.

CASE STUDY: The Venezuelan Refugee Crisis

Over five million Venezuelan refugees and asylum seekers are desperately searching for a home country where violence, threats, insecurity, and constant shortages of medicine and food are not a constant struggle. These people have left everything they know and love behind. They are on the streets. They have no food or clean water, no roof over their heads, and no one to care for them.[64] Since 2014, there has been over an 8,000 percent increase in the amount of native Venezuelans living outside of Venezuela. Because these Venezuelans lack access to legal paperwork or education about how to become a legal citizen in the country they are fleeing to, they do not receive basic human rights in many of these countries. The lack of basic human rights in these countries given to the refugee Venezuelans forces them to be more vulnerable to sexual abuse, trafficking, discrimination, and violence.[65] They leave behind even their own families to escape the turmoil.

As means of traveling out of Venezuela, many of the refugees find short maritime routes to the Caribbean islands or travel over borders illegally without documentation, leaving them vulnerable to trafficking and smugglers since they are undocumented.[66] When the refugees do not take routes overseas, they almost always travel ruthless trips by foot across countless miles, often in very harsh weather conditions or when they are in desperate need of medical attention, not to mention the dangers they face in the people they may meet on the road that are not safe, including traffickers, smugglers, and other violent individuals.

Seeing the arrival of the COVID 19 pandemic earlier this year in 2020, the pandemic has brought many Venezuelans back to their home country. However, with a lack of funding and organized government, there is an extreme lack of proper food and water resources as well as a lack of proper sanitation.[67] There were also shortages of clean water and electricity during the pandemic, causing riots to break out. Even before COVID 19 arrived, Venezuela had a shortage of medicine and proper medical care, and now that the pandemic hit they do not have the proper resources to treat their people.

The UNHCR sees these desperate refugee people and has a plan of action towards helping them out of their situation, or at least to help make the situation more bearable. They have created the Regional Response Plan for Refugees and Migrants (RMRP) with over ninety partners helping them.[68] The main objective of this response plan is to take action in Venezuela in the fastest and most organized way possible. The UNHCR asked for about 350 million dollars for the effort of aiding the refugees but only about 25% of that funding was actually raised, leaving so many refugees helpless and without humanitarian aid or help. In addition to creating this response plan, the UNHCR has sent out humanitarian aid volunteers to the main countries where the refugees are going, as well as put out protection interventions for vulnerable groups of migrants including the elderly, separated children, the disabled, the LGBT community, and victims of sexual violence. These protection services are vital to the rescue operation because the lack of legal documentation makes refugees especially vulnerable to violence and discrimination based upon aspects of themselves that they cannot control. If they are hurt, it does not easily go on record, making it easy for them to be a target for crime and violence of all kinds.

Due to extreme shortages of food resources and the fact that when one does come across clean food it is costly, undernourishment rates are through the roof.[69] People are starving because they may not even have access to food in the first place, but even if they do come across clean food every once in a while, they cannot afford it. This is one of the reasons the migrants are

leaving their home country, because of the lack of food security. Even when they flee the country, however, they are faced with trying to afford food without employment, usually going hungry. The UNHCR strives to do something about this, but with limited donations, their funding is too little to do much work in Venezuela, especially considering that most of the problem is coming from the unstable government.

Another organization is reaching out to help with the Venezuelan crisis, and its name is CARE. The main role of CARE is to provide refugees with cash vouchers that can be used to purchase food as well as shelter, transport tickets, and SIM cards for phones.[70] The program also provides sanitary kits for women and their possible babies that include sanitation necessities and diapers. In the future and with more funding, the CARE Program helps to reach out to more vulnerable groups like children and teens, as well as the LGBT community of refugees with counseling and reform policies.

One of the main issues with the Venezuelan refugee crisis and many others is the lack of funding. Compared to the Syrian refugee crisis that got over 7.4 billion dollars in funding in the first four years of the situation versus the 580 million dollars given to efforts for the Venezuelan crisis overall, that is a huge problem.[71] Without proper funding, nothing can be done about the countless issues migrants are facing right now in the many refugee crises throughout the world including food and medicine shortages, violence and discrimination, illegal documentation or lack of thereof, poor sanitation, and many more.

QUESTIONS

1. In many cases, refugee camps have become overly dependent on external humanitarian aid. What are some ways to make refugee camps more self-reliant and sustainable for the long term?
2. How does your nation approach the Rohingya ethnic group and their persecution in Myanmar, and in what ways might that factor into your policy regarding the topic?
3. Is your country willing and open to accepting refugees? If so, what steps can your country take to get the refugees legally documented to lessen their vulnerability to trafficking and smuggling?
4. What are the levels of food security in your country? What can your country do to improve the issue of food security for refugees in your country and around the world?
5. What are some vulnerable groups of refugees to discrimination, and what can your country to do eliminate discrimination-based violence on migrants?
6. What are some approaches to better hygiene and sanitation that your country can take in the Rohingya crisis and others in order to prevent the easy spread of disease between refugees?

Endnotes

1. https://www.cdc.gov/immigrantrefugeehealth/profiles/syrian/health-information/infectious-disease/index.html
2. https://www.who.int/about/structure/organigram/htm/en/
3. https://www.ncbi.nlm.nih.gov/books/NBK470303/
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