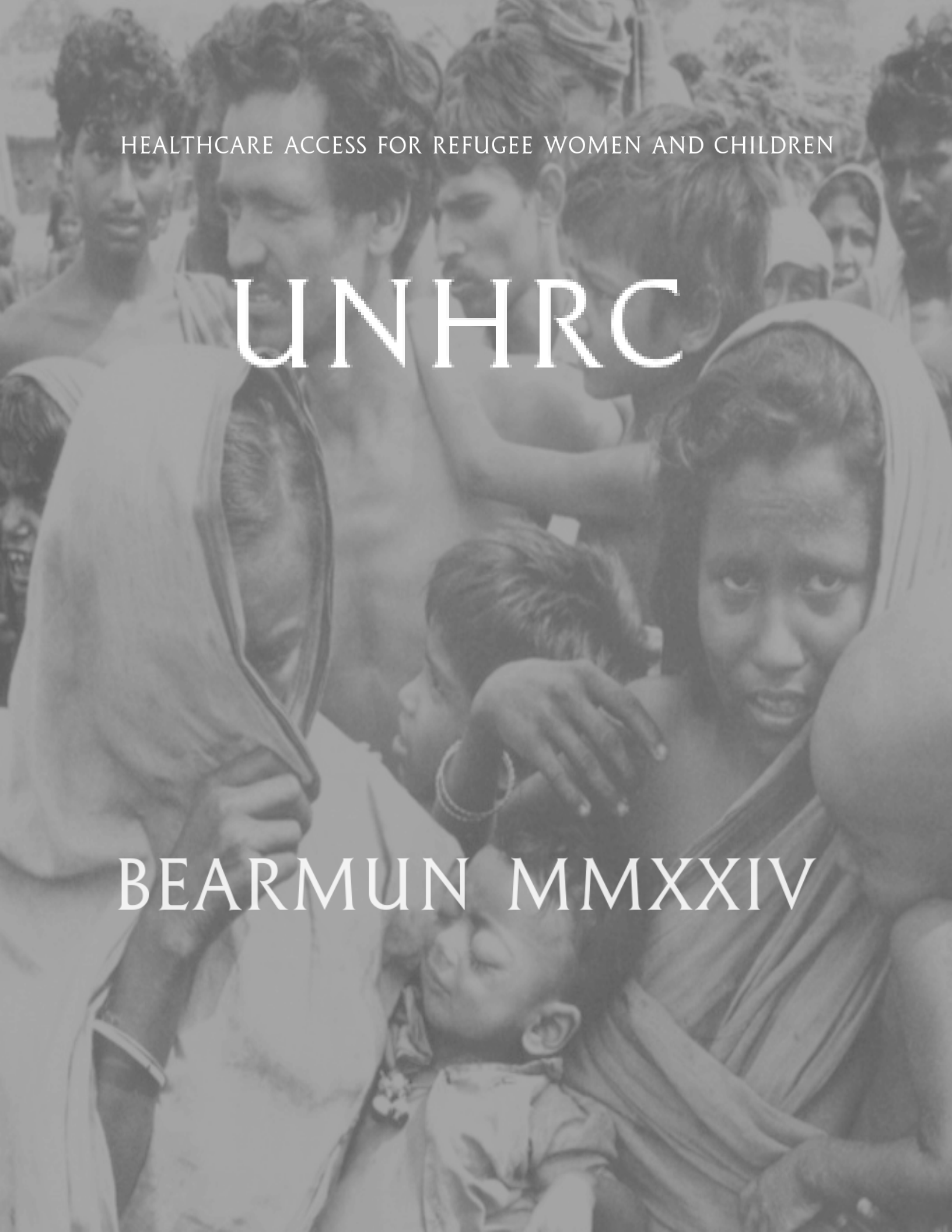

HEALTHCARE ACCESS FOR REFUGEE WOMEN AND CHILDREN

UNHRC

BEARMUN MMXXIV

CSU Archives/Everett Collection / Bridgeman Images

UNHRC: Healthcare Access for Refugee Women and Children

Letters from the Dais

Greetings delegates,

Welcome to UNHRC! My name is Nishita Belur (she/her), and I am excited to be your Chair for the United Nations Security Council. I am a senior from the Bay Area studying Neurobiology and Public Health, and I have been on the UCBMUN travel team since the fall of my freshman year. Throughout these years, I have staffed conferences, competed on both coasts and had a (short-lived) tenure as General Assembly Head Delegate. Outside of MUN, I research substance abuse at UCSF, read fantasy books, and obsessively binge cooking competition shows.

Our aim is to foster a respectful, engaging, and intellectually stimulating environment where you can develop your skills in research and critical thinking. Remember that the ultimate goal of the UNHRC is to protect and promote human rights for all individuals, and your contributions in this committee can simulate the impact that international cooperation can achieve. As a Public Health major, I really look forward to seeing the connections you all make from human rights to important public health matters like sanitation, water rights, and availability of medicines/vaccines. All three are often disrupted by conflict, tensions, and war and discussing these demonstrates a well rounded understanding of our topics.

We look forward to meaningful debates on the political, economic, and environmental policies necessary to address the complex situations UNHRC often encounters. I am so excited to meet all of you, and I hope you all have a great conference!

Nishita Belur
Chair
nishitabelur@berkeley.edu

Dear Delegates,

I am ecstatic to welcome you to BearMUN's UNHRC committee! I am especially thrilled to be spending the next few days hearing your perspectives on a topic that has increasing global prevalence, and is a passion of mine.

A little about myself- I am from Orange County, California and am a third-year at Berkeley, pursuing Public Health on the premedical track. In addition to chairing for BearMUN, I am the Under-Secretary General of General Assemblies for our upcoming collegiate conference: UCBMUN XXIX. Like many of you, I am relatively new to the world of MUN. While I joined UCBMUN to explore my interest in health policy, I stayed for the thrill of competing, excitement for leading, and feeling of community it has fostered. Whether this is your first or fifteenth conference, I hope you can leave BearMUN MMXXIV with some of these sentiments.

Outside of MUN, I can be found thrifting trinkets, going for night drives, or eating sushi. I am sure that many of you share these interests, and I cannot wait to swap music recommendations in between committee sessions! One of my true passions in life, in addition to The Neighborhood, is expanding health equity, especially within vulnerable communities.

The United Nations Human Rights Council plays a critical role in furthering the overall goal of the UN: promoting global well-being. Too often, people are encouraged to look towards their individual governments in ensuring their reception of basic privileges. But what happens when a person no longer has a government to look to? Refugee rights are a highly contested, relevant, and multifaceted topic. I encourage you to think critically about the unique landscape of healthcare in the context of asylum-seekers, and why seemingly simple solutions may not be so feasible. With this in mind, please know that I am beyond intrigued to hear your diverse and fresh takes on a decades-old issue, and hope you can go back home with a newfound or fortified interest in human rights. Welcome to UNHRC!

Sincerely,
Sameera Menon
Vice Chair
sameeramenon@berkeley.edu

How to MUN

General Assembly committees of Model United Nations conferences consist of delegates debating specific topics as their pre-assigned countries. Throughout debate speeches are given debating the best solutions for the topic at hand, and delegates seek to work together with others who share common ideas, forming what are called “blocs”, which eventually author resolution papers (UN Policy) together to try and resolve the global issue at hand. In order for debate to be conducive and equitable, and to more greatly resemble the real life United Nations, Model United Nations utilizes **parliamentary procedure,** or rules governing how debate must flow within committee. The dais (the co-chairs and any vice chairs) will help enforce these established rules and will call on delegates to take in points or motions. The following section will go over the basics of parliamentary procedure so the delegates are able to handle debate in an organized and equitable way.

Points: Points are used by delegates to communicate with the dais on something outside of substantive debate. Generally speaking, the three most important points are the point of order, point of personal privilege, and point of inquiry.

- *Point of Order*: A Point of Order is used when you believe the chair did something *procedurally wrong*, such as mistaking the ordering of motions from most to least disruptive. A point of order can be used at any time, except when another delegate is speaking, and will immediately be ruled upon by the dias.
- *Point of Personal Privilege*: A Point of Personal Order can be used when you are experiencing discomfort, such as being unable to hear another person’s speech or the room being too hot. Similar to the point of order, please do not use the point of personal privilege during another person’s speech.
- *Point of Inquiry*: A Point of Inquiry can be used to ask a question, and thus would generally be asked as a question (ie: “Point of inquiry, when does the next committee session begin”). While these can be done at any time except during another person’s speech, points of inquiry will generally be reserved until the dias asks if there are “any points or motions on the floor”. Points of inquiry can include both logistical questions, as well as more substantive questions, though the dias may not directly answer some more substantive questions by delegates.

Motions: Motions are used by delegates to communicate with the chair on how they would like the flow of debate to go, and thus, this section will go over both possible motions as well as the general timeline of the committee. The dias may rule certain motions ‘dilatory’, meaning that the dias is refusing to entertain the motion at this time; reasons for a motion being ruled dilatory may include timing reasons, repetitiveness, or wanting to see a different type of debate.

During specific times of debate, the dias will ask if there are “any points or motions on the floor”. At this time, delegates may give any motions they’d like to suggest, which the dias will take a limited amount of. After accepting motions, the dias will allow for voting on the motions, in order from “most disruptive to least disruptive”, with the first motion passed by a majority of delegates going into effect.
The order of disruptive motions will generally be as follows:

- Motion to Open/Close/Suspend/Resume Debate
- Any motion for an extension
- Motion to move into voting bloc
- Motion for unmoderated caucuses (in order of longest time to shortest time)
- Motion for moderated caucuses (in order of most speakers to least speakers, followed by overall time, followed by order of submission)

Details about the motions are as follows:

1. *Motion to Open/Resume/Suspend/Close debate*
    - The motion to open debate will be used at the beginning of any debate to mark the beginning of the committee; any motions made prior to the passing of this motion will be ruled dilatory by the dias. The motion to open debate will generally be accepted following the initial attendance role call of delegates.
    - The motion to close debate should be used to signify the end of committee, and should be used during the last committee session.
    - The motions to resume debate and suspend debate are respectively similar to the motion to open and close debate, but will be used in-between committee sessions.
2. *Motion to open speakers list*
    - This motion would be used at the beginning of the debate to allow speakers to sign up for speeches. The delegate who opens the speakers list will be given the opportunity to be the first speaker. These will generally be the prepared speeches.
3. *Motion for moderated caucuses*
    - A moderated caucus is a type of debate that focuses on a specific topic related to the debate. Speeches will be done in succession with a variety of speakers having the opportunity to speak. Motions for moderated caucuses should include the total time of the moderated caucus, the speech time for each individual speaker, and the topic of the caucus (ie: motion for a 5 minute moderated caucus with 30 second speaker time focusing on the topic of WADA).

4. *Motion for unmoderated caucuses*
    - An unmoderated caucus (unmod) is a type of debate that is not controlled by the dias, and allows the delegates to freely walk around and discuss potential solutions with fellow delegates for the duration of the unmod. The unmod will generally be used for creating blocs (groups of delegates that would work together to write a resolution together) and working on the working papers and draft resolutions.
5. *Motion to present working papers/draft resolutions*
    - A motion to present working papers/draft resolutions will allow the presentation of the multiple working paper/draft resolution. Generally, each working paper will get the same amount of time to present, and the presentation will be divided between members of the bloc discussing their working paper clauses, and a Q&A section by other delegates. Amending the rules, this novice committee at BearMUN will allocate a specific time for presentation and a specific time for Q&A, with that time being reasonably determined by the committee.
6. *Motion to enter/exit voting bloc*

- Motion to enter the voting bloc will lead to the voting of draft resolutions and seeing whether these draft resolutions pass or not; if passed, no one can enter or exit until the end of the voting period. A delegate can only abstain from voting if they did not say they were "present and voting" during attendance.

Resolution Structure

1. *Sponsors and Signatories*
    - Sponsors are delegations who added substance to the resolution
    - Signatories are delegations who support the resolution being presented, whether or not they fully support everything in the resolution.
2. *Preambulatory Clauses*
    - Preambulatory Clauses are clauses that help establish the context of the situation
    - Verbs beginning the clauses should end in "-ing"
    - ex: Recognizing the importance of equality in sport competitions both domestically and internationally
3. *Operative Clauses*
    - Operative Clauses are clauses that explain the policy solutions that would be used to help solve the problem in more detail
    - The clauses should end in "-s" such as "*Calls for"* or "*Establishes*"

Healthcare Systems in Refugee Camps

Global refugee camps often emerge in response to violent conflicts, political instability, and severe economic hardships, forcing people to flee their homes in search of safety. These camps are scattered across various regions, primarily in countries bordering conflict zones. The largest camps are often found in Africa and Asia, hosting hundreds of thousands of refugees. For instance, the camps in Cox's Bazar, Bangladesh, home to the Muslim Rohingya refugees fleeing persecution and genocide in Myanmar, are currently the world's largest, with over 900,000 inhabitants.[1] Similarly, Dadaab and Kakuma camps in Kenya accommodate large populations of refugees primarily from the Somali Civil War and instability in South Sudan.[2]

The state of medical care in many of these camps is frequently dire, plagued by significant challenges in accessibility and quality. The doctor-to-patient ratio is alarmingly low, sometimes as extreme as five doctors per 10,000 patients, far below the World Health Organization's recommended standard.[3] Additionally, the nature of refugee camps as short-lived unplanned settlements contributes to a lack of public infrastructure that is critical for healthcare staff. Emergency care is particularly strained; limited resources mean that response times can be slow, and facilities are often under-equipped to handle critical cases.[4] In developed countries, emergency situations are dealt with by a team of experienced doctors, but in refugee camps, emergency situations are routine and doctors are short. Often, there is only one doctor and a few volunteers to treat emergencies like childbirth. Additionally, emergency responses are dependent on rapid short-term response. In areas with basic infrastructure, this means that medical response teams (paramedics, etc.) need to traverse a few streets with sirens to reach the patient. However, refugee camps often consist of ramshackle bamboo/wood and tarpaulin structures raised without proper planning. They are not navigable by vehicles and need medical staff to be able to traverse narrow unpaved, dangerous alleys with stretchers and medical equipment to reach patients. Delays in emergency care can be fatal and result in adverse health outcomes for refugees.

While emergency care in refugee camps can be severely limited and ineffective due to a lack of

[1] https://data.unhcr.org/en/country/bgd
[2] https://www.unrefugees.org/news/inside-the-worlds-five-largest-refugee-camps/
[3] https://www.who.int/data/gho/data/indicators/indicator-details/GHO/medical-doctors-(per-10-000-population)
[4] https://www.doctorswithoutborders.ca/medical-needs-increasing-for-rohingya-in-bangladesh-as-funding-stagnates/

public infrastructure, it remains one of the dominant forms of healthcare administered in these camps. Healthcare workers often use a prioritization system, called triage, to categorize the time sensitivity of care. One common triage system is the colors system, in which green-tagged patients need urgent care; yellow-tagged patients display abnormal vital signs and require full body examinations; and red-tagged emergency patients are experiencing major panic attacks, extreme pain, life-threatening wounds, or contractions indicating imminent child delivery.[5] Triaging and doctor shortages result in a large percentage of clinic visits becoming emergency care visits. For example, the nonprofit "Emergency USA" reports that in 2017 (pre-COVID pandemic), their clinics administering healthcare to Syrian refugees in Iraqi camps reported that 30% of all referrals were urgent.[6] For a comparison, the Department of Healthcare Access and Information in California reported that in 2021 (post-COVID pandemic), emergency visits comprised 13.5 percent of all referrals.[7] Emergency care comprises a much larger percentage of healthcare administered in refugee camps largely due to limited resources and staff, resulting in chronic, long-term conditions, non-communicable diseases (NCDs) not being addressed.

The WHO reports that 25-35% of the populations in low and middle income countries suffer from NCDs;[8] they constitute a large portion of the target population in refugee camps. For refugees diagnosed with NCDs like cardiovascular disease, hypertension, diabetes, asthma and cancer, the long, arduous journeys away from unstable regions to refugee camps exacerbate these conditions. Their journeys also cause an interruption in the continuous treatment essential for the management of NCDs. Refugee's immediate concerns are most often shelter, safety, food and water, not continuous management of their conditions. Thus, interruptions in care can accumulate and result in emergency situations. Even in refugee camps, NCDs are difficult to treat with resource limitations. For example, volunteers who worked in Doctor of the World's Idomeni clinic in northern Greece treated hundreds of people suffering from NCDs but maintaining the stocks of necessary drugs (insulin, etc.) could be difficult.[9] If left untreated, NCDs only increase in severity, as does the risk of premature death. Chronic illnesses such as

[5] https://www.theguardian.com/world/2020/feb/09/moria-refugee-camp-doctors-story-lesbos-greece

[6] https://www.emergencyusa.org/prj/iraq/healthcare-clinics-in-refugee-and-idp-camps/#:~:text=In%202017%2C%20over%2030%25%20of,under%2014%20years%20of%20age.

[7] https://hcai.ca.gov/visualizations/emergency-department-volume-and-capacity-by-facility/#:~:text=and%20Mental%20Health.-,Key%20Findings,is%201%2C270%20visits%20per%20station.

[8] http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/migrant-health-in-the-european-region/migration-and-health-key-issues

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6297302/

diabetes can be easily treated with access to the right medicine, but without that access, they can become life-threatening. For those refugees who have undiagnosed NCDs, there is also a higher risk of problems during pregnancy.

Despite the current research and default healthcare systems in refugee camps often focusing on communicable diseases, NCDs and an inability to tackle modifiable risk factors are actually the key factors that increase morbidity and mortality for migrants and refugees. Though often seen as chronic and so not an immediate priority, not responding to NCDs in an emergency setting can have significant adverse impacts on the long-term health outcomes for refugee populations. Prevention and early detection of NCDs are undoubtedly more cost-effective than managing the later stages of disease. The current system's lack of NCD management infrastructure generates a large human and economic cost.[9]

Overall, resource and staffing shortages characterize a majority of healthcare administered in refugee camps. This directly affects vulnerable populations– women and children– the most.

Topic 1: Preventative and Reproductive Care

1. Prenatal Care

1.1 Medical Check-ups

Regular prenatal visits are vital for monitoring the health of both the mother and the developing fetus. These visits are typically scheduled monthly during the first and second trimesters, bi-weekly during the third trimester, and weekly in the final month of pregnancy. Early and consistent prenatal care helps detect and manage potential complications such as gestational diabetes, preeclampsia, and fetal growth restrictions.[10] During these visits, healthcare providers conduct various assessments, including blood pressure checks, weight monitoring, and urine tests to detect protein levels, which can indicate preeclampsia.[11] Ultrasound scans are also routinely performed to monitor fetal growth and development, typically around 18-22 weeks to confirm gestational age, check for congenital anomalies, and assess placental position.[12]

Prenatal care is difficult to provide consistently in refugee camps, for various reasons. First, safety is an issue. Female refugees in particular have some of the highest rates for risk for sexual violence.[13] Leaving home, even for medical visits, on a regular basis is unsafe and actively can put young women in danger. Without safety, young women cannot go to prenatal care appointments often enough to receive sufficient care. Secondary issues to prenatal care include staff shortages and equipment shortages due to small amounts of funding that actually reach humanitarian efforts. Strong incentives are needed to recruit and retain talented medical professionals.[14] Tertiary issues include cultural restrictions that preclude young pregnant women from receiving appropriate medical care, for example, blood transfusions or care from male doctors.

1.2 Nutrition

Proper nutrition is a cornerstone of prenatal care. Pregnant women need a balanced diet rich in essential nutrients to support fetal development and maintain maternal health. Women's

[10] https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/prenatal-care
[11] https://www.preeclampsia.org/preeclampsia-tests
[12] https://my.clevelandclinic.org/health/diagnostics/22644-20-week-ultrasound
[13] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4012695/
[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5572099/#:~:text=are%20deeply%20traumatized.-,2,value%20to%20ntheir%20medical%20curriculum.

diets in many countries contain limited fruits, vegetables, dairy, fish, and meat. Key nutrients include folic acid, iron, calcium, and omega-3 fatty acids. Folic acid is crucial in preventing neural tube defects and is recommended at a daily intake of 400-800 micrograms before and during early pregnancy.[15] Iron is vital to prevent anemia, which can lead to complications like low birth weight and preterm delivery. Pregnant women should consume iron-rich foods such as lean meats, spinach, and legumes, or take iron supplements if recommended by their healthcare provider. Additionally, calcium supports the development of fetal bones and teeth, while omega-3 fatty acids are important for brain development.[15] During pregnancy, poor diets lacking in key nutrients can cause anemia, pre-eclampsia, hemorrhage and death in mothers. They can also lead to stillbirth, low birth weight, wasting, and developmental delays for children. Poor nutrition during breastfeeding makes it more challenging for mothers to replenish their nutrient stores and meet their additional dietary needs.

Nutrition is part of a larger problem in refugee camps, a problem of food insecurity and limited enforcement ability to keep people responsible for their own allocated rations.[16] The lack of nutrition affects pregnant women especially, and the lack of nutrition at early ages affects development irreversibly and dramatically. Nutrition services need to reach underserved populations like pregnant women first in refugee camps.

1.3 Physical Activity

Regular physical activity, unless contraindicated, is beneficial during pregnancy. Exercise can help alleviate common pregnancy discomforts such as back pain, improve mood, and enhance overall health. Safe activities include walking, swimming, and prenatal yoga, which can help maintain cardiovascular fitness, manage weight gain, and reduce the risk of gestational diabetes.[17] Physical activity is difficult to continue with high rates of sexual violence conducted towards women in refugee camps. Refugees barely leave their own tents, and receive neither the stress-relieving social aspects of physical activity nor the biologically beneficial aspects.[13] Safety is a prerequisite for physical activity as a positive behavior to reduce risk factors for chronic diseases, worse quality of life, and early death.

[15] https://www.acog.org/womens-health/faqs/nutrition-during-pregnancy
[16] https://www.unhcr.org/us/what-we-do/protect-human-rights/public-health/nutrition-and-food-security
[17] https://www.acog.org/womens-health/faqs/exercise-during-pregnancy

1.4 Health Education and Support

Education and emotional support are vital components of prenatal care. Pregnant women are encouraged to attend childbirth education classes, which provide valuable information about labor, delivery, and newborn care. These classes can also prepare them for breastfeeding and parenting. Education on birth preparedness and complication readiness is crucial. Pregnant women should be informed about the signs of labor, the importance of choosing a birth plan and recognizing symptoms that require immediate medical attention, such as severe headaches, vision changes, or decreased fetal movement. Psychological support is equally important, particularly for those experiencing anxiety or depression during pregnancy. Access to mental health resources and counseling can help manage these conditions and improve overall pregnancy outcomes. These educational opportunities are far and few between in refugee camps.[18]

Mental health is a critical consideration during pregnancy. Pregnant women should be screened for depression and anxiety, given the significant impact these conditions can have on both maternal and fetal outcomes. Supportive counseling and, if necessary, appropriate therapeutic interventions should be made available. Managing stress through relaxation techniques, such as meditation and deep breathing exercises, can also promote mental well-being during pregnancy.

40% of refugees are affected by post-traumatic stress (PTSD), depression- and anxiety disorders and women seeking asylum during pregnancy and after childbirth are at greatest risk.[19] Many refugees will have experienced trauma on the journey to refugee camps and during their stay. Mental health is the last consideration in a camp and is often only offered once mental health services can sustain the less concentrated outflows from refugee camps. However, addressing it early can reduce the risk of chronic diseases and short-term death.

1.5 Vaccinations and Screening Tests

Routine vaccinations and screening tests are important aspects of prenatal care. Vaccinations, such as the flu shot and Tdap (tetanus, diphtheria, and pertussis), are recommended to protect both the mother and the baby from preventable diseases. Screening tests for conditions

[18] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10214470/

[19] https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-023-06054-x#:~:text=An%20estimated%2040%25%20of%20refugees,at%20greatest%20risk%20%5B15%5D.

like gestational diabetes, anemia, and infectious diseases are also crucial for identifying and managing potential health issues early. Additionally, genetic screening and diagnostic tests can help detect chromosomal abnormalities and other genetic conditions, allowing for informed decision-making and early intervention if necessary.[20]

Genetic screening and diagnostic tests can rarely happen for pregnant women, with the limited medical resources within refugee camps. This results in a higher rate of genetic malformations and disabilities among children, affecting life expectancy and quality of life on a population level. Additionally, up to date vaccinations need to be delivered to refugee camps without proper infrastructure. Deliveries need to be made inside active war zones on unpaved, rocky roads and need to be made with enough equipment to keep vaccinations and medications at optimal temperature and keep their abilities active.[21]

2. Childbirth, Fetal Care, and Early Childhood

Childbirth requires comprehensive care to ensure the safety and well-being of both the mother and the baby. Each of these medical care areas will need to be implemented with an eye towards safety, physical accessibility through paved roads, appropriate resources keeping medications and vaccinations at optimal temperatures, sufficient staff, and consistent educational communications while respecting local customs. Preparing for childbirth involves creating a birth plan that outlines preferences for labor and delivery, including pain management options, preferred delivery positions, and who will be present during the birth. It's important to discuss this plan with healthcare providers to align expectations and ensure all necessary arrangements are made in advance. Continuous monitoring during labor is crucial. This includes tracking the mother's vital signs, such as blood pressure, pulse, and temperature, as well as monitoring the baby’s heart rate. This helps detect any signs of distress that might necessitate medical intervention. All of these aspects of medical care are limited in refugee camps, where birth plans can go awry and labor occurs without proper monitoring equipment.[13]

2.1 Care during Active Labor

Pain management is a significant aspect of childbirth care. Options range from non-medical techniques like breathing exercises and laboring in water to medical interventions such as epidurals and spinal blocks. The choice of pain management should be guided by the mother's preferences and medical advice

[20] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7992376/
[21] https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf

from her healthcare provider. Medical staff may provide physical and emotional support throughout labor. This includes helping with positioning, offering encouragement, and ensuring the mother is hydrated and comfortable. The presence of a supportive birthing partner, whether a spouse, family member, or doula, can also be beneficial. Pain medication is difficult to obtain and administer to appropriate amounts in refugee camps and trauma from the environments that led to resettlement can lead to loss of family and support. Emotional and physical health in the pregnancy is key to a safe delivery; complications are more likely to occur when the pregnant mother experiences stress and high levels of pain without proper preparedness.[22]

2.2 Interventional Medicine team

Certain situations might require medical interventions to ensure a safe delivery. This can include the use of forceps or vacuum extraction if the baby needs help moving through the birth canal, or performing a cesarean section if a vaginal delivery poses risks to the mother or baby. Episiotomies, once common, are now only performed when absolutely necessary. After delivery, immediate postpartum care involves monitoring the mother's vital signs and managing any bleeding. The baby is assessed using the Apgar score to evaluate heart rate, breathing, muscle tone, reflex response, and color. Skin-to-skin contact and early initiation of breastfeeding are encouraged to promote bonding and milk production. Preparedness for complications is a critical component of childbirth care. Hospitals and birthing centers are equipped to handle emergencies such as preeclampsia, postpartum hemorrhage, and neonatal distress. Having a neonatal intensive care unit (NICU) on-site can be crucial for managing complications that arise with newborns. Refugee camps are not often equipped with the technology needed to establish NICUs or prepare for complications.[23] Additionally, performing necessary surgical procedures can be difficult without proper hygiene or sufficient staff in camps.[13]

2.3 Childhood Care

Medical care for toddlers and children is essential to ensure they grow up healthy, develop properly, and avoid preventable illnesses. This care includes regular checkups, vaccinations, screenings, and attention to both physical and mental health. By ensuring that children receive the appropriate medical care, we can set the foundation for a lifetime of wellness. One of the most important aspects of medical care for toddlers and children is regular well-child visits. These appointments allow healthcare professionals to monitor the child’s growth, development, and overall health. During these visits, pediatricians measure the child’s height, weight, and head circumference, comparing them to established growth charts. These

[22] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7863987/
[23] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10566266/

metrics provide crucial insights into whether a child is developing normally for their age. Routine checkups are also an opportunity to discuss concerns about nutrition, sleep patterns, and developmental milestones such as speech, motor skills, and social behavior. Regular medical visits also help in the early detection of any underlying conditions that may require special attention, such as congenital heart issues or developmental disorders like autism.

2.4 Vaccinations

Vaccinations are a key component of medical care for toddlers and children. They protect young children from serious illnesses that were once common but are now preventable. Vaccines, such as those for diphtheria, tetanus, and whooping cough (DTaP), measles, mumps, and rubella (MMR), and polio, are typically administered according to a well-defined schedule recommended by health authorities. These immunizations not only protect individual children but also contribute to community health by creating herd immunity. For example, in many countries, access to the polio vaccine has almost eradicated the disease, which was once a major global health concern. More recently, vaccines like those for COVID-19 have been adapted for younger populations, playing a significant role in curbing the spread of new infections. Ensuring timely vaccinations protects children from potentially life-threatening diseases and prevents the spread of illness in schools and communities.

2.5 Other Forms of Care

Early childhood is a critical time for identifying and addressing sensory issues like vision and hearing problems. Screenings for these issues are often included in regular checkups. Vision problems, if left undetected, can interfere with a child's learning and cognitive development, while hearing issues can delay language development. Simple tests conducted by pediatricians can detect these issues early, allowing for intervention through glasses, hearing aids, or other treatments as needed. Early detection of vision and hearing problems can make a significant difference in a child's academic success and social interactions. Dental checkups should begin as early as the first tooth's appearance, typically around 6 months of age. Regular visits to a pediatric dentist help prevent tooth decay, which is one of the most common chronic diseases among children. Dentists can also offer advice on proper oral hygiene habits, such as brushing and flossing, which are crucial for long-term dental health.

In addition to physical health, the mental and emotional well-being of children should be monitored. Pediatricians often assess a child's emotional and behavioral development during checkups, asking parents about the child's temperament, social interactions, and any concerns related to behavior. Addressing mental health early can prevent the escalation of issues such as anxiety, depression, or behavioral disorders later in life. For example, if a toddler exhibits signs of anxiety or difficulty adjusting

to new situations, healthcare providers might recommend early intervention strategies such as therapy or behavioral support. This proactive approach ensures that children receive the help they need before mental health challenges become more complex.

3. Case Studies

3.1 A Pregnant Woman's Personal Experience in a Nigerian Refugee Camp

From CNN–

"Aisha Aliyu is eight-months pregnant and sprawled out on a mat in front of her house with four of her children spread around her feet. Two-year-old Hauwa and five-year-old Abba are both crying and tugging at their mother's coffee-colored hijab. She, in response, rolls her eyes and clicks her tongue at them. She looks tired.

The child Aliyu is carrying is her tenth. The last four were delivered in the Durumi Camp, a place in Nigeria's capital city, Abuja, that she and an estimated more than 3,000 other internally displaced people call home.

In 2013, Aliyu fled her home in the village of Wala in Nigeria's northeastern Borno State to its capital, Maiduguri. She said her village was attacked and much of it burned down by the armed Islamist group, Boko Haram. The now 39-year-old saw having many children as a way of replacing her relatives killed by the insurgents,

The space initially set up as a birthing suite at the camp was rudimentary and barely hygienic. If gloves were available, the birth attendant used them and if not, she explains that she covered her hands with polythene bags and cut umbilical cords with a razor blade. In 2019, a non-governmental organization set up the camp's health post where Aliyu's ninth child, Hauwa, was delivered in 2021. The post is a small clinic located inside a repurposed 20ft shipping container, where wooden boards partition the space to create a delivery suite which looks more like a storage space and just about holds a bed, a baby cot, a drip stand, a broken chair, a trolley and empty containers that should contain water. The set up is far from adequate. A camp nurse tells CNN: "We don't even have folic acid or anti-malarial medicine to give them. I have to write these for them to go and buy." Malaria is endemic in Nigeria and infections pose various risks during pregnancy, such as premature labor and miscarriage, and folic acid is recommended for those who are pregnant or planning to become pregnant, to reduce the risk of certain birth defects. But for most of the 64 women recorded in the camp's birth register this year, these costs are prohibitive. Folic acid, for example, costs ₦3,000 ($3.74) for 100 tablets and Aliyu tells CNN she could not possibly have afforded that cost for the duration of her pregnancy. She says she's only been able to take this vital supplement

when NGOs have donated them free of charge. Back home in Wala, her N100 ($0.11) hospital card had entitled her to free folic acid as well as other resources while pregnant.

Getting clean water at the camp is also a challenge, Aliyu shares, explaining that it's a time-consuming, strenuous task requiring her to make several trips daily and is one she can no longer do in the final weeks of her pregnancy. Instead, she now pays for it to be delivered. At its cheapest, enough water to make the family's breakfast of pap (porridge made from ground corn) and other domestic chores for a month costs ₦24,000 ($28.43). Costs can rise by 25% on days when there is no electricity and a generator is needed to work the pumps, or when water sellers must go farther to fetch it. With Aisha almost full term, she is no longer able to fetch water and now has to pay up to ₦500 daily for it to be delivered to her home.

There are also the costs of giving birth in Abuja that Aliyu didn't have back home. To immunize her babies at the camp, the mother of nine has to take them to the nearest government hospital where nurses have certain expectations that fall to the mother, she tells CNN. These include making sure the baby is wearing diapers and bringing various items including cotton wool and baby lotion, which Aliyu says she doesn't have money to buy. "In Borno, it was not compulsory to use [diapers] when going to the hospital. We just used our wrappers (a piece of fabric women tied around their waist). But here, the nurses insist that (the babies) must wear diapers and (we must) have an extra one in our bag," Aliyu says. Multiple mothers shared similar concerns with CNN.

In the meantime, Aliyu says she is struggling to meet all her needs and those of her children. To afford what she can, Aliyu makes and sells wigs and traditional caps worn by men, earning on average ₦10,000 ($12.49) a month. Money is not her only concern. Aliyu worries about catching malaria and about not being able to

produce enough breast milk because of the poor quality of her diet. Her family survives on staples such as pasta

and maize in different forms. "I can't afford the treatment" for malaria, says Aliyu. "If it happens, I am dead." “[24]

3.2 Solutions

Two financial support studies, from the United States and Pakistan, found that providing free or low-cost reproductive health (RH) services for undocumented migrant and refugee women boosted service use. In Pakistan, healthcare subsidies through insurance plans doubled awareness of contraceptive methods and increased approval among women, their peers, and partners. Women with access to subsidized care saw a 29% rise in contraceptive use compared to those without subsidies.[25] Similarly, in the U.S., pregnant

[24] https://www.cnn.com/2023/11/29/africa/nigeria-women-health-risks-as-equals-intl-cmda/index.html
[25] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3487847/

undocumented migrant women in states offering Medicaid subsidies (California and New York) were more likely to access prenatal care during the first trimester, with 22% more receiving adequate prenatal services than in states where Medicaid was restricted.[26]

Two studies from Pakistan and Lebanon highlighted the positive effects of improving health service delivery in refugee areas on reproductive and maternal health. In Pakistan, the establishment of emergency obstetric care units and community outreach efforts led to an increase in prenatal visits and a drop in maternal mortality.[27] In Lebanon, strengthening primary healthcare in refugee-dense regions resulted in higher RH service use among refugees, sometimes surpassing that of local women.[28] These interventions were implemented over three years and incorporated cultural and gender-sensitive approaches.

Two studies in Thailand focused on providing access to safe abortion for migrant women.[29] [30]One evaluated a referral program for free abortion services, while the other assessed an initiative with community health promoters who offered counseling and access to oral misoprostol. Both interventions were successful, with high referral rates and successful abortion outcomes. Women reported feeling empowered, with a greater ability to advocate for their RH rights. The costs for these services, including transportation and interpreters, were fully subsidized, so women did not bear any financial burden.
Four studies from Guinea, Uganda, and Thailand examined the impact of educational interventions on RH outcomes for migrant and refugee women. Most studies included qualitative components. Two involved community outreach and training programs, one raised awareness about folic acid to prevent neural tube defects, and another trained refugee women to provide RH education, referrals, and contraceptives.[31] [32]
One study used peer education to improve knowledge among migrant women sex workers on human rights and RH,[33] while another looked at the effects of RH literacy sessions for refugee women living in camps.[34] The results of these educational interventions varied. Some showed significant increases in RH knowledge, particularly when peer-led, though these improvements didn't always translate into behavioral changes or greater use of services. For example, while healthcare workers learned about the importance of folic acid, it did not lead to increased consumption among women. However, these interventions often built self-confidence, motivated women to become RH advocates, and were especially beneficial for marginalized groups. Among migrant sex workers and transgender women, peer education helped

[26] https://pubmed.ncbi.nlm.nih.gov/16394053/
[27] https://pubmed.ncbi.nlm.nih.gov/19232603
[28] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6420751/
[29] https://pubmed.ncbi.nlm.nih.gov/29210341
[30] https://pubmed.ncbi.nlm.nih.gov/28780239
[31] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3080804/
[32] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6086336/
[33] https://pubmed.ncbi.nlm.nih.gov/29231800
[34] https://pubmed.ncbi.nlm.nih.gov/19153909

improve access to information, communication skills, and the ability to discuss RH topics with peers and clients.

Ultimately, providing free or low-cost services to migrant women and female refugees in prolonged situations is essential for ensuring access to comprehensive sexual, reproductive, maternal, and newborn care. The findings align with other research showing that such interventions lead to increased use of contraceptive methods and prenatal care. Studies involving non-migrant populations also show that economic assistance programs or reduced healthcare costs increase the use of reproductive and prenatal services. Financial subsidies help remove barriers to accessing medical services and supplies, and can encourage migrants, who may otherwise avoid spending out-of-pocket due to their difficult socioeconomic conditions. Public subsidies, in particular, provide undocumented migrants with access to conditions similar to citizens, helping migrant women exercise their right to reproductive health care. [35]

Health system structures need to be strengthened to ensure migrant and refugee women can access available services. Employing culturally competent, well-trained healthcare staff positively influences contraception use and reduces maternal and neonatal complications. Setting up care units involves hiring qualified staff, and studies should account for financial considerations and sustainability. In Tanzania, research with non-migrant populations found that the median cost per patient across six facilities was $290, with the largest expenses being personnel and equipment. Providing information on the minimum budget required for similar interventions in border regions or with refugee and migrant populations would be beneficial for those aiming to replicate these initiatives. While each country's budgetary needs will differ, comparing the proportion of health expenditures allocated to reproductive health services in countries with successful outcomes among undocumented female migrants and refugees can provide useful insights. [35]

[35] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9771456/

Topic 2: Infrastructure: Sanitation, Water Access, and Malnutrition

1.Sanitation Infrastructure

1.1 Waste Management Systems

Efficient waste management systems in refugee camps handle both solid and liquid waste safely, preventing disease transmission and minimizing environmental pollution. Proper waste management reduces health hazards associated with improper waste disposal and potentially creates opportunities for refugees to participate in waste management programs, empowering them economically and socially. Safe waste disposal reduces exposure to hazardous waste, which can cause injuries and infections.[36] Additionally, educational programs on waste management teach refugees important hygiene practices, fostering long-term healthy behaviors and contributing to the overall cleanliness of the camp.

The sustainability and effectiveness of sanitation infrastructure in refugee camps depend on regular maintenance and upkeep. Ensuring that latrines and waste management systems are kept clean and functional prevents the deterioration of sanitary conditions and reduces the spread of disease. Regular cleaning schedules, timely repairs, and community involvement in maintenance activities are essential. Involving refugees in the maintenance and management of sanitation facilities creates job opportunities, promotes a sense of ownership, and ensures consistent access to clean and safe sanitation, enhancing the overall living conditions within the camp.

1.2 Latrine Construction

The construction of latrines is fundamental to improving sanitation in communities..Properly designed and strategically located latrines are essential in refugee camps to reduce open defecation, which significantly lowers the incidence of waterborne diseases such as cholera, dysentery, and typhoid. These latrines in refugee communities provide secure and private spaces that protect individuals, particularly women and children, from the risk of sexual harassment and violence. Accessible latrines promote menstrual hygiene management, enabling women to manage menstruation with dignity and privacy.[37] Furthermore, child-friendly latrines ensure young children have access to facilities that are appropriately sized and easy to use, contributing to their overall health and hygiene.[38]

The lack of materials and readily available shelter in refugee camps leaves little room for robust sanitation infrastructure. The need for latrines and effective waste management has implications beyond comfort- open defecation and excretion propagate the spread of cholera,

[36] https://oxfamilibrary.openrepository.com/bitstream/handle/10546/126687/tbn18-hazardous-wastes-210508-en.pdf;jsessionid=C897AC5D4B23CF5E009F475C30D8D1D9?sequence=5
[37] https://globalcommunities.org/blog/if-you-care-about-ending-violence-against-women-and-girls-care-about-toilets/
[38] https://jhumanitarianaction.springeropen.com/articles/10.1186/s41018-021-00107-6

dysentery, and typhoid, potentially contaminating the limited water supply in these camps. On average, one child dies from diarrhea every two minutes, underscoring the importance of mitigating sanitation-related bouts with facility construction. Moreover, the tendency to openly defecate in camps, exposing others to fecal matter, highly increases the likelihood of intestinal worm infections.[39] Such infections cause cognitive and developmental delays in especially vulnerable populations like children.

2.Water Availability

2.1. Clean Drinking Water Supply

Ensuring access to clean drinking water is critical for the health and survival of refugees. Regular water quality testing and treatment are necessary to prevent waterborne diseases such as cholera and dysentery. Establishing reliable sources of clean drinking water reduces the burden on refugees, who often travel long distances to fetch water, and provides a foundation for other health and sanitation initiatives. Efficient and equitable water distribution systems are vital in refugee camps to ensure all individuals have access to sufficient water. Strategically locating water points throughout the camp minimizes travel distances and waiting times. Maintenance of these systems is crucial to prevent breakdowns and water shortages.[40]

Developing robust emergency water supply plans ensures that refugees have access to water during crises, such as natural disasters, infrastructure breakdowns, or sudden population influxes. Establishing water storage facilities and setting up contingency plans for the rapid deployment of water resources are critical components. Emergency water supply planning ensures that refugee camps can quickly adapt to changing circumstances, safeguarding the health and well-being of residents, as dehydration is one of the most common causes of death for refugees.[40]

2.2. Regular Water Testing

Regular testing of water sources for contaminants such as bacteria, viruses, and chemicals is essential to ensure the water provided to refugees is safe for consumption. Establishing protocols for routine water quality monitoring helps detect and address potential issues promptly, preventing outbreaks of waterborne diseases. Protecting water sources from contamination is crucial for maintaining water quality in refugee camps. Creating buffer zones around water sources to prevent pollutants from entering and controlling potential contamination sources such as latrines and waste disposal sites are important measures. Community engagement in source protection activities fosters a sense of ownership and responsibility among refugees, ensuring that water sources are respected and maintained. Without these measures, the already scarce resource of water faces contamination.[41]

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[39] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6090371/
[40] https://www.unhcr.org/us/what-we-do/protect-human-rights/public-health/water-sanitation-and-hygiene
[41] https://ec.europa.eu/echo/files/evaluation/watsan2005/annex_files/UNHCR/UNHCR5%20-%20Water%20Supply%20in%20Refugee%20Situations.pdf

2.3. Safe Water Storage

Promoting the use of safe water storage containers and practices helps prevent recontamination of treated water. Educating refugees on proper storage techniques, such as keeping containers covered, using clean containers, and storing water in cool, shaded areas, reduces the risk of waterborne diseases. Distribution of safe storage containers can significantly improve water safety at the household level. Additionally, community-level storage solutions ensure a reliable supply of safe water.[42]

3. Malnutrition

Women and girls in refugee populations are often disproportionately affected by malnutrition due to gender-based disparities in food distribution and access to resources. Cultural norms and practices may result in women and girls receiving less food or lower-quality food compared to men and boys. Addressing gender inequalities in food aid and nutritional programs is crucial to ensuring equitable access to nutrition for all refugees, and promoting better health outcomes and gender equality within refugee communities (UN WFP).

Sanitation, water access, and malnutrition are deeply interconnected issues that profoundly affect the health and well-being of refugees, presenting a complex challenge in camps and settlements. Inadequate sanitation facilities often lead to unsanitary conditions, exacerbated by overcrowding, limited access to toilets and bathing facilities, and insufficient waste disposal systems[43]. These conditions result in the contamination of living spaces and water sources, promoting the spread of diseases such as cholera and dysentery[44]. The impact is particularly severe for women and children, who face not only health risks but also increased vulnerabilities, including the risk of sexual violence[45].

The problem of poor sanitation is closely tied to the challenge of accessing clean water. Many refugee camps suffer from a scarcity of safe drinking water, forcing residents to rely on contaminated sources. This scarcity is influenced by geographical, infrastructural, and demographic factors, which can lead to a high incidence of waterborne diseases[46]. The effort required to obtain clean water often falls on women and children, who face additional risks and burdens, including potential harassment and violence.

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[42] https://www.cdc.gov/global-water-sanitation-hygiene/about/about-safe-water-storage.html
[43] "Domestic and Refugee Camp Waste Management Collection and Disposal" — Oxfam.
[44] "Water, Sanitation, and Hygiene" — UNHCR
[45] "Clean Water, Decent Toilets and Child Health Measures Could Save 700,000 Children a Year" — WaterAid
[46] "Guidelines for Drinking-water Quality" — WHO

The consequences of inadequate sanitation and limited water access are compounded by food insecurity, which significantly contributes to malnutrition among refugees. Contaminated water and poor sanitation lead to frequent gastrointestinal illnesses, impairing the body's ability to absorb nutrients from food. This exacerbates malnutrition, particularly among children, who are more vulnerable to nutrient deficiencies[47]. The disruption of traditional food sources due to displacement and reliance on food aid with limited nutritional diversity further aggravates the situation. Micronutrient deficiencies, such as those of vitamin A, iron, and iodine, become prevalent, resulting in severe health issues including anemia, weakened immunity, and developmental delays[48].

Overall, the combined impact of poor sanitation, inadequate water access, and malnutrition creates a severe health crisis in refugee camps. Children are especially affected, facing stunted growth, cognitive impairments, and increased mortality rates[49]. Pregnant and lactating women also face heightened risks, as malnutrition can lead to complications during pregnancy and childbirth[50]. The elderly and those with pre-existing health conditions are disproportionately affected, with compromised immune systems making them more susceptible to infections and chronic diseases[51]. This interwoven crisis highlights the urgent need for comprehensive strategies to address these fundamental issues and improve the overall health and quality of life for refugees.

[47] "Nutrition and Growth for Immigrant and Refugee Children" — CDC
[48] "Malnutrition Fact Sheet" — WHO
[49] "Nutrition and Growth for Immigrant and Refugee Children" — CDC
[50] "Supporting Evidence for Breastfeeding" — CDC
[51] "Drowning and Dehydration are Main Causes of Migrant Deaths in the Horn of Africa" — IOM

Case Studies

4.1 Bangladesh

One case highlighting the impact of sanitation infrastructure and malnutrition on communities is the Rohingya refugee crisis, which has resulted in a massive influx of religiously persecuted refugees into Cox's Bazar, Bangladesh, placing significant strain on local resources. The Rohingya refugee crisis, ignited by a violent crackdown by Myanmar's military in August 2017, has led to one of the largest and most urgent humanitarian crises in recent history. Over 960,000 Rohingya fled to Cox's Bazar, Bangladesh, creating an immense population density in what was once a relatively rural area[52]. The sudden and massive influx has placed an enormous strain on local resources, with the refugee camps becoming one of the most densely populated places on earth.

The provision of clean water has been a critical challenge. The refugee population's needs have outstripped local water resources, leading to a reliance on water trucking and the installation of temporary wells. Organizations like UNICEF and the International Federation of Red Cross and Red Crescent Societies (IFRC) have spearheaded efforts to improve water infrastructure by installing larger-scale water distribution systems and enhancing the capacity of existing wells[53]. However, these solutions are often temporary, and the sheer scale of the crisis has made it difficult to ensure a consistent and adequate water supply.

Sanitation in the camps is fraught with difficulties. The high population density has led to severe overcrowding, which exacerbates the challenges of maintaining hygiene. The construction of emergency latrines has been a priority, but these facilities often struggle to keep up with the demand. Efforts by humanitarian organizations have focused on improving the design and management of latrines, implementing waste management systems, and promoting hygiene education[54]. Despite these efforts, outbreaks of waterborne diseases like cholera and diarrhea remain a concern.

The crisis has also led to significant issues with food security. The Rohingya refugees face high rates of malnutrition, driven by a lack of sufficient, diverse, and nutritious food. Humanitarian agencies have responded with nutritional programs that provide supplementary feeding, particularly for children and pregnant women. These programs include the distribution of fortified food and the establishment of community-based nutrition education initiatives to improve dietary practices.

Despite these many efforts, massive political and socio economic strain remains in the area.

4.2 Uganda

South Sudan, which gained independence from Sudan in 2011, has been embroiled in conflict since late 2013. The civil war and subsequent violence have driven millions to flee, with Uganda becoming a major host country due to its open-door policy[55].

[52] "Rohingya Refugee Crisis Explained," UNHCR

[53] "Myanmar Refugee Relief Operation (MRRO)," Bangladesh Red Crescent Society

[54] "Rohingya Crisis," UNICEF

[55] "Uganda's Open-Door Policy for Refugees Strained by Arrivals from Sudan, DRC, and South Sudan," UNHCR

Water Access: Access to clean water is a critical issue for South Sudanese refugees in Uganda. The rapid influx has necessitated the drilling of boreholes and the construction of new water points to meet the increased demand. Organizations like UNICEF and the Water Mission have been involved in expanding water infrastructure and ensuring that refugees have access to safe drinking water[56].

Sanitation: The rapid population growth in refugee settlements has led to sanitation challenges. Emergency responses include the construction of latrines and the implementation of waste management systems to address the increased need. Educational initiatives aim to promote good hygiene practices and prevent disease outbreaks. Despite these efforts, maintaining sanitation standards remains challenging due to the scale of the refugee influx.

Malnutrition: Malnutrition is a pressing concern among South Sudanese refugees, driven by food insecurity and inadequate dietary diversity. The Uganda Red Cross and other humanitarian organizations have been active in providing food assistance and nutrition support, including supplementary feeding programs and food distribution to vulnerable groups such as children and pregnant women[57].

[56] "Life for South Sudanese Refugees in Uganda on Hold: Beatrice's Story," Oxfam

[57] "South Sudan Emergency," UNHCR

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