MACMUN 2019

WORLD HEALTH ORGANIZATION

BACKGROUND GUIDE

McMaster University

MSU CLUBS

The following content was developed by members of the McMaster Model United Nations conference planning team for the sole purpose of framing delegate discussions and debate at the conference and does not represent any official position of the University or anyone engaged in preparing the materials. Delegates should use this information to guide their research and preparation for the conference but should not assume that it represents a complete analysis of the issues under discussion. The materials should not be reproduced, circulated or distributed for any purpose other than as may be required in order to prepare for the conference.

Dear Delegates,

Welcome to the World Health Organization! On behalf of this year's dais, your chairs would like to give you all a quick introduction to ourselves, as well as the committee. We are incredibly excited for MACMUN 2019 and have channelled this enthusiasm into creating a background guide that piques your interest, while remaining comprehensive and strengthening your understanding of the topics of debate.

This year, we will be covering two primary topics, with the first involving illegal human organ trafficking — an often overlooked issue that remains a pressing concern, particularly within the context of the global organ donation deficit that we currently face. Our second topic will be exploring the realms of healthcare within refugee camps worldwide — an incredibly complex matter that has become even more urgent, and thus necessary, to discuss, given the escalation of the world refugee crisis over the past several years. Given this knowledge, it is an incredibly pivotal moment in time for the WHO to address these two topics so as to improve and ensure a better, healthier future for individuals all over the world.

Below you'll find a short description about each of us — we can't wait to get to know you all better!

Rhea Jangra is a second year student currently studying Health Sciences here at McMaster. Since this will be her 6th year being involved in MUN, she is incredibly excited to use her experiences to make the World Health Organization, as well as MACMUN 2019 as a whole, as engaging and enriching as possible for all delegates. Outside of her time dedicated to MUN, you will likely find Rhea reading, napping spontaneously, coxing on the rowing team, or looking for free campus bagels. She hopes that the knowledge and skills that delegates develop during MACMUN will extend far beyond the conference weekend, and allow individuals to help enact greater change in the world.

Ahmed Shoeib is a third year student currently studying Biochemistry. He has been involved in MUN as a high-school student, and had the chance of participating as a delegate in last year's MACMUN conference. This year, he is very honoured and excited to chair the WHO committee and to provide an engaging and fun MACMUN 2019 conference! Besides MUN, Ahmed enjoys playing video games, hiking, and watching TV shows. He finds global policy very interesting and loves to engage in debate and gain knowledge from it. He hopes that delegates will find this MACMUN conference engaging and informative, all the while being fun and enjoyable.

We hope you have the most wonderful time preparing for the conference. Please feel free to contact us at any time prior to the conference with any questions you may have.

Warm regards,
Rhea and Ahmed
who@macmun.org

Committee Overview

Mandate and Function of the Committee

The goal of the World Health Organization (WHO) is to build a better, healthier future for people on a global scale. The organization is headquartered in Geneva, Switzerland and has 194 member states. The WHO was founded on April 7, 1948, a date celebrated globally as "World Health Day."[1] In 1945, diplomats met in San Francisco and agreed that there was insufficient collaboration between countries to control the spread of dangerous diseases across the world. Together, they decided on the need for a global organization overseeing global health. This eventually culminated in the creation of the WHO.[2]

Currently, the organization has six regional offices and a Secretariat that works synergistically with governments and other partners, ensuring the highest attainable health for all peoples. The WHO strives to combat infectious diseases, like Zika, influenza, and human immunodeficiency virus (HIV), and also noncommunicable ones, such as cancer and heart disease. It also aims to facilitate access to adequate air, food, and water; it also maintains the quality and availability of critical medicines and vaccines. By looking at health trends and new threats, it always seeks new opportunities to improve public health.

The WHO also hires top experts to examine critical health issues and identify the best solutions. From there, they deliver and implement the strongest recommendations. In this manner, it helps prepare countries for health emergencies by determining necessary actions when emergencies strike, such as the Ebola epidemic in West Africa. Its ultimate goal is reflected in the following statement: "No country or person should miss out on the opportunity to live a healthy life in all aspects."[3]

The WHO has six leadership priorities, aimed towards accelerating the new Sustainable Development Goals (SDGs) for health:[4]

I. Advancing universal health coverage;
II. Achieving health-related development goals;
III. Addressing the challenges of noncommunicable diseases (NCDs) and mental health, violence, injuries, and disabilities;

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[1] "WHO | History of WHO" *WHO*. (2018), online, Internet, 29 Oct. 2018. , Available: http://www.who.int/about/history/en/.

[2] "WHO | History of WHO" *WHO*.

[3] "WHO brochure, Working for better health for everyone, everywhere," n.d., online, Internet, 29 Oct. 2018. , Available: http://www.who.int/about/what-we-do/who-brochure/.

[4] The Global Guardian of Public Health, vols., 2016, online, Internet, 16 Oct. 2018. , Available: http://www.who.int/about/what-we-do/global-guardian-of-public-health.pdf.

IV. Ensuring that all countries can detect and respond to acute public health threats under the International Health Regulations;
V. Increasing access to quality, safe, efficacious and affordable medical products (medicines, vaccines, diagnostics and other health technologies); and
VI. Addressing the social, economic and environmental determinants of health as a means to reducing health inequalities between countries.

History of the Committee

These dates mark major accomplishments of the WHO, and also help illustrate its function and significance:[5]

- **1948**: The WHO constitution is passed and the organization begins its work by focusing on mass campaigns against tuberculosis (TB), malaria, yaws, syphilis, smallpox and other communicable diseases transmitted from person to another, or from animal to person.
- **1950**: The discovery of present-day antibiotics occurs and the WHO starts advising countries on their controlled usage.
- **Mid-1950s**: The poliovirus vaccine is discovered by Jonas Salk and Albert Sabin, paving the way for mass global campaigns facilitated by the WHO, which have since led to the near eradication of polio.
- **1969**: The first International Health Regulations are established by the World Health Assembly (WHA), representing an agreement between the WHO Member States that enables and encourages them to work together to prevent and respond to acute public health risks that have the potential to cross borders and threaten worldwide health.
- **1972**: The Training in Human Reproduction (HRP) program is created within the WHO; it is the sole body within the UN system that possesses a global mandate to carry out research on sexual and reproductive health and rights.
- **1975**: The WHO creates the programme for Research and Training in Tropical Diseases (TDR), which helps to facilitate, support and influence efforts to combat diseases of poverty. As of 2016, five of the eight diseases that the programme was created to tackle are close to eradication.
- **1978**: The aspirational goal of the WHO, "Health for All," is set by the International Conference on Primary Health Care (ICPHC) in Kazakhstan. This lays the groundwork for the WHO's first leadership priority: advancing health coverage.
- **1979-1983**: A 12-year global vaccination campaign held by the WHO against smallpox is hailed successful as the disease is eradicated. During this period, HIV, which causes AIDS, is discovered.
- **1987**: The priorities of the WHO shift as AIDS spreads globally; the first antiretroviral medication to control HIV infection and prevent its progression to AIDS is licensed.

[5] "History of the United Nations | United Nations," n.d., online, Internet, 16 Oct. 2018. , Available: http://www.un.org/en/sections/history/history-united-nations/index.html.

- **1999**: A new partnership is formed between major players in global immunization, including the WHO, government representatives, and leaders of the vaccine industry. This is called the Global Alliance for Vaccines and Immunization (GAVI), which aims to overcome barriers and allow millions of children worldwide to receive vaccines.
- **2000**: 189 UN members adopt the Millennium Development Goals (MDGs). These goals have a set deadline for 2015 and include specific goals for health, such as eradicating poverty and eliminating gender disparities in governments. Moreover, the WHO Global Outbreak Alert and Response Network (GOAR) is established to detect and combat international spread of outbreaks. This year was arguably the most important in WHO evolution and progression.
- **2003**: The WHO's first global public health treaty, called the WHO Framework Convention on Tobacco Control (FCTC), is unanimously adopted by the WHA. This is aimed towards reducing tobacco related deaths worldwide. A major "3 by 5" initiative is also instituted to bring treatment to three million people living with HIV by 2005; the figure reaches thirteen million in 2013.
- **2004**: Following the Indian Ocean Tsunami disaster, the Strategic Health Operations Centre (SHOC) is built to serve as the nucleus of the networks of emergency operations.
- **2005-2008**: The WHO's first successful campaign from its initiation is achieved: the number of children who die before their fifth birthday declined below ten million for the first time in recent history. By 2008, NCDs, such as heart disease and stroke, emerge as the number one killers globally. This global shift is noted by the WHO, which strengthens its focus on NCDs. In 2012, global leaders sign off, for the first time in history, on global standards targeted towards controlling and preventing heart disease, diabetes, cancer, lung disease and others.
- **2009**: The first influenza pandemic since 1968 emerges as a result of the emergence of the new H1N1 influenza virus. The WHO works with collaborating centres on controlling the virus and developing vaccines in record time.
- **2014**: West Africa experiences the biggest outbreak of Ebola virus disease. The WHO Secretariat mounts an unprecedented response to the outbreak, deploying thousands of experts, support staff and medical equipment to the ground.
- **2015**: Delegates from around the world at the UN Summit sign off on the 2030 SDGs, which apply to all countries worldwide and move beyond the failed MDGs. The SDGs add economic, social and environmental objectives on top of the millennium goals in the pursuit of a more peaceful and inclusive global community.
- **2016**: WHO announces zero cases of Ebola in West Africa, but warns populations that the disease might flare up without caution, and that countries in the region need to remain vigilant and prepared. The WHO convenes the Emergency committee and conclude that the neurological birth defects appearing to be related to the Zika virus in pregnant women represent a public health emergency of international concern.

Simulation Style

The WHO will be composed of two designated Chairs who will moderate the debate and ensure it adheres to the appropriate Model UN rules and procedures. The Chairs will be responsible for opening and closing the debate, setting the agenda, managing the list of speakers, and facilitating the discussion. Furthermore, they will give the final rule on disputed points, and state when the delegates must vote on motions. The Chairs will also decide when to introduce the draft resolutions for debate.

The WHO will consist of 35 delegates representing their assigned Member States. Each Member State of the WHO will have one vote. Matters are decided by simple majority. Decisions on important issues, such as international health coverage, admitting new members and the UN budget, are decided by a two-thirds majority. All delegates are expected to adequately research the two committee topics, submit a position paper, and be prepared for discourse regarding their country or organization's stances on both issues.

A page will be present during the meetings to pass notes between delegates. Pages will be screening notes to ensure appropriate content and to maintain a professional environment.

Recent Activity (2016 to 2018)

Most recently, the WHO has taken a strong focus on the Zika and Ebola viruses, especially in heavily-affected areas.[6] Emergency areas like the Democratic Republic of the Congo have put emphasis on the WHO to assist in their efforts to eradicate the viruses. Furthermore, the WHO has also placed a strong focus on climate change and its health effects. They recently published a report in October 2017 discussing the management of the health risks associated with climate variability and change.[7]

Forming Resolutions

Resolutions represent the consolidated opinions of the United Nations body and act as proposed comprehensive solutions to the issues at hand. They are a final result of the discussions and negotiations regarding the topics, and detail recommended courses of action. These papers are composed of **preambulatory clauses** (*reasons* for addressing this issue) and **operative clauses** (*solutions* to the issue). A resolution is first considered a draft resolution prior to being voted on by the committee.

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[6] "WHO | Publications" *WHO*. (2018), online, Internet, 16 Oct. 2018. , Available: https://www.who.int/globalchange/publications/en/.

[7] "WHO | Publications" *WHO*..

During the course of debate, delegates may work individually or collaborate with others to write a draft resolution. At the end of the debate, many draft resolutions can be submitted to the Chairs, and the Chairs will proceed to read all the draft resolutions until the delegates vote and pick the final resolution(s). The delegates writing the resolution are deemed the "sponsors" and states that support seeing the resolution presented are signed on as "signatories." Signatories are simply members who want to bring the resolution to debate; they do not have to necessarily support the resolution.

The WHO requires 1-3 sponsors and 8 signatories on a resolution. The draft resolutions are open to amendments suggested by other delegates. Once brought to debate, amendments can be made until the final resolution is voted on by the committee. *For detailed instructions on how to write resolutions*, including a list of preambulatory and operative phrases, and a sample resolution, please refer to https://www.macmun.org/resources of our website.

Instructions for Writing Position Papers

The position paper is a detailed essay of your country's policies and position on the topics that are going to be discussed in the committee. This will help you to organize your thoughts and successfully engage with the committee. You are required to submit a paper to be eligible for any conference award, and the writer of the best position paper in each committee will be given the Book Award.

A strong MACMUN position paper should include the following:

1. Discussion of the topic in general.
2. How your country is affected by the issues.
3. Your country's policies with respect to the issues.
4. Quotations from your country's leaders about the topics.
5. Actions that your country has taken with regard to the issues.
6. What your country believes should be done to address the issues.
7. What your country would like to accomplish in the committee's resolution.
8. A description of your relationship with other countries as it relates to the issues at hand.

Include your name, assigned country, and committee. Please do not include illustrations, diagrams, decorations, national symbols, watermarks, or page borders.

Length: 1 page per topic.
Format: Times New Roman, size 12, single-spaced.
Citation style: Your choice (please include a reference page; not counted in page limit).
Due date: Sunday, February 3, 2018 at 11:59pm to who@macmun.org

For detailed instructions on how to write a position paper, including a template and sample paper, please refer to https://www.macmun.org/resources of our How To MUN guide on our website.

Topic #1: Illegal Human Organ Trafficking

> *"We don't have enough solid organs for transplantation; not enough kidneys, livers, hearts, lungs. When you get a liver and you have three people who need it, who should get it? We tried to come up with an ethically defensible answer. Because we have to choose."*
> *— Ezekiel Emanuel*

Introduction

According to the World Health Organization (WHO), illegal organ trade occurs when organs are removed from the body for the purpose of commercial transactions.[9] The international human organ trade is on the rise, fuelled by growing demand, as well as unscrupulous traffickers. The rising trend has prompted a serious reappraisal of current legislation. The WHO has called for more protection for the most vulnerable populations worldwide, who might be tempted to sell a kidney for as little as $1,000 USD.[10] In 2010, according to the WHO, 11,000 human organs were obtained on the black market. It is estimated that an organ is sold every hour, every day of the year. It is often the poorest slums of the world in countries like India, Pakistan, Egypt and China where people supply organs to recipients from wealthy countries like the U.S., Europe, UK, Israel, and Canada.[11]

History and Description

The first reports on commercial trade in human organs date from the 1980s and concern the selling of kidneys by poverty-stricken Indian citizens to foreign patients, especially from the Middle East.[12] It was reported that around 80% of all kidneys procured in Indian hospitals for transplantation were transplanted into patients coming from the Gulf States, Malaysia, and Singapore. The first scientific report on the topic appeared in *The Lancet* and revealed that 131 kidney patients from the UAE and Oman had travelled to India, together with their doctors, and were transplanted with kidneys from local paid "donors." This took place before the passage of

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[9] Tazeen H. Jafar, "Organ Trafficking: Global Solutions for a Global Problem" *American Journal of Kidney Diseases*. 54.6 (2009): 1145–1157, online, Internet, 15 Oct. 2018. , Available:

[10] "WHO | Organ trafficking and transplantation pose new challenges" WHO. (2011), online, Internet, 23 Sep. 2018. , Available: http://www.who.int/bulletin/volumes/82/9/feature0904/en/index1.html.

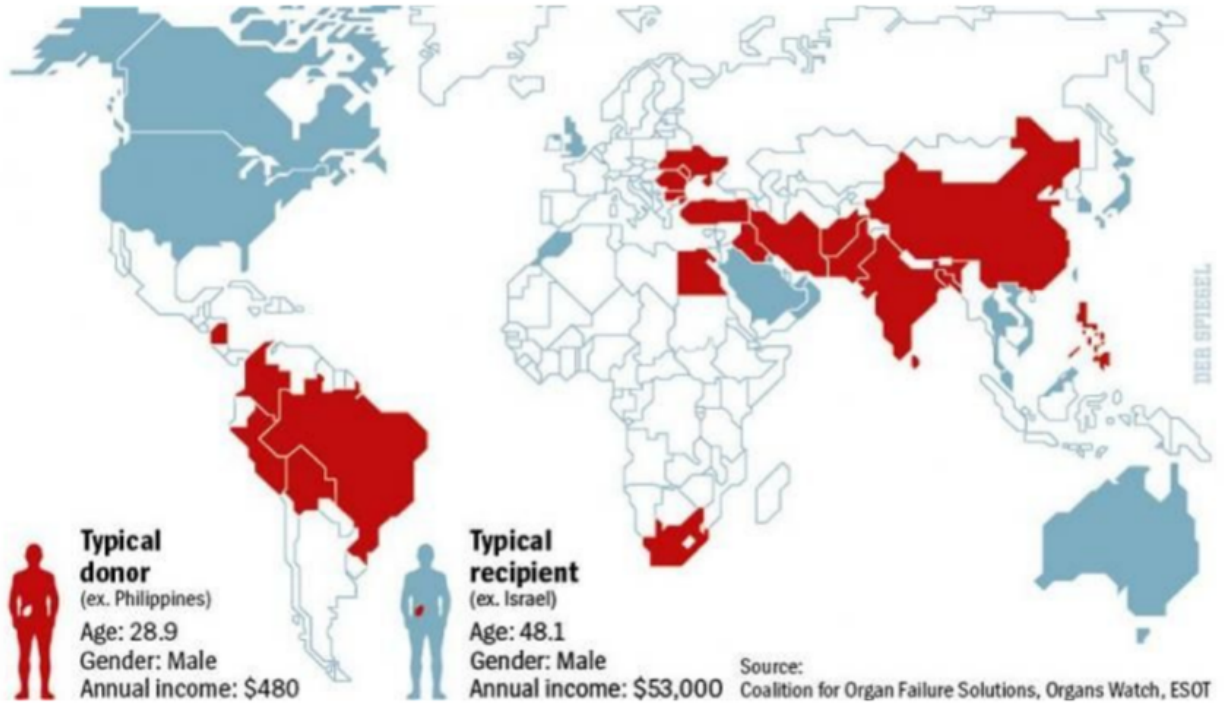
[11] Philip Perry, "What You Need to Know about Illegal Human Organ Trafficking," n.d.

[12] Michael Bos. "DIRECTORATE-GENERAL FOR EXTERNAL POLICIES POLICY DEPARTMENT Trafficking in human organs" (2015), online, Internet, 23 Sep. 2018. Available: http://www.europarl.europa.eu/RegData/etudes/STUD/2015/549055/EXPO_STU(2015)549055_EN.pdf.

the *Indian Transplantation of Human Organs Act* in 1994, which outlawed the selling and buying of human organs.[13]

At the beginning of 2000, two other European countries were found to be involved in the trafficking of human tissues.[14] The State Forensic Medical Centre in Riga (Latvia), from 1994 to 2003, delivered human tissue material to the German company Tutogen, which paid 'compensation' to the Forensic Centre. Over the 10-year period, tissues were taken from at least 400 deceased persons. In 2006, the case was reopened; in 2015, the European Court of Human Rights ruled that selling the tissues without consent constituted a violation of the *European Convention of Human Rights*, and required Latvia to pay financial compensation to the relatives of the deceased.[15]

The Declaration of Istanbul on Organ Trafficking and Transplant Tourism, established in 2008, brought pressure on a number of countries and governments to change their legislation and ban trafficking of organs. As a consequence, trafficking of organs has decreased in a number of countries.[16] However, trafficking operations have since shifted to other countries and new routes have been opened. According to recent information from the UN Office on Drugs and Crime (2014), around 0.3% of all reported persons trafficked are trafficked for organ removal, and some 50 countries around the globe are in some way involved in the trafficking of organs.[17]



[16] Michael Bos. "DIRECTORATE-GENERAL FOR EXTERNAL POLICIES POLICY DEPARTMENT Trafficking in human organs."

[17] Michael Bos. "DIRECTORATE-GENERAL FOR EXTERNAL POLICIES POLICY DEPARTMENT Trafficking in human organs."

Figure 1: A visual representation of the global distribution of donors and recipients of organ trafficking.

Case study: Gurgaon Trafficking Network Scandal, India

The Gurgaon organ trafficking case is among the most extensive trafficking scandals worldwide. This operation came to light in January 2008 when local police arrested several people who were accused of performing illegal transplant activities.[18] The key figure in the operation was Amit Kumar, who owned a private clinic where the illegal organ transplants took place. Amit Kumar and two of his associates escaped being arrested after being tipped-off by local police. The investigation was handed over to the Indian Central Bureau of Investigation (CBI), which issued arrest warrants for Kumar and his associates. Amit Kumar was soon arrested by special police early February 2008 in a wildlife park in Nepal.[19]

According to police investigators, the trafficking network had been in operation for at least seven years, and 400-500 transplants may have been carried out.[9] Suppliers were mostly urban pavement dwellers or unemployed rural peasants who were approached on the labour market, where they were looking for work.[20] Kumar had never had any medical training but had performed hundreds of transplants and organ removals. He was fined and sentenced to seven years imprisonment for criminal conspiracy, criminal intimidation, running a clandestine hospital facility without a licence, and forgery of documents.

Case study: Rosenbaum trafficking network, USA

On 27 October, 2011, Levy Rosenbaum pleaded guilty on three counts of violating US legislation concerning the prohibition of commercial transaction involving human organs, and one count of violating US legal code concerning taking part in conspiracy.[21] Rosenbaum was sentenced to 30 months imprisonment and confiscation of the criminal proceeds of the three transplants that had been proved.

During the prosecution, it was established that Rosenbaum had acted as an organ trafficking broker since 2001. He contacted his associates in Israel to locate suitable suppliers based on blood/tissue matching and selected ‘donors’ were looked after during the pre-transplant screening procedure. Rosenbaum coached the recipient in the US to make up a cover story to mislead the hospital staff performing the screening.

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[18] Michael Bos. “DIRECTORATE-GENERAL FOR EXTERNAL POLICIES POLICY DEPARTMENT Trafficking in human organs.”

[19] Michael Bos. “DIRECTORATE-GENERAL FOR EXTERNAL POLICIES POLICY DEPARTMENT Trafficking in human organs.”

[20] Michael Bos. “DIRECTORATE-GENERAL FOR EXTERNAL POLICIES POLICY DEPARTMENT Trafficking in human organs.”

[21] Michael Bos. “DIRECTORATE-GENERAL FOR EXTERNAL POLICIES POLICY DEPARTMENT Trafficking in human organs.”

Current Situation

The number of transplants today is at 115,000 globally, which only covers 15% of all patients on the waiting list.[22] The UN strongly prohibits trafficking for the purpose of organ removal, as stated in the Palermo Protocol to the UN Convention against Transnational Organized Crime.[23] Today, 120,771 people are waiting for an organ and 18 will die every day while waiting, yet just one donor has the ability to save up to 8 lives.[24]

According to the WHO, approximately 7,000 kidneys are illegally harvested annually by traffickers worldwide and the prices vary widely by country. The average buyer spends $150,000 USD (though prices in excess of $200,000 USD are common), while the average donor gets $5,000 USD.[25] Organ tourism has subsequently skyrocketed and has catalyzed other human trafficking issues, such as child trafficking. Though the *Declaration of Istanbul* attempted to embody a universal and legally binding resolution, it is not in fact legally binding for countries today. The WHO has identified the Philippines as one of the global hotspots for organ trafficking, along with China, Pakistan, Egypt, and Colombia.[26]

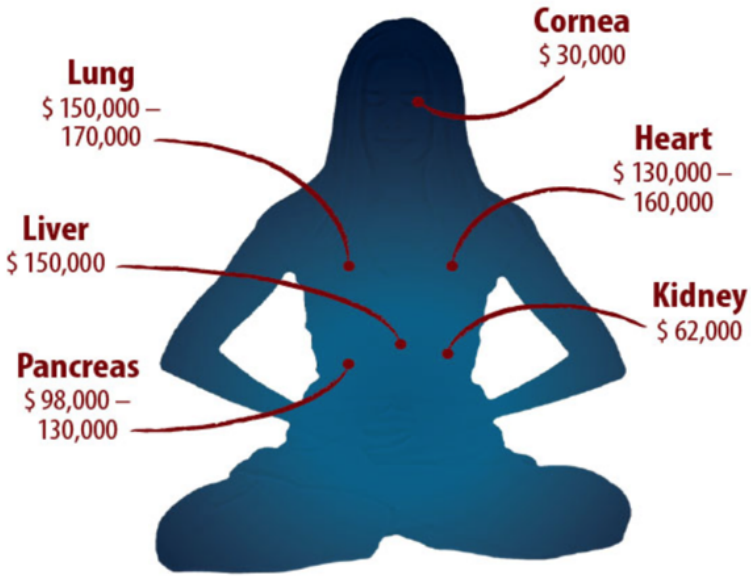

Figure 2: This portrays the average cost of organs in demand in USD.

[22] Michael Bos. "DIRECTORATE-GENERAL FOR EXTERNAL POLICIES POLICY DEPARTMENT Trafficking in human organs."

[23] Michael Bos. "DIRECTORATE-GENERAL FOR EXTERNAL POLICIES POLICY DEPARTMENT Trafficking in human organs."

[24] Dale Archer, "Body Snatchers: Organ Harvesting For Profit | Psychology Today Canada," 2013, online, Internet, 23 Sep. 2018. Available: https://www.psychologytoday.com/ca/blog/reading-between-the-headlines/201311/body-snatchers-organ-harvesting-profit.

[25] Dale Archer, "Body Snatchers: Organ Harvesting For Profit | Psychology Today Canada."

[26] "Transplant tourism: Philippines still fighting organ trafficking | IMTJ," n.d., online, Internet, 15 Oct. 2018. , Available: https://www.imtj.com/news/transplant-tourism-philippines-still-fighting-organ-trafficking/.

Bloc Analysis

More often than not, recipients come from the "global north" countries (e.g. USA, Canada, Australia, Israel, Japan), while suppliers are primarily from the poorer "global south" countries (China, India, Pakistan, Egypt and Colombia).

Notably, Iran is the only nation that allows organs to be bought and sold legally.[27] However, it does place restrictions on the commercial organ trade in an attempt to limit transplant tourism. The market is contained within the country; foreigners are not allowed to buy the organs of Iranian citizens. The Charity Association for the Support of Kidney Patients (CASKP) and the Charity Foundation for Special Diseases (CFSD) control the trade of organs, with the support of the government.[28] Iran currently has no waitlists for kidney transplantation.Some critics argue that the Iranian system is coercive, as over 70% of donors are considered poor by Iranian standards. There is also no short-term or long-term follow-up on the health of organ donors.[29] Some people in the United States believe that adopting a system for regulating organ trading similar to Iran's will help to decrease the national shortage of kidneys. They argue that the U.S. could adopt similar policies to better promote accountability, ensure safety in surgical practices, employ vendor registries, and provide donors with lifetime care.[30]

Committee Mission & Focus Questions

The WHO is committed to ensuring that the unsafe and unethical practice of illegal human organ trafficking is addressed. In collaboration with fellow member states, an action plan must be established that takes into account ethical, moral, and medical considerations. The WHO committee must make it a priority to ensure the health and safety of all human life.

Questions to consider include:

1. How can we implement more uniform legal frameworks to combat international human organ trafficking?
2. How does illegal human organ trafficking affect your country? Is it possible to work with other countries in a similar situation to develop a combined plan of action?
3. If organ trafficking were to be regulated, how would your country contribute to making it a safe and ethical practice that protects the dignity of all humans involved?
4. Has your country pledged financial or medical aid to affected countries? If so, what has it done? If not, what future plans does your government have regarding this issue?

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[27] Anne Griffin, "Kidneys on demand." BMJ (Clinical research ed.). 334.7592 (2007): 502–5, online, Internet, 15 Oct. 2018. , Available: http://www.ncbi.nlm.nih.gov/pubmed/17347232.

[28] Anne Griffin, "Kidneys on demand."

[29] Anne Griffin, "Kidneys on demand."

[30] Anne Griffin, "Kidneys on demand."

Topic #2: Healthcare in Refugee Camps and Settlements

> *"Refugees are mothers, fathers, sisters, brothers, children, with the same hopes and ambitions as us — except that a twist of fate has bound their lives to a global refugee crisis on an unprecedented scale."*
> *— Khaled Hosseini*

Introduction

The past decade has seen a dramatic increase in the number of displaced individuals worldwide. The 1951 Refugee Convention defines a refugee as the following: "Someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion." [32]

As of June 2018, the United Nations High Commissioner for Refugees (UNHCR) reported the highest levels of human displacement on record, with an unprecedented 68.5 million people around the world forced from their homes.[33] Indeed, the sheer magnitude of the global refugee crisis has been one of the driving factors behind a predominantly ineffective and cohesive global response to combat the issue. A significant portion of such refugees often end up in refugee camps—temporary accommodation for fleeing individuals, often constructed as crises unfold. Camps for refugees and the internally displaced are meant to provide spaces of security for individuals and communities when they are at their most vulnerable state, existing explicitly to provide for those who are in their greatest need and to protect their wellbeing, in addition to their general physical and mental health.

Within the context of refugee health, the WHO has played a critical role in protecting the rights of refugees, including their right to health. Nevertheless, many refugees often lack basic access to health services and financial protection for healthcare within camp settings.[34] Often overlooked in refugee camps are the medical challenges faced by refugees and the lack of

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[32] United Nations. "Figures at a Glance." UNHCR, www.unhcr.org/figures-at-a-glance.html.

[33] United Nations. "Figures at a Glance." UNHCR, www.unhcr.org/figures-at-a-glance.html.

[34] Silbermann, Michael, et al. "Middle Eastern Conflicts: Implications for Refugee Health in the European Union and Middle Eastern Host Countries." Journal of Global Oncology, 2016, doi:10.1200/JGO.2016.005173. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5493250/.

standardized, quality healthcare practices. In the face of global demographic trends and recent political experience, addressing concerns of public health equity in the context of refugee and other forcibly displaced populations has become more complex and challenging, given that health and human rights are often intrinsically related. Issues of supplying qualified health professionals to rural settings, creating mental health support systems, diminishing the transmission of sexual health diseases, and managing non-communicable diseases form the primary challenges faced by individuals in refugee camps.[35] As such, it is critical to note that refugee access to quality essential health services is of paramount importance to rights-based health systems, global health security, and public efforts aimed at reducing health inequities and addressing the social determinants of such issues.

History and Description

The movement and displacement of individuals around the world has remained a seemingly constant phenomenon since the establishment of the first human settlements and civilizations. Indeed, one of the first recorded instances of migration occurred in 740 BC within Canaan, or present-day Lebanon, and involved the Assyrian conquest of ancient Israel, as well as the subsequent expulsion of numerous tribes in the region—a subject of highly contentious historical and religious debate.[36] A more modern example of this occurred under the Ottoman Empire in 1783, where, during a time frame of 150 years, 5-7 million Muslims arrived in present-day Turkey from other countries to escape persecution in their home countries.[37]

The onset of World War II, which took place between 1939-1945, marked the greatest global conflict to date, resulting in the expulsion of approximately 40 million refugees within Europe and beyond.[38] It was during this time that the first modern "refugee camps" for the displaced emerged, in which approximately 850,000 people were housed across Europe during and following the conflict.[39] The scale of the disaster was so significant that international law and international organizations tasked to deal with refugees were urgently created and quickly evolved to form the foundation that is still relied upon today to address refugee issues. In particular, the creation of the UNHCR in 1950 marked a new era for international diplomacy and

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[35] Silbermann, Michael, et al. "Middle Eastern Conflicts: Implications for Refugee Health in the European Union and Middle Eastern Host Countries."

[36] Chalabi, Mona. "What Happened to History's Refugees?" The Guardian, Guardian News and Media, 25 July 2013, www.theguardian.com/news/datablog/interactive/2013/jul/25/what-happened-history-refugees#Pogroms.

[37] Şeker, Nesim, and Nesim. "Forced Population Movements in the Ottoman Empire and the Early Turkish Republic: An Attempt at Reassessment through Demographic Engineering." European Journal of Turkish Studies, 2013. Available from: https://journals.openedition.org/ejts/4396.

[38] Chalabi, Mona. "What Happened to History's Refugees?" The Guardian, Guardian News and Media, 25 July 2013, www.theguardian.com/news/datablog/interactive/2013/jul/25/what-happened-history-refugees#Pogroms.

[39] Chalabi, Mona. "What Happened to History's Refugees?"

concerted international efforts to battle refugee crises as they arose.[40] Their mandate remains to "provide, on a non-political and humanitarian basis, international protection to refugees and to seek permanent solutions for them."[41]

The UNHCR remained a principal actor in all subsequent refugee crises, establishing refugee camps and delivering healthcare services to individuals in need during said conflicts. Two primary examples of this include the Balkans conflicts of 1992 and the Great Lakes Refugee crisis in Rwanda. These were two of the first major refugee crises that would set the stage for many of the current health challenges that refugees continue to face within displacement camps to this day.[42] Modern challenges include, but are not limited to, the implementation of standardized health information systems, disease surveillance and outbreak containment, resource allocation and monitoring, and standardized levels of care for sexual and mental health.[43]

Case Study 1: Reproductive Health Group, Guinea

The need to involve refugees in their own reproductive health services has long been recognized, but there is a lack of published examples describing how this can be achieved collaboratively between refugee initiatives, UNHCR, bilateral development organizations and international relief agencies. However, a prime illustration of this type of collaboration occurred in the aftermath of the 1993/1994 Guinean refugee crisis, which stemmed from the 1989 civil conflicts in Liberia and Sierra Leone. During this time, Guinea accommodated a population of over 600,000 refugees.[44]

Between the years of 1996 and 2000, the Reproductive Health Group (RHG), an organization of Liberian and Sierra Leonean refugee midwives and laywomen, was established to provide reproductive health services to fellow refugees in Guinea's Forest Region.[45] Working as part of the Guinean health system, RHG midwives and community facilitators helped make reproductive health services in their region the most effective in Guinea at the time. Looking at RHG's achievements, as well as the challenges overcame, it can be argued that refugee organizations can plan and implement reproductive health services for refugees in tandem with community

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[40] The State of The World's Refugees. United Nations High Commissioner for Refugees, 2000, http://www.unhcr.org/pubs/sowr2000/intro.pdf.

[41] "Emergency Handbook." UNHCR, UNHCR - The UN Refugee Agency, emergency.unhcr.org/entry/113370/unhcrs-mandate-for-refugees-stateless-persons-and-idps.

[42] Chalabi, Mona. "What Happened to History's Refugees?" The Guardian, Guardian News and Media, 25 July 2013, www.theguardian.com/news/datablog/interactive/2013/jul/25/what-happened-history-refugees#Pogroms.

[43] "Refugee Health Profiles." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 10 Jan. 2017, www.cdc.gov/immigrantrefugeehealth/profiles/syrian/healthcare-diet/index.html.

[44] Von Roenne, Anna, et al. "Reproductive Health Services for Refugees by Refugees: An Example from Guinea." Disasters, 2010, doi:10.1111/j.1467-7717.2009.01112.x. Available from: https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1467-7717.2009.01112.x.

[45] Von Roenne, Anna, et al. "Reproductive Health Services for Refugees by Refugees: An Example from Guinea."

engagement, provided the UNHCR and its international partners ensure that they receive funding and technical assistance.[46]

Case Study 2: Healthcare Services in Syrian Refugee Camps, Turkey

Since the beginning of the Syrian conflict in 2011, the government of Turkey has allowed its borders to remain open to individuals fleeing the turmoil. As of May 2012, approximately 22,960 refugees resided in Turkish camps; as of May 2017, this number had increased to 260,000.[47] Due to the rapid influx of Syrians fleeing across Turkish borders, concerns continue to evolve about adequate preparation and the availability of humanitarian and medical assistance for this emergency situation.

A 2012 study evaluated the efficacy and conditions of several individual refugee camp hospitals.[48] Based on direct observation and available data, the report concluded that the emergency response of the Turkish authorities demonstrated a high level of responsibility and accountability of these clusters. This situation logically reflects the considerable effectiveness of health structures when organized to the best of the partners' abilities with adequate funding over a protracted period. What the study acknowledges, however, is that, despite the general effectiveness of the system, there is a critical lack of mental health services provided to refugees. It goes on to elaborate on good practice recommendations for providing adequate mental health care to vulnerable populations, including sufficient funding, service organization, and culturally sensitive staff training.[49]

Current Situation

By the end of 2017, the number of refugees worldwide totalled 25.4 million, approximately 33% of whom resided in refugee camps.[50] This figure includes 5.4 million Palestine refugees under the mandate of the United Nations Relief and Works Agency (UNRWA) for Palestine Refugees in the Near East. More than half come from five primary countries: the Syrian Arab Republic (6.3 million), Afghanistan (2.6 million), South Sudan (2.4 million), Myanmar (1.2 million), and Somalia (986,400).[51] In addition to these statistics, one should note the opposite end of the spectrum: for the fourth consecutive year, Turkey hosted the largest number of refugees

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[46] Von Roenne, Anna, et al. "Reproductive Health Services for Refugees by Refugees: An Example from Guinea."

[47] Alghothani, Nora, et al. "Evaluation of a Short-Term Medical Mission to Syrian Refugee Camps in Turkey." Avicenna Journal of Medicine, 2012, doi:10.4103/2231-0770.110738. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3696205/.

[48] Sahlool, Zaher, et al. "Evaluation Report of Health Care Services at the Syrian Refugee Camps in Turkey." Avicenna Journal of Medicine, 2012, doi:10.4103/2231-0770.99148. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3507073/.

[49] Sahlool, Zaher, et al. "Evaluation Report of Health Care Services at the Syrian Refugee Camps in Turkey."

[50] "Refugee Statistics." USA for UNHCR, www.unrefugees.org/refugee-facts/statistics/.

[51] "Refugee Statistics." USA for UNHCR, www.unrefugees.org/refugee-facts/statistics/.

worldwide, at 3.5 million people. It was closely followed by Pakistan (1.4 million), Uganda (1.4 million), and Lebanon (998,900).[52]

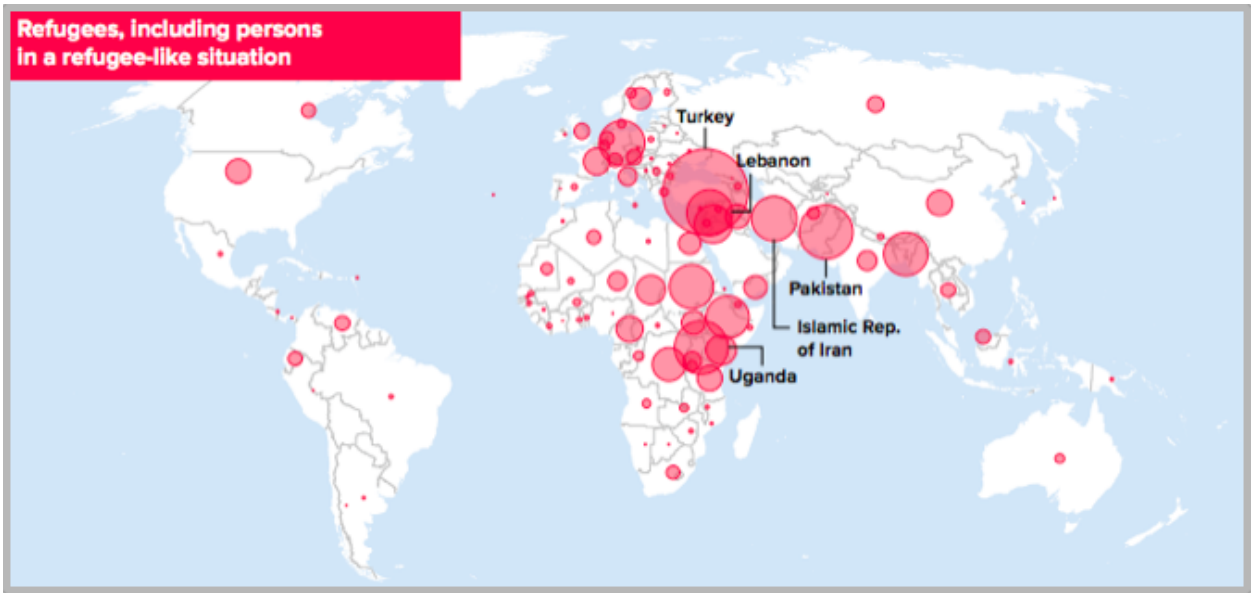

Figure 3: Populations of concern to the UNHCR by category, as of the end of 2017.[53]

In regards to the health situation within these vulnerable regions, the inequities and issues faced by the populations in question vary significantly based on the region in which they reside. It is also important to note that the world's refugee population overwhelmingly hails from its least developed nations, with nine of the ten most common countries of origin falling into this category.[54] Many refugees suffer from a number of chronic ailments and mental health conditions that often go unrecognized and untreated.[55]

Chronic illnesses, or non-communicable diseases (NCDs), continue to plague refugees and play a significant role in determining the quality of life that individuals lead following arrival in a receiving country.[56] The exposure of migrants to the risks associated with population movements–psychosocial disorders, reproductive health problems, higher newborn mortality,

[52] "Refugee Statistics." USA for UNHCR, www.unrefugees.org/refugee-facts/statistics/.

[53] "Refugee Statistics." USA for UNHCR, www.unrefugees.org/refugee-facts/statistics/.

[54] "Migration and Health: Key Issues." World Health Organization, World Health Organization, 17 Nov. 2015, www.euro.who.int/en/media-centre/events/events/2015/11/high-level-meeting-on-refugee-and-migrant-health/news/news/2015/09/population-movement-is-a-challenge-for-refugees-and-migrants-as-well-as-for-the-receiving-population/migration-and-health-key-issues/.

[55] "Migration and Health: Key Issues." World Health Organization.

[56] "Frequently Asked Questions on Migration and Health." World Health Organization, World Health Organization, 20 Mar. 2017, www.who.int/features/qa/88/en/.

drug abuse, nutrition disorders, alcoholism, and exposure to violence–often increase their vulnerability to NCDs.[57] For example, a recent study of 1,400 Syrian refugees in Lebanon demonstrated that 50% of households reported the presence of hypertension, cardiovascular disease, diabetes, chronic respiratory disease, or arthritis in one or more household members.[58] In determining appropriate responses, it is imperative to acknowledge the growing burden of NCDs in both resource-rich and resource-poor countries, the extended timeframe of modern-day displacement, and the need for healthcare both within and outside of refugee camp settings in order to compel new thinking and new policies.

In general, refugee populations are often under-vaccinated compared to hosting communities, as their vaccination records may be lost or incomplete, and their immunization statuses may not be in line with recommendations of receiving countries.[59] Refugees may live in overcrowded or unsanitary conditions prior to resettlement, increasing risk of exposure to vaccine-preventable diseases, such as hepatitis A and influenza.[60]

It is not uncommon for refugees to have been exposed to violence, torture, imprisonment, civil unrest and other trauma in the past, which have potentially long-term consequences for mental health.[61] Under ideal circumstances, a comprehensive array of programs should be provided, including social and psychotherapeutic interventions, mental health services and rehabilitative services, as well as special programs for vulnerable groups.[62] Creating sustainable services, ensuring best practices, practicing evidence−based approaches, and promoting equity of access must remain the goals of future developments, a daunting challenge given that most refugees reside in settings where skills and resources in mental health care are in extremely short supply.[63]

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[57] "Frequently Asked Questions on Migration and Health." World Health Organization.

[58] Doocy, Shannon, et al. "Prevalence and Care-Seeking for Chronic Diseases among Syrian Refugees in Jordan." BMC Public Health, 2015, doi:10.1186/s12889-015-2429-3. Available from: https://www.ncbi.nlm.nih.gov/pubmed/26521231?dopt=Abstract.

[59] WHO. Vaccination in Humanitarian Emergencies: Literature Review and Case Studies. 7th ed., vol. 13, World Health Organization, 2017, pp. 1–92, Vaccination in Humanitarian Emergencies: Literature Review and Case Studies. Available from: http://apps.who.int/iris/bitstream/handle/10665/255575/WHO-IVB-17.03-eng.pdf;jsessionid=BFEC6ADDC9E8FF37F5F695BC884E4BEF?sequence=1/.

[60] WHO. Vaccination in Humanitarian Emergencies: Literature Review and Case Studies.

[61] Silove, Derrick, et al. "The Contemporary Refugee Crisis: An Overview of Mental Health Challenges." World Psychiatry, 2017, doi:10.1002/wps.20438. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5428192/.

[62] Silove, Derrick, et al. "The Contemporary Refugee Crisis: An Overview of Mental Health Challenges."

[63] Silove, Derrick, et al. "The Contemporary Refugee Crisis: An Overview of Mental Health Challenges."

Risky sexual practices were a cited determinant for exposure to HIV among rural–urban migrants in China, and continue to remain a prevalent health risk within refugee camp settings.[64] In addition to this, those living with HIV often suffer, given the lack of treatment, care, and personnel trained to administer appropriate interventions (such as antiretroviral therapy). In Cambodia, a large segment of the sex work sector is comprised of migrants from Vietnam who face a high risk of HIV due to their irregular migration status, unsafe working and living conditions, policies that may confine migrants to a specific location, and stigma and discrimination.[65]

In the same vein, sexually transmitted infections (STIs) pose a significant risk to refugees within camps, particularly women and children.[66] During crises, adolescents may begin to have sexual relations at an earlier age and women and children may be coerced into having sex in order to meet their survival needs.[67] Statistics show that during times of war or conflict, the risks of sexual abuse, domestic violence, and exploitation rise. Additionally, close proximity to peacekeeping forces, military and police has long been associated with higher rates of STIs.[68]

A number of actions must be taken to improve the health and well-being of women, children and adolescents living in refugee and migrant settings, while simultaneously promoting gender equality and empowering refugee and migrant women and girls. Although healthcare services often exist for refugees in host countries, they are often very general and there is little gender-specific care available.[69] The conditions of refugee camps, coupled with a lack of prenatal and antenatal care and reproductive, obstetric and gynaecological care, create a dire need for sexual health services in such environments.[70] For example, although contraceptives are freely available to married couples in both Lebanon and Jordan, the reported number of Syrian women using family planning during displacement has dipped to just 34.5%, down from 60% before the war.[71] Services to promote gender equality and the health of migrant women and girls should include violence-specific aid facilities and protection centres for women and children affected by

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[64] Health of Refugees and Migrants: Regional Situation Analysis, Practices, Experiences, Lessons Learned and Ways Forward. 7th ed., vol. 1, World Health Organization, 2018, pp. 1–52, Health of Refugees and Migrants: Regional Situation Analysis, Practices, Experiences, Lessons Learned and Ways Forward. Available from: http://www.who.int/migrants/publications/WPRO-report.pdf/.

[65] Health of Refugees and Migrants: Regional Situation Analysis, Practices, Experiences, Lessons Learned and Ways Forward.

[66] Women's Refugee Commission." Women's Refugee Commission Website, www.womensrefugeecommission.org/about/123-programs/programs/reproductive-health/gender-based-violence/.

[67] Women's Refugee Commission." Women's Refugee Commission Website.

[68] Women's Refugee Commission." Women's Refugee Commission Website.

[69] Corbis. "Women's Health in Refugee Camps: A Hidden Cost of War | CORBIS - Sussex Global Health." CORBIS - Sussex, CORBIS - Sussex, 18 Apr. 2018, corbissussex.org/womens-health-in-refugee-camps-a-hidden-cost-of-war/.

[70] Corbis. "Women's Health in Refugee Camps: A Hidden Cost of War | CORBIS - Sussex Global Health."

[71] Corbis. "Women's Health in Refugee Camps: A Hidden Cost of War | CORBIS - Sussex Global Health."

domestic and sexual violence.[72] Interventions for at-risk female migrant populations will succeed only if they are focused on the broader social and economic constraints that hinder women from accessing and receiving the type of care they need.

Bloc Analysis

The difficult situation in South Sudan, where armed conflict, disease, and malnutrition continue to take a huge toll on the population, was the main cause of refugee displacement in 2017. Over 1 million new refugees fled the country, with most remaining in the general region.[73] Those forced to leave South Sudan were granted protection on a *prima facie* basis in the bordering countries of Sudan, Uganda, Ethiopia, the DRC, and Kenya.[74] The continued conflict in Syria forced even more people to flee the country in 2017, with 745,200 Syrians newly registered in Turkey, Lebanon, Greece, and Jordan.[75] The third-largest group of new refugees originated from Myanmar. Mainly due to the outbreak of violence in the Rakhine State at the end of August 2017, 655,500 Rohingya people were forced to cross the border into Bangladesh, where they were granted protection.[76] The majority of the other new displacements were due to armed conflict and human rights abuses in central and eastern Africa, most notably in the Central African Republic, the DRC, Burundi, Eritrea, Sudan, Nigeria, Mali, and Somalia.[77] The civil war in the Central African Republic resulted in 110,500 new refugees in the region, particularly in the DRC and Cameroon.[78]

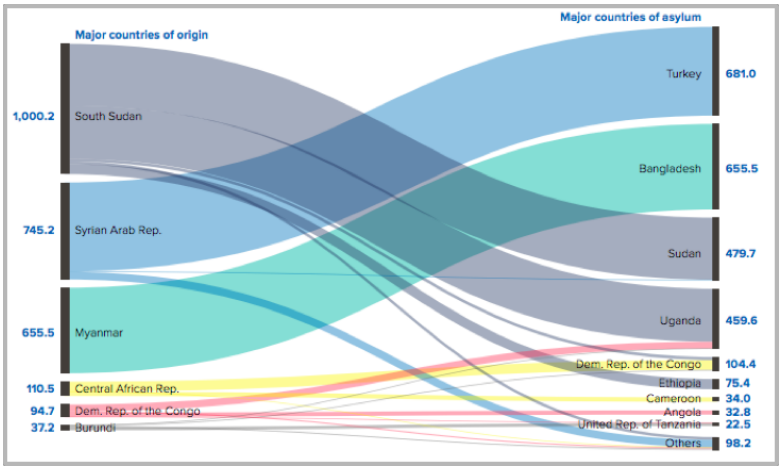

Figure 2: More than 2.7 million people fled their homes to another country in 2017, the vast majority of whom (88%) originated from just three countries (South Sudan, Syria, Myanmar) and found protection in bordering countries

[72] Corbis. "Women's Health in Refugee Camps: A Hidden Cost of War | CORBIS - Sussex Global Health."

[73] "Global Refugee Crisis – by the Numbers." Amnesty International, www.amnesty.org/en/latest/news/2015/10/global-refugee-crisis-by-the-numbers/.

[74] "Global Refugee Crisis – by the Numbers." Amnesty International.

[75] "Global Refugee Crisis – by the Numbers." Amnesty International.

[76] "Sexual and Reproductive Health Needs Immense among Rohingya Refugees." United Nations Population Fund, 29 June 2018, www.unfpa.org/news/sexual-and-reproductive-health-needs-immense-among-rohingya-refugees/.

[77] Global Trends: Forced Displacement in 2017. United Nations High Commissioner for Refugees, 2017, Global Trends: Forced Displacement in 2017. http://www.unhcr.org/5b27be547.pdf/.

[78] Global Trends: Forced Displacement in 2017. United Nations High Commissioner for Refugees.

or their immediate region.[79]

Turkey, Pakistan and Lebanon currently have approximately 30% of the world's refugee population, who primarily come from Syria.[80] Turkey, in particular, has claimed to have spent $25 billion on managing two dozen domestic refugee camps, which collectively house approximately 250,000 Syrian refugees.[81] Syrians residing within the country have only been granted "temporary protection," which allows them a more limited set of rights than they would have if they were granted full refugee status.[82] Numerous statistics from the country have raised cause for concern. Less than 60% of 900,000 school-age Syrians are enrolled in education programs, and as of 2017, only 1% of the working-age refugee population has garnered work permits.[83] It has been suspected that Turkey has remained hesitant to integrate refugees in an effort to diminish the number of incoming migrants. In tandem with a progressive rise in racism against Syrian refugees, this has intensified the situation at hand.[84]

Pakistan, in contrast, has been in the process of "repatriating" over 3 million Afghan refugees, forcing them to return to Afghanistan.[85] These individuals crossing the border face a bleak future back in their home country. Security has deteriorated amid the rise of ISIS in the country's east and the increasing gains of the Taliban around the country; meanwhile, unemployment stands at 40%.[86] While the UN has warned that such a forced return could result in a "major humanitarian crisis," the Pakistani government continues to push for such a movement, though in the interim it has extended stay of 1.4 million registered refugees.[87]

As of 2016, Lebanon is housing approximately 1 million registered refugees, with the majority having come during the beginning of the Syrian Civil War.[88] Over the past decade, the country has seen an enormous strain being put on infrastructure and other expenditures that are necessary to support the enormous refugee population. Given these numbers, it remains concerning that

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[79] Global Trends: Forced Displacement in 2017. United Nations High Commissioner for Refugees.

[80] "Turkey Is Taking Care of Refugees, but Failing to Integrate Them." The Economist, The Economist Newspaper, 29 June 2017, www.economist.com/europe/2017/06/29/turkey-is-taking-care-of-refugees-but-failing-to-integrate-them/.

[81] "Turkey Is Taking Care of Refugees, but Failing to Integrate Them." The Economist.

[82] "Turkey Is Taking Care of Refugees, but Failing to Integrate Them." The Economist.

[83] "Turkey Is Taking Care of Refugees, but Failing to Integrate Them." The Economist.

[84] "Turkey Is Taking Care of Refugees, but Failing to Integrate Them." The Economist.

[85] Report, Bureau. "Pakistan Still Hosting 1.4 Million Registered Afghan Refugees." DAWN.COM, 29 Aug. 2018, www.dawn.com/news/1429540/.

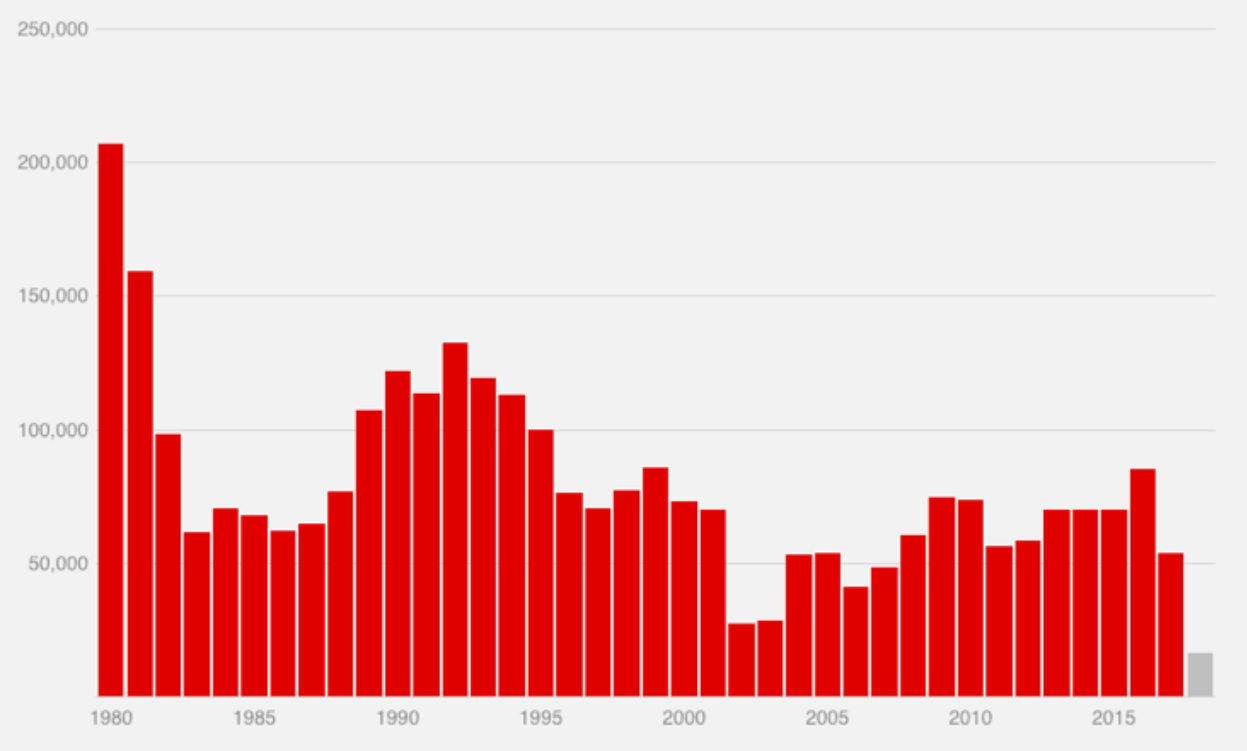
[86] Report, Bureau. "Pakistan Still Hosting 1.4 Million Registered Afghan Refugees."

[87] Report, Bureau. "Pakistan Still Hosting 1.4 Million Registered Afghan Refugees."

[88] Sherlock, Ruth. "In Lebanon, Syrian Refugees Met With Harassment And Hostility." NPR, NPR, 2 Sept. 2017, www.npr.org/sections/parallels/2017/09/02/547906231/in-lebanon-syrian-refugees-met-with-harassment-and-hostility/.

Lebanon has not signed the *1951 Refugee Convention*, although it has signed most other human rights treaties relevant to the protection of refugees.[89] The country also refuses to run refugee camps overseen by the UNHCR. The past several years have seen a heightening in tensions between civilians and Syrian refugees. Most recently, Lebanese officials have been calling for refugees to return to areas in Syria that they deem safe.[90]

The United States resettlement program is one of the largest in the world, given that the U.S. has been the global leader in resettling refugees since the 1970s. However, since Donald Trump's election to the presidency, the new administration has criticized the acceptance of refugees by other nations and significantly slowed the flow of refugees into the U.S. while rejecting the existence of a "global refugee crisis." They have also cut funding for some refugee programs worldwide, such as the United Nations Relief and Works Agency for Palestine Refugees in the Near East.[91]



[89] Sherlock, Ruth. "In Lebanon, Syrian Refugees Met With Harassment And Hostility."

[90] Sherlock, Ruth. "In Lebanon, Syrian Refugees Met With Harassment And Hostility."

[91] Krupa, Michelle, and Bethlehem Feleke. "The US Is on Track to Admit the Fewest Number of Refugees since the Resettlement Program Began." CNN, Cable News Network, 29 June 2018, www.cnn.com/2018/06/29/us/refugee-arrivals-us-trnd/index.html/.

Figure 3: Refugee admissions to the US between 1980 through May 2018. The number of refugees admitted to the United States this year is on pace to be the lowest since the advent of modern US refugee policies in 1980.[92]

Committee Mission & Focus Questions

It is difficult to convey the sheer magnitude of the refugee crisis, as well as the public health concerns associated with it, within a finite amount of time and space. In looking towards global solutions to the health problems that these vulnerable populations face, a focus must be placed on promoting and implementing refugee- and migrant-sensitive health policies. In addition, delegates must work towards legal and social protections for refugees and interventions to provide equitable, affordable and acceptable access to essential health services for refugees and migrants. This, combined with addressing the social determinants of health and health inequality, will allow for continuity in quality of care for refugees around the world.

Questions to consider include:

1. How might sustainable mental health services be implemented within refugee camp settings? How will best practice be insured while simultaneously promoting equity of access in resource-poor settings?
2. What are the ramifications of the involvement of non-governmental organizations (NGOs) and national governments within the context of healthcare provision in refugee camps?
3. How might global and regional standards be put in place for refugees in receiving countries in ensuring continuity and quality of care for persons with disabilities, people living with HIV/AIDS, tuberculosis, malaria, other chronic health conditions, as well as those with physical trauma and injury?
4. What kinds of health monitoring and health information systems may be used to most effectively ensure quality and access of care to vulnerable refugee populations worldwide? Do such interventions already exist? If so, how successful has system implementation and training been, and where might it be improved, particularly in global crises and instances of violence?
5. How will strong coordination of health services be ensured to ensure emergency responses covers all needs of refugees, and that referrals across services as well as individual follow-ups are assured?

[92] Krupa, Michelle, and Bethlehem Feleke. "The US Is on Track to Admit the Fewest Number of Refugees since the Resettlement Program Began."

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