Cerritos Advanced Conference 2020

Office of the United Nations High Commissioner for Human Rights (OHCHR)

Topic A: Global Health Equity

Topic B: Promoting Self Reliance For Refugees

Director: Liesel Arauz Vallecillo

POSITION PAPERS DUE on October 17th by 11:59 pm to Committee Email

October 24-25, 2020

To Delegates of CHSMUN Advanced 2020

Dear Delegates,
Welcome to CHSMUN Advanced 2020!

It is our highest honor and pleasure to welcome you all to our 2020 online advanced conference here at Cerritos High School. On behalf of the Cerritos High School Model United Nations program, we are proud to host our very first advanced conference, where you will become more knowledgeable on international issues, participate in intellectually stimulating discussions, and create new and everlasting friendships.

The CHSMUN program continues to compete around the world as a nationally ranked MUN program. Our delegates utilize diplomacy in order to create complex solutions towards multilateral issues in the global community. Our head chairs are selected from only the best seniors of our program, undergoing a rigorous training process to ensure the highest quality of moderating and grading of debate. Furthermore, all the topic synopses have been reviewed and edited numerous times. We strongly believe that by providing each and every delegate with the necessary tools and understanding, he or she will have everything they need to thrive in all aspects of the committee. We thoroughly encourage each delegate to engage in all of the facets of their topic, in order to grow in their skills as a delegate and develop a greater knowledge of the world around them.

Although this wasn't what we expected, our advisors and staff have put in countless hours to ensure delegates have an amazing experience at the online conference. Our greatest hope is that from attending CHSMUN 2020, students are encouraged to continue on in Model United Nations and nevertheless, inspired to spark change in their surrounding communities. With this strong circuit consisting of 6 schools and over 500 delegates, CHSMUN Advanced 2020 will provide a quality experience for intermediate delegates to enhance their speaking and delegating skills.

If you have any questions, comments, or concerns, please contact us! We look forward to seeing you at CHSMUN Advanced 2020!

Sincerely,

Anjali Mani and Karishma Patel

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Secretary-Generals

A Note From The Director

Delegates,

My name is Liesel Arauz and I am very excited to be your OHCHR committee chair this year! I started in the Cerritos Model United Nations program during my freshman year and since then I have made so many unforgettable memories. Although within this program I've gotten the opportunity to learn about a multitude of different international topics, the ones I am most passionate about are those related to human rights and health. When I'm not working in MUN, I can almost always be found either coordinating drama club events, acting in theatrical productions, teaching music as a student music director, or studying public health and epidemiology for Science Olympiad. Outside of school, I spend most of my time in music theory, voice, musical theater, and acting classes at Colburn School of Music and other online theater programs. Additionally, I also am a Los Angeles County Department of Public Health Youth Advisory Council Member which is why I chose one of the topics to be about global health equity. When I do have free time, I love reading, binging Netflix shows, or watching movies. My favorite shows currently are Criminal Minds and obviously the Avatar the Last Airbender series. Anyways, I hope you have a fun experience at the Cerritos Fall Conference and I'm wishing you the best of luck!

Sincerely,

Liesel Arauz Vallecillo

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Director, OHCR

Committee Introduction:

The Office of the United Nations High Commissioner for Human Rights (OHCHR) was established on December 20, 1993, by the General Assembly resolution 48/141. The OHCHR is the principal UN program on human rights. Its goal is to promote and protect the rights of all people by encouraging the implementation and ratification of international human rights treaties. The Office of the United Nations High Commissioner for Human Rights works to sustain the three pillars of the United Nations which are peace and security, human rights, and development. Although the issues covered by the OHCHR range from climate change to violent extremism to protecting refugees and IDPs, when regarding health some of the more focused on issues are the right to health and its relation to public policy, accessibility, financing, global health, and discrimination. The OHCHR firmly believes that governments have the primary responsibility to protect the human rights of all its citizens. To ensure that global human rights are being upheld in all areas around the globe, the OHCHR is divided into three divisions which are TESPRDD, CTMD, and FOTCD which assist the international community. The Thematic Engagement, Special Procedures, and Right to Development Division (TESPRDD) provide guidance, tools, resources, and policy recommendations to strengthen the nations' human rights capacities and to raise awareness on human rights issues globally. The Human Rights Council and Treaty

Mechanism Division (CTMD) assists in setting a standard for human rights by providing research and secretarial support to the Human Rights Council (HRC) and other human rights treaty-related entities. It also aids the Universal Periodic Review (UPR) which is used to monitor human rights violations as well as progress made by governments to improve the human rights situations in their nations. The outcome of the information found by the UPR provides recommendations, commentary, and questions to the nation that the report pertains to. The Field Operations and Technical Cooperation Division (FOTCD) oversees and implements international human rights standards in the field by collaborating with governments, the UN, non-governmental organizations, and citizens. These operations can include identifying, highlighting, or developing responses to human rights challenges or issues. The FOTCD also provides training, forums, and assistance in legislative reforms to improve human rights education and ensure that human rights standards are being met.

Topic A: Global Health Equity

Background:

Health equity is the absence of avoidable or unfair differences in the quality and accessibility of health care services among groups of people that are defined socially, demographically, geographically, economically, or other forms of stratification. When health equity isn't achieved, health disparities and inequalities arise which lead to numerous negative economic and health-related consequences for the international community and its citizens. Health care disparities refer to the differences in accessibility and quality of healthcare among various population groups. One of the most important factors interfering with health equity is socioeconomic in nature. Affordability and inaccessibility lead to higher rates of uninsured people. Uninsured people are less likely to have a regular doctor or to receive preventative care. Therefore, there are more likely to delay any treatment until their condition has reached a crisis stage which increases the level and cost of the care needed. Additionally, lower-income individuals tend to receive fewer diagnostic tests and medications due to cost and limited coverage. Research done by the National Institutes of Health found that regardless of race the lower the individual's income, the higher the rate of emergency department visits and amputations. Contrastingly, the higher the income level, the higher the rate of usage for preventative and diagnostic services such as mammograms or ambulatory visits. Lack of affordability is one of the most prominent obstacles deterring people from using healthcare services. This is why nations with low health equity levels are often impoverished and have a low life expectancy. For example, according to the World Health Organization (WHO), children from the poorest 20 percent of sub-Saharan Africa are nearly twice as likely to die before their fifth birthday as compared to the children in the richest 20 percent. Additionally, sub-Saharan Africa contains 27 of the world's 28 poorest countries, and children in this region are 14 times more likely to die before the age of five than the rest of the world. Disparities are not only caused

by socioeconomic factors but also by racism in healthcare systems. Doctors may take an oath to treat every patient equally regardless of race or other forms of stratification. However, misinformation and unconscious bias lead to differences in the quality of healthcare. For example, a 2016 study published by the *Proceedings of the National Academies of Science* found that half of all participants believed at least one or more false beliefs related to biological differences over race. Although this much of this information is outdated and incorrect, a meta-analysis conducted over 20 years found that in numerous settings African American patients were 22 percent less likely to receive pain medications in comparison to white patients due to 19-century incorrect information about biological differences and nerve endings spreading. Besides misinformation leading to mistreatment, racism in healthcare systems in both the past and present have also resulted in many minorities distrusting the system. For instance, in the Tuskegee experiment, the U.S. Public Health Service allowed syphilis to go untreated in about 600 African American men for 40 years so that they could record the stages of the disease and its effects inside the body. Although this occurred back in 1932, projects such as these have dissuaded many minorities from utilizing these services. Another component that obstructs health equity is resource allocation. An investigation in redlined communities in California demonstrates that residents who were segregated into specific neighborhoods based on race have faced greater health risks than in other unsegregated areas. For example, in the eight cities that they studied they discovered that there were higher incidence rates of asthma and trips to the emergency room. Modern segregation results in certain areas having more or less resources compared to other communities which can further combat achieving health equity. Aside from the lack of resources, health disparities can worsen in these communities as redlined areas have higher prevalence of poor health due to higher amounts of environmental hazards such as pollutants. Another deterrent would be the lack of a bridge between culturally-responsive medicine practices and clinical medicine. Cultural barriers, especially pertaining to mental health, can also be a challenge to many individuals who want to seek health services. The stigma surrounding mental illness, societal and familial expectations, and a lack of understanding can lead to denial or neglect of mental health or other aspects of physical health. Other groups that are affected by health disparities are the LGBTQ+ community, persons with disabilities, and immigrants. Discrimination and restrictions related to these communities inhibit achieving health equity. For example, homophobia can lead to differences in the quality and accessibility of care. About 8 percent of LGB individuals and nearly 27 percent of transgender individuals that had HIV reported being denied treatment and medication outright due to their sexual orientation. Although there have been laws implemented in many nations against LGBTQ+ discrimination, there are still occurrences where patients are discharged early or turned away from the hospital because they are LGBTQ+ or they have same-sex parents. Additionally, research indicates a connection between LGBTQ+ related health disparities and societal stigma, discrimination, and the denial of their human and cival rights. Violence and overall discrimination affect the mental health and safety of these individuals as well. Another vulnerable group would be those with disabilities. According to the World Health Organization, the two main issues for those with disabilities were not being able to afford health services and not having the transportation to get to facilities. In low income countries, about 32 to 33 percent of people without a disability are unable to afford healthcare; however, also in these areas, 51 to 53 percent with a disability claim having the same financial barrier. Additionally, research in Uttar Pradesh and Tamil Nadu states of India discovered that after cost, the lack of services in the area for those with a disability were

the second most significant barrier preventing them from using facilities. Another group that is at high risk of health disparities are immigrants. A Health Equity study found that immigrant families often are dissuaded from utilizing health care and social services because they fear interactions with public agencies. Consequently, immigrants were found to have lower rates of health insurance and lower quality of care than U.S. born populations. Immigration status as well as language barriers in some cases can make it difficult for these individuals and their families to receive adequate and accessible healthcare. Health equity is a significant issue that affects the international community as adequate and accessible healthcare is a universal human right. Health inequity leads to lower life expectancy rates and economic problems. For instance, health inequity and inequalities result in losses in productivity and other costs which can total to a large amount of the country's GDP. The European Parliament estimated that losses related to this issue cost about 1.4 percent of their gross domestic product (GDP). Conversely, when there is health equity, especially due to accessible and affordable mental health services, an effect can be lower crime rates. A study done by Jason Hockenberry, Janet R. Cummings, and Heifei Wen who is a faculty member of the Health Policy and Insurance Research indicated that the expansion of Medicaid crime-reducing effect. Graduate research assistants also conducted a similar study which showed that increases in accessibility led to a reduction in the crime rate. Besides keeping people from being incarcerated, having adequate health services within prisons can cut recidivism rates and calm chronic behavior. However, having available services for those who are incarcerated is not a reality in many countries which makes prisoners another at risk group for health disparities. This is evident in the fact that the Center for Prisoner Health and Human Rights reported that only about a sixth of jail inmates who need mental health received it while serving time.

United Nations Involvement:

The United Nations has actively participated in providing healthcare rights and leading the way for adequate and affordable health services internationally in many different ways. The UN has created two crucial documents that explicitly state the rights entitled to every individual. These two documents are the Universal Declaration of Human Rights and the International Covenant on Economic, Social, and Cultural Rights. The Universal Declaration specifically pertains to health in Article 25 where it states that everyone has the right to health. The OHCHR explained in their Right to Health report that this included far more than just access to health care and building hospitals. It includes determinants and factors that lead to a healthy life. This includes sanitation, potable water, adequate nutrition and shelter, healthy working and environmental conditions, and health literacy. The right to health also calls for systems that provide equality and prevent discrimination. Although there are many specific facets elaborated on by the OHCHR relating to health, one of the main components of this right is that all resources, facilities, and services must be available, accessible, and of good quality. The International Covenant on Economic, Social, and Cultural Rights which was ratified in 1966 recognized that every human being has the right to the highest attainable standard of physical and mental health. It mandates that State Parties to this Covenant ensure this right by providing

resources for healthy child development and infant mortality mitigation. It also calls for improving all facets of environmental and industrial hygiene and health. Lastly, this covenant encourages countries to create programs or policies that assure that all medical services and attention are available in the event of illness. The UN has also created resolutions that promote health equity and recommend action plans to achieve it. The United Nations General Assembly (GA) adopted A/RES/67/81 on December 12, 2012, which incentivizes member states to work toward universal health coverage and equity by bringing attention to the link between health accessibility and sustainable development and national finance mechanisms. This resolution requests that member states improve their health care systems and services with a strong focus on removing any socioeconomic obstacles. The United Nations Human Rights Council also adopted A/HRC/32/L.24/Rev.1 on June 30, 2016, which increases access to medicines by using TRIPS flexibilities that respect the protection of new medicines being intellectual property while also expressing concerns on the medicines' prices. It recommends that the Member States invest in new medicines and vaccines while building on existing mechanisms and forming partnerships with institutions that create new medicine-related innovations. Lastly, the resolution invites the United Nations High Commissioner for Human Rights to prepare a report on health frameworks that could aid in the implementation of the health-related sustainable development goals. Additionally, in 2017, the General Assembly also adopted A/RES/72/139 which addresses the most vulnerable groups in regards to health disparities. This resolution depicts ensuring that physical, mental, and social wellbeing are being completely attainable for the members' citizens is a precondition to having sustainable development. It also urges nations to use policy measures and programs to establish community-based health services that are gender-responsive and human rights-based. To enhance health equity and equality, A/RES/72/139 promotes Member States financing initiatives that make medicines, vaccines, and antimicrobials more affordable. It also recognizes the impact of discrimination within the realm of health which is why it also invites nations to take action in creating a more inclusive society for vulnerable populations. Other actions the UN has taken to promote health equity are creating International Universal Health Coverage Day and delegating related responsibilities to other UN bodies. Since 2017, the United Nations has declared December 12 to be the International Universal Health Coverage Day. The purpose of this event is to raise awareness of the issue and to urge leaders to make larger investments in health. Aside from raising awareness, the UN delegates responsibilities related to the promotion of health equity to not only the Office of the United Nations High Commissioner for Human Rights but the World Health Organization (WHO) as well. WHO is responsible for leading global health initiatives, providing technical support to nations, setting the standards for health, and monitoring international health trends. WHO created the *Engaging for Health, Eleventh General Programme of Work: A Global Health Agenda* which highlights seven priority areas which include universal coverage and health related human rights issues. It has partnered with UNICEF and other nation's Ministries of Public Health to support community projects that improve accessibility to health services as well.

Case Study: Chile

Chile has two major healthcare plan categories that their citizens fall under. About 69 percent of their population is covered by public health insurance plans (FONASA); whereas private insurance plans cover another 17 percent of the population (ISAPREs). Those who aren't covered by either get insurance from another public agency or go without any healthcare coverage. Although the Chilean government has worked with the Ministry of Health to provide more health services to the community. Healthcare costs are still a main deterrent to individuals using services. About 38 percent of total health expenditure comes from out-of-pocket spending. This figure primarily affects lower-income families. In fact, an estimated four percent of families are in danger of impoverishment for their medical spending.Factors such as the mother's education level and the household income were found to cause great health disparities in Chile. Low socioeconomic status whether measured in terms of the status of the individual's occupation, their education level, or their income level was said to have higher prevalence rates of chronic conditions and premature mortality. For example, the infant mortality rate for respiratory diseases is about 14.3 times greater in children of mothers with basic education rather than those who have a high school diploma or university degree. Additionally, according to the National Health Survey (NHS), those who had less education had higher prevalence rates of hypertension and diabetes. Both of these ailments are some of the major causes or risk factors of many chronic diseases. Another main issue that causes differences in the health of the Chilean population is based on the location of the individual. Studies found that regions in the country with the highest proportion of indigenious people had a higher degree of preventable morbidity than in their population than in nonindigenous populations. For example, the prevalence of tuberculosis is higher in the Arica-Parinacota, Tarapaca, and Los Lagos regions which make their indigineous population a vulnerable group to health disparities. Most of the causes for the differences in the health of nonindigenous and indigenious people in this country are caused by inaccessibility to healthcare. In response to the increase in inequalities after the introduction of private healthcare coverage, Chile released a reform plan in 2006. The AUGE plan established the coverage of sixty-nine health conditions that must be covered for free by the public and private system.

Bloc Positions:

Western Bloc: Most of the countries that have the highest life expectancy are from the Western bloc. This could partially be influenced by the fact that many of the nations in this region are considered to be first world countries and have high Gross National Incomes (GNI). However, the nations in this bloc still struggle with disparities caused by differences in educational and socioeconomic levels as well as inequalities caused by discrimination. In many western European countries, inequalities are caused by educational level differences. For example, the difference between having upper secondary education or having an education equivalent to a university degree can add or reduce life expectancy by about 8 years. Another issue for many western nations is accessibility, especially in rural and remote areas. Additionally, a lack of doctors and nurses make it difficult to provide timely services to all their citizens. For the EU countries specifically, one of their major policy issues is the long waiting times for elective

surgeries. In the US, one of the major issues affecting Americans is the lack of insurance. About 44 million Americans lack insurance and another 38 million have inadequate health insurance. The following are factors that left many Americans uninsured: high coverage costs, not having an occupation that offers coverage, not being aware of what financial assistance is available, residing in a state without expanded Medicaid coverage, and immigration status.

Latin America and the Caribbean Bloc: The International Labor Organization reported that more than 140 million people are being denied access to health care services in Latin America and the Caribbean. Even with healthcare coverage, cultural, financial, and geographical barriers prevent them from fully utilizing that resource. One of the major issues facing countries in this bloc is socioeconomic inequality especially its relation to infant and maternal mortality. Many diseases that kill children in these regions could have been prevented had the families had the financial capabilities and resources to treat the child. Another important health issue in Latin America and the Caribbean bloc was the gaps in health due to the status of their occupation and the sanitation resources offered in their area.

African Bloc: Although countries in the African bloc have reduced health inequity, these nations still face disparities arising primarily from socioeconomic factors, lack of healthcare professionals and infrastructure, and inadequate healthcare systems. In many sub-Saharan African countries, healthcare services are only offered in urban areas if at all. This leads to fewer children receiving vaccinations or necessary treatment for basic illnesses which can lead them to develop lifelong preventable disabilities or health ailments. Many of the lower or middle-income areas in Africa lack testing or funding for health-related services. A survey done in May by Reuters found that in Africa there is less than 1 intensive care bed per 100,000 people. Other health equity challenges in African countries are barriers set by cultural beliefs that stigmatize disabilities. Additionally, differences in traditional versus clinical medicine may lead to some individuals being discouraged from going to a hospital instead of seeing a traditional herbalist or healer.

Asian-Pacific Bloc: According to the Organization for Economic Cooperation and Development, women in low-income households in rural areas are less likely to access healthcare services due to distance and financial barriers. In Nepal, Pakistan, and the Solomon Islands, about two in three women reported having unmet care needs due to distance. Additionally, 40 percent of women from households even with the highest income also reported having financial difficulties with accessing care in Cambodia. Aside from socioeconomic status, education level largely influences the standard of health an individual has in the Asian Pacific. In Cambodia, mothers who have no education have a 136 in 1000 chance of their children dying; whereas the infant death rate for children of mothers who have the highest level of education is about 53. Another major issue for these nations is health inequity relating to poor living conditions and malnutrition. This is a significant issue to the Asian Pacific bloc as food insecurity and poor living standards can lead to more health ailments and needing more treatment.

Basic Solutions:

When trying to promote health equity, it is important to keep in mind the different populations that are being largely affected by the issue as well as the different factors that contribute to the problem. Feasible solutions relating to this issue should be cost-effective as those who are most affected are third world countries. Delegates are encouraged to not use commonly mentioned solutions and instead look for more innovative ones. Additionally, although education and lack of resources such as nutrition or shelter are important parts of this topic, the overall focus should be on increasing accessibility, inclusivity, and affordability of healthcare services. Delegates are also recommended to analyze different health initiatives, programs, or services to determine their effectiveness and shortcomings. Before presenting these as possible solutions to the committee, delegates should think about how that program could be improved or altered to fit other countries that have a similar problem but have different resources or obstacles.

An example of a successful solution that has been implemented in Africa is the usage of programs that teach clinical medicine to traditional herbalists to combat cultural barriers. This program was created to uphold the 1961 Convention on Psychiatry and Pan African Tradition. It trained over 100 Kenyan herbalists who were then able to identify more than 675 cases of mental illness and subsequently refer people seeking traditional help to psychiatric services. It led to a 15 percent increase in the number of Kenyans who sought mental health services. Delegates are also encouraged to not use NGOs as the main source for solutions and instead formulate unique solutions that cover the issues most significant to their country.

Questions to Consider:

1. How is your country dealing with health inequality and inequity and what steps has it taken to ensure better coverage for all its citizens?
2. Are there any groups in your country that are at high risk or are highly discriminated against? What actions can be taken to reduce stigma or make healthcare more culturally sensitive?
3. How can you ensure that healthcare is accessible in rural areas or areas that lack resources? What transportation methods can make healthcare more accessible to certain individuals?
4. How can you make healthcare more accessible and affordable for lower-income individuals and in third world countries?
5. Are there any solutions that help alleviate determinants of health besides just enhancing healthcare systems and updating policy?
6. What healthcare systems and programs have been successful in your country? How can these be altered or improved to work for other nations in the committee?

Sources:

1. " UN Documentation: Human Rights." *United Nations*, United Nations, 9 May 2019, 5:23 PM, research.un.org/en/docs/humanrights/OHCHR.
2. "Africa: Covid-19 Exposes Healthcare Shortfalls." *Human Rights Watch*, 6 Aug. 2020, www.hrw.org/news/2020/06/08/africa-covid-19-exposes-healthcare-shortfalls#.
3. Altaweel, Mark. "How Redlining Communities Affects Health." *Geography Realm*, 29 June 2020, www.geographyrealm.com/how-redlining-communities-affects-health/.
4. Arpey, Nicholas C., et al. "How Socioeconomic Status Affects Patient Perceptions of Health Care: A Qualitative Study." *Journal of Primary Care & Community Health*, vol. 8, no. 3, 2017, pp. 169–175., doi:10.1177/2150131917697439.
5. Bhopal, R. S. "Racism in Health and Health Care in Europe: Reality or Mirage?" *The European Journal of Public Health*, vol. 17, no. 3, 2007, pp. 238–241., doi:10.1093/eurpub/ckm039.
6. Casas, Juan Antonio, et al. *Health Disparities in Latin America and the Caribbean: The Role of Social and Economic Determinants*. citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.551.6956&rep=rep1&type=pdf.
7. "The Convention in Brief Enable." *United Nations*, United Nations, www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/the-convention-in-brief.html.
8. "Determinants of Health." *Determinants of Health | Healthy People 2020*, US Department of Health and Human Resources, 5 Aug. 2020, www.healthypeople.gov/2020/about/foundation-health-measures/determinants-of-health.
9. "Disability and Health." *World Health Organization*, World Health Organization, 16 Jan. 2018, www.who.int/news-room/fact-sheets/detail/disability-and-health.
10. DL. Cameron, S. Nixon, et al. "Barriers and Facilitators to Healthcare Access for Children with Disabilities in Low and Middle Income Sub-Saharan African Countries: a Scoping Review." *BMC Health Services Research*, BioMed Central, 1 Jan. 1970, bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4822-6.
11. EK, Swift. "Rates for Selected Medicare Services, Age 65 Years and Over, by Race and Income, 1993." National Academy of Sciences, 2002.
12. European Commission. OECD, 2018, pp. 1–211, *Health at a Glance: Europe 2018*.
13. Friel, Sharon, and Phillip I. Baker. *Equity, Food Security and Health Equity in the Asia Pacific Region*. National Centre for Epidemiology and Population Health, 19 Oct. 2009, apjcn.nhri.org.tw/server/APJCN/18/4/620.pdf.
14. "Health." *ILGA*, Freedom House, www.ilga-europe.org/what-we-do/our-advocacy-work/health.
15. "A History of Universal Health Coverage in the UN." *UHC2030*, 2019, www.uhc2030.org/un-hlm-2019/a-history-of-universal-health-coverage-in-the-un/.
16. Institute of Medicine (US) Committee on Guidance for Designing a National Healthcare Disparities Report. "MEASURING THE EFFECTS OF SOCIOECONOMIC STATUS ON HEALTH CARE." *Guidance for the National Healthcare Disparities Report.*, U.S. National Library of Medicine, 1 Jan. 1970, www.ncbi.nlm.nih.gov/books/NBK221050/.

17. “International Covenant on Economic, Social and Cultural Rights.” *OHCHR*, 3 Jan. 1976, www.ohchr.org/en/professionalinterest/pages/cescr.aspx.
18. “Latin America: Unequal Access to Health Care Is Still No. 1 Killer for Moms and Kids.” *World Bank*, World Bank, 11 Sept. 2013, www.worldbank.org/en/news/feature/2013/09/11/mother-child-healthcare-inequalities-latin-america.
19. Mirza , Shabab Ahmed, and Caitlin Rooney. “Discrimination Prevents LGBTQ People From Accessing Health Care.” *Center for American Progress*, Center for American Progress, 13 Aug. 2019, www.americanprogress.org/issues/lgbtq-rights/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.
20. Monique Tello, MD. “Racism and Discrimination in Health Care: Providers and Patients.” *Harvard Health Blog*, 9 July 2020, www.health.harvard.edu/blog/racism-discrimination-health-care-providers-patients-2017011611015.
21. “More than 140 Million Denied Access to Health Care in Latin America and the Caribbean.” *International Labor Organization*, International Labor Organization, 29 Nov. 1999, www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_007961/lang--en/index.htm.
22. Nardone, Anthony, et al. “Associations between Historical Residential Redlining and Current Age-Adjusted Rates of Emergency Department Visits Due to Asthma across Eight Cities in California: an Ecological Study.” *The Lancet Planetary Health*, vol. 4, no. 1, 2020, doi:10.1016/s2542-5196(19)30241-4.
23. New, William. “UN Human Rights Council Adopts Access To Medicines Resolution.” *Intellectual Property Watch*, Intellectual Property Watch, 23 June 2017, www.ip-watch.org/2017/06/23/un-human-rights-council-adopts-access-medicines-resolution/.
24 OHCHR. “Brief History.” *OHCHR*, Office of the United Nations High Commissioner for Human Rights, www.ohchr.org/EN/AboutUs/Pages/BriefHistory.aspx.
25. OHCHR. “Frequently Asked Questions.” *OHCHR*, United Nations Human Rights Office of the High Commissioner, www.ohchr.org/EN/AboutUs/Pages/FrequentlyAskedQuestions.aspx.
26. OHCHR. “How We Do It.” *OHCHR*, Office of the United Nations High Commissioner for Human Rights, www.ohchr.org/EN/AboutUs/Pages/HowWeDoIt.aspx.
27. OHCHR. “List of Issues.” *OHCHR*, Office of the United Nations High Commissioner for Human Rights, www.ohchr.org/EN/Issues/Pages/ListofIssues.aspx.
28. OHCHR. “What We Do.” *OHCHR*, Office of the United Nations High Commissioner for Human Rights, www.ohchr.org/EN/AboutUs/Pages/WhatWeDo.aspx.
29. OHCHR. “Who We Are.” *OHCHR*, Office of the High Commissioner for Human Rights, www.ohchr.org/EN/AboutUs/Pages/WhoWeAre.aspx.
30. Orgera, Kendal, et al. “Disparities in Health and Health Care: Five Key Questions and Answers.” *KFF*, Kaiser Family Foundation, 1 Apr. 2020, www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/.
31. “Poverty in Africa.” *Compassion International*, Compassion International, www.compassion.com/poverty/poverty-in-africa.htm.

32. “Poverty.” *Poverty | Healthy People 2020*, US Department of Health and Human Services, www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/poverty.
33. Puras, Dainius. “Issues in Focus.” *OHCHR*, Office of the United Nations High Commissioner for Human Rights, 2014, www.ohchr.org/EN/Issues/Health/Pages/IssuesFocus.aspx.
34. RWJF. “Immigration, Health Care and Health.” *RWJF*, Robert Wood Johnson Foundation, 26 July 2019, www.rwjf.org/en/library/research/2017/09/immigration-status-and-health.html.
35. Sabin, Janice A. “How We Fail Black Patients in Pain.” *AAMC*, 6 Jan. 2020, www.aamc.org/news-insights/how-we-fail-black-patients-pain.
36. Saez, Catherine. “Access To Medicines Resolution Adopted By UN Human Rights Council.” *Intellectual Property Watch*, 1 July 2016, www.ip-watch.org/2016/07/01/access-to-medicines-resolution-adopted-by-un-human-rights-council/.
37. Silva-Peñaherrera, Michael, et al. “Health Inequity in Workers of Latin America and the Caribbean.” *International Journal for Equity in Health*, vol. 19, no. 1, 2020, doi:10.1186/s12939-020-01228-x.
38. Sisson, Jordan. “Yale Psychiatry's Calhoun Shares Her Experiences With Racism in the Medical Field.” *Yale School of Medicine*, Yale School of Medicine, 17 Feb. 2020, medicine.yale.edu/news-article/22678/.
39. “Tuskegee Study - Timeline - CDC - NCHHSTP.” *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 2 Mar. 2020, www.cdc.gov/tuskegee/timeline.htm.
40. “Tuskegee Study and Health Benefit Program - CDC - NCHHSTP.” *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 2 Mar. 2020, www.cdc.gov/tuskegee/index.html.
41. UN General Assembly. “Resolution Adopted by the General Assembly on 12 December 2017.” *A/RES/72/139 - E - A/RES/72/139*, United Nations, 12 Jan. 2017, undocs.org/A/RES/72/139.
42. UN General Assembly. “United Nations Official Document.” *United Nations*, United Nations, 12 Dec. 2012, www.un.org/en/ga/search/view_doc.asp?symbol=A%2FRES%2F67%2F81.
43. United Nations Human Rights Council. “Basic Facts about the UPR.” *OHCHR*, United Nations Human Rights Council, www.ohchr.org/en/hrbodies/upr/pages/basicfacts.aspx.
44. WHO. “Health Equity.” *World Health Organization*, World Health Organization, 8 July 2020, www.who.int/topics/health_equity/en/.

Topic B: Promoting Self Reliance For Refugees

Background:

Refugee rights are an international issue because according to the United Nations High Commissioner for Refugees (UNHCR), 25.4 million of the 68.5 million people who are forcibly displaced worldwide due to persecution, conflict, violence, or human rights violations are refugees. Even after leaving areas of conflict, refugees still face stressors such as poor living conditions, lack of education and employment opportunities, and persecution. From the late 1970s to the early 2000s, the UNHCR agreed with multiple countries that refugees were to be confined to the refugee camps. Due to this agreement, refugees were unable to move freely which limited their access to land and economic opportunities. This restriction inhibits the refugee's ability to become self-reliant so instead many were forced to depend on humanitarian assistance programs. Although now many countries have policies that allow refugees out of the camps and into the community, host states can often be reluctant to extend citizenship or public services to them. An obstacle to promoting self-reliance for refugees is that some countries are reluctant to open borders to refugees much less offer them opportunities outside of the camps. One of the reasons some communities and countries aren't willing to host many refugees is because they fear that refugees may take their jobs, put a strain on public resources, and undercut wages. This is evident by the Pew Research Center Survey's finding that about 50 percent of respondents reported viewing forcibly displaced people as economic burdens that put pressure on jobs and social benefits. Biased and false opinions relating to an association between refugees and crimes also lead communities to alienate or discriminate against refugees. For example, in eight of the ten European countries surveyed, about half or more believed that an influx of refugees would increase the likelihood of terrorism in their country. Similarly, an estimated 30 percent blamed the majority of crime on refugees. This form of discrimination can extend past just social alienation but also to the job market as well leading to higher levels of refugee unemployment. The United Nations encourages refugees to move outside of the camps however one factor that deters this is negative attitudes refugees may have regarding being in a host community that struggles with poverty, weak economic markets, and lack of opportunities.

Being moved to an area that is already struggling may make them feel like living outside would be impossible without camp services. However, refugee camps were only set up to be temporary locations for displaced persons to reside until they returned to their home country or resettled elsewhere. The camp system as it is run currently is often rife with violence, disease, poverty, and malnutrition. Due to the average length of displacement being about 10 to 15 years, it is important to look for more long term solutions, integration, and inclusion initiatives rather than short term humanitarian responses. Low and middle-income countries host about 85 percent of the world's refugees. Although hosting refugees does require some of the budgets to go toward infrastructure, health, and education systems, refugee integration can lead to positive effects for both the host nations and refugees. These communities gain productive workers who can contribute to taxes, entrepreneurialism, and provide more connections to diverse markets. A National Bureau of Economic Research working paper found that on average, refugees to the U.S. pay about $20,000 more per person in taxes than they collect in benefits. Additionally, a study conducted by the UNHCR and the World Bank Group found that the 180.000 refugees who lived in and around the Kakuma camp in Kenya contributed to an economy worth about $56 million US dollars a year. This indicates that hosting refugees can promote economic growth in other countries. It can also cost the country significantly less to host the refugee outside of the camp. The UNHCR estimated that the annual costs per refugee in a camp are about $1980, whereas those for outside camps cost about $980. Being hosted outside the camp is advantageous to the refugees because it can increase their standard of living and wages. Additionally, the country from which the refugee fled can benefit as well since eventually, some refugees may bring back the skills and assets they acquired from the host country during displacement. Therefore one of the major parts when solving this issue is helping developing nations balance supporting their citizens and the refugees they host. This would include aiding these nations if they struggle with poverty or lack of employment opportunities. Once these issues are resolved, refugee integration will be much easier and beneficial for both the refugees and those living within the community.Other contributing factors that prevent refugees from becoming self-reliant are the lack of documentation, vulnerability to corrupt schemes, shelter insecurity, and the language barrier. Refugees face greater challenges in having their credentials recognized due to not being able to always produce documentation proving their training, skill set, or level of education. The reasons why refugees are unable to provide such documentation are usually linked to it have been lost, destroyed, or confiscated. A study done by the Norwegian Refugee Council (NRC) discovered that out of 580 interviewed Syrian refugee households in three different countries, about 70 percent of them lacked basic identity documents. Not having identification or property ownership documents impacts their ability to claim their rights or protect themselves in both their host and native country if they choose to return. Additionally, establishing an individual's identity is often necessary to obtain employment, medical care, housing, insurance, and education. The NRC also found that about 24 percent of forcibly displaced children under the age of five were not properly registered which could lead to many refugee children being left stateless. Having no documentation can be particularly detrimental as some countries subject these individuals to detention or deportation without it. Therefore some refugees may use illegal means to obtain documentation. About 17 percent of households interviewed by the Norwegian Refugee Council reported that they had to obtain false documentation. This exposes these individuals to adverse legal consequences and exploitation. For example, refugees might use illegal means to support their livelihoods since, in some

countries, such as Jordan, refugees aren't allowed to work without a permit. This permit requires documentation that an estimated 200,000 to 300,000 Syrian refugees do not have. Should a refugee be found working in this nation without a permit, the punishment is being arrested. Corruption also hinders refugee self-reliance because it puts refugee lives at risk while making them at risk for labor exploiting schemes since they may feel that there's no other choice. This issue is highly tied to the issue of housing insecurity. According to the United Nations High Commissioner for Refugees, shelter is the main concern for Syrian refugees living outside the camps. About 90 percent of refugees in Lebanon are in debt. This survey also found that an estimated 40 percent of refugees are in debt to their landlords. To prevent themselves from losing their homes or being unable to support their family, many refugee families send their children to work. According to UNICEF, more than three-quarters of the refugees in Lebanon are severely impoverished with only $4 of earnings to survive on a day. Consequently, less than half of the refugee children in the country attend school. This indicates an association between the lack of stable household income and increased risk of child labor. Another component that hinders forcibly displaced persons from achieving self-reliance is the language barrier. About two-thirds of refugees live in countries where the official language differs from their native language. This language can limit the refugee's ability to use health and education resources. According to a report by the UN Refugee Agency, more than half of the 7.1 million refugee children of school age globally do not go to school. A lack of education increases a woman's risk for sexual and gender-based violence (SBGV). Additionally, it can hinder refugee self-sufficiency by making it more difficult for them to integrate into the labor market and society.

UN Involvement:

The United Nations has actively been involved in aiding refugees to achieve self-reliance using multiple different strategies and approaches. The UN has created four documents that outline the rights of refugees and promote self-reliance. For example, Article 23 of the Universal Declaration of Human Rights states that everyone has the right to work and be protected against unemployment. This article also guards against any form of discrimination within the workplace regarding unequal payment for the same amount of work. To further protect the rights of refugees as a whole, the UN adopted the 1951 Refugee Convention. Its central purpose is to combat and prevent refoulement as well as provide a definition as to who is considered a refugee. It also recognizes that the rights of refugees are a worldwide issue which means that it requires the cooperation of the whole international community. Additionally, the Convention states the minimum basic standards for the rights and treatment of refugees. Article 17 mandates that all state parties must give refugees the right to engage in wage-earning employment. Article 24 requires that all contracting states must give refugees the same treatment as the citizens there in regards to social security, matters governed by labor laws, and the right to compensation in the event of an employment-related death. In articles 21 and 22, the Geneva Convention encourages nations to give equal treatment regarding housing and educational opportunities as they would another immigrant. Under Article 27 and 28, it also mandates that ratifying states issue

Convention Travel Documents or other identity papers to refugees lawfully staying in their territory. Another crucial document is the International Covenant on Economic, Social, and Cultural Rights. Signed on December 16, 1996, article six of the covenant reiterates the same sentiments expressed in the aforementioned article of the Universal Declaration of Human Rights. However, it elaborates by encouraging state parties to the Covenant to implement technical and vocational training or guidance programs as well as policies that would safeguard work-related political and economic freedoms. Additionally, the Covenant promotes that all individuals regardless of gender or status be able to become self-reliant and live with dignity. Another key framework that the UN adopted was the Comprehensive Refugee Response Framework (CRRF) in September 2016. The CRRF promotes the idea of refugees being included in host communities so that they can access educational facilities and the labor markets. It emphasizes that if forcibly displaced individuals have access to such resources, they can develop valuable skills and contribute to the economy.Other actions the UN has taken to encourage refugee self-reliance are the creation of the UN Refugee Agency (UNHCR) and its partnerships with other UN bodies. Formed on December 14th, 1950, the UNHCR was established with the intent of assisting and protecting refugees. As of May 31, 2018, the UNHCR works in 128 countries and assists nearly 59 million refugees. The UN Refugee Agency provides humanitarian aid, transportation packages, and creates income-generating projects for resettling refugees. One of the many initiatives that the UN Refugee has done is partner with the World Food Programme (WFP) to create the Joint Strategy. The Joint Strategy's mission is to promote self-reliance while considering the food insecurity, nutrition, and socioeconomic status of host populations. Through this program, the UNHCR and WFP have interacted with multiple governments and host communities to address any arising tension. When addressing any conflict between refugees and those naturalized in the communities, the Joint Strategy looks for a sustainable solution that benefits both sides.

Case Study: Ethiopia

According to the UNHCR, Ethiopia hosted an estimated 883, 546 refugees in 2017 making it the second-largest refugee-hosting country in Africa. Most of the refugees there are located in one of the 26 camps. These camps have limited supplies and opportunities which means many are heavily dependent on humanitarian assistance there. To better promote self-reliance, Ethiopia has enacted legislation that allows refugees the right to work and live outside the camps. The Out-of-Camp Scheme was adopted in 2010 and since then it has gotten 17, 345 refugees to live in Addis Ababa. The main issues the country is facing aside from COVID-19 is harsh weather conditions, inadequate infrastructure, and high levels of poverty. Lack of accessible transportation makes it difficult for refugees to move and find better opportunities or resources. To promote self-reliance, Ethiopia became one of the first countries to use the Comprehensive Refugee Response Framework. Under the plan, Ethiopia established the Biometric Information Management System (BIMS) which recorded information about the refugee's level of education and professional capabilities and family profiles. This system allowed refugees to access CRRF opportunities and helped resolve some aspects of the issue of documentation. When implemented in the country, it enrolled about 17,000 refugees into the

testing phase of the program. Another action Ethiopia has taken is the gradual replacement of refugee camps by industrial parks and host communities. Ethiopia was assured of a $500 million aid package by the European Union to fund industrial parks which are expected to create up to 100,000 jobs, of which 30 percent will be allotted to refugees. This plan benefits the host community because of the addition of new social infrastructures such as schools and health centers that can be used by the refugees and citizens alike. Therefore, it combatted the negative stigma that the community it was implemented in had towards refugees.

Bloc Positions:

Western Bloc: Many nations in the western bloc have taken in significant numbers of refugees; therefore, many are now reducing the amount that can enter the country. For example, the United States has significantly decreased the number of refugees it used to accept. For the 2020 year, pre-pandemic, the Trump Administration had announced that it would only accept about 18,000 refugees. This would be the lowest US intake of refugees since 1980. Although these nations are reducing the number of refugees admitted into the country, many of these nations still believe in assisting the refugees that come from war-torn areas. An estimated 75 percent of citizens from Spain, France, the Netherlands, and the United Kingdom showed support for taking in refugees from war-torn nations. However, countries from around the Greek and Italian regions have begun to express negative views toward refugees after an influx following the 2015 migration surge. This is evident in Hungary passing legislation that made it illegal to assist refugees after having thousands of migrants seek asylum in 2015. The main challenge facing the western bloc is the integration of refugees into their communities. Studies indicate that the barrier preventing effective social integration in these areas was linked to racism. Negative portrayals of refugees in the media undermine the integration process as it can lead to hate crimes or high levels of discrimination. As for economic integration, language barriers and non-recognition of their qualifications seem to be the largest obstacle in promoting economic self-reliance for refugees. For instance, although there are an estimated 120,000 refugees in the UK that have the right to work, the unemployment rate for their population is about three times more than that of those born in the UK.

Latin America and Caribbean Bloc: All Latin American countries except for Cuba and Guyana are State members to the 1951 Refugee Convention. Due to having high numbers of refugees and being unable to provide a proper life for many of them, the Latin American bloc has reduced its number of incoming refugees immensely. Many do so by increasing border security or requiring a larger amount of documentation for a refugee to enter a country. For example, Chile has begun to demand passports and visas from Venezuelan refugees which many of them don't have. Without forms of identification, it can be difficult for these refugees to find work without a valid permit. Chile and other countries also struggle with a wage gap which is evident by the fact that Chileans with advanced degrees are paid about 20 percent more than refugees with the same amount of education. Although many of the governments in this bloc support refugee rights, humanitarian and refugee crises can make it difficult for them to accept or support large numbers. For example, the humanitarian and food crisis in Venezuela has led an estimated 16 percent of the population, including some refugees, to flee the country. Therefore, helping

host countries and the countries where refugees fled from to resolve their crises is an important part of ensuring that refugees have a place where they can become self-reliant outside of their native country. Other main challenges for the members of this bloc are the lack of freedom of movement, alternatives to detention, a cycle of organized crime, and problems related to discrimination.

African Bloc: Nations from the African bloc host more than 26 percent of the world's refugee population. This is because many of them have open border policies. For example, Ethiopia with its open-door policy accepts about 740,000 refugees making it the largest refugee population in a single African country. Recognizing that most displacements span over many years, the nations in the bloc prioritize promoting long-term solutions that emphasize self-reliance, the integration of refugees and reduce the humanitarian aid dependency of refugees. One of the central ways, some of these nations have done this is by allowing forcibly displaced individuals to participate in the local economy. For instance, Uganda gives refugees small plots of lands in villages to better integrate them into the host community. In Tanzania, about 200,000 refugees have been granted citizenship which gives them land and political rights. Although this region has had successes in supporting refugees, hosting refugees puts more pressure on budgets and social structures. This is why empowering local governments is a crucial objective for members of this bloc.

Asian-Pacific Bloc: Nations in the Asian-Pacific region host about 3.5 million refugees with a majority of them coming from Afghanistan and Myanmar. The countries in this bloc are often deterred from accepting more refugees because of the needs of their citizens. For example, former President Benigno Aquino of the Philippines stated that to accept more refugees, they'd first need to solve the issue of having 25 percent of their population living below the poverty line. Another key issue for these nations is promoting economic inclusion. The Refugee Work Rights Report found that most refugees in this region do not have respected or protected work rights. They often live in fear of detention or deportation which causes them to rely on humanitarian aid and look for informal, possibly exploitative work to survive. In Indonesia, it is not uncommon to have to wait for about 10 years before the bureaucracy let them move out of the transit country. Due to this issue, about 13,679 refugees and asylum seekers were put in detention centers while waiting for this process to finish. Besides a fear of detention, restrictions on mobility, the ability to own property, and the type of job sector category make it difficult for refugees to achieve self-reliance. Another contributing factor is also that many refugees struggle with having their skills and diplomas recognized by employers as well as unconscious bias from those living in the host community.

Basic Solutions

When promoting self-reliance in refugee camps, it is important to approach all the factors that may keep a refugee from fully being able to meet their essential needs without a dependency on external assistance. This means combatting critical issues such as the lack of documentation, language barriers, discrimination, and more. Feasible solutions should be cost-effective

considering that one of the main issues that make it difficult to promote effective integration can be linked to the economic restraints or situation of the host country. Additionally, delegates are encouraged to consider solutions that would help host countries resolve any food insecurity or poverty-related problems before or during the period where they've accepted refugees. It is also important to recognize that although self-reliance involves refugees not needing humanitarian assistance, the reduction of such aid should be gradual so that refugees aren't left completely without support if not prepared. Additionally, any solutions regarding integration should be sensitive to arising any conflict between refugees and naturalized residents. To prevent any tension, solutions should benefit both the host community and refugees rather than giving the impression that one side is being favored over the other.

Delegates are highly encouraged to find innovative and creative solutions that can be implemented in multiple countries around the world rather than using well-known solutions. For example, a successful solution to address the lack of documentation is the usage of civil registration. Civil registration is recorded by the UNHCR and UNICEF. It records the main events in a refugee's life such as birth, death, and date of marriage. Recognizing that there are more than 15 million stateless refugees globally, the utilization of civil registration would be beneficial as it protects human rights and prevents statelessness. It does so by establishing a legal identity that gives them access to the medical, educational, and psychological services they need. Civil registration has been effectively implemented in Ethiopia where it has given an estimated 70,000 refugee children registration rights.

Questions to Consider

1. How can your country expand the rights of refugees to access the labor markets and educational opportunities in their host countries?
2. Are there any solutions that can assist schools and universities with refugees in linking them with future employers?
3. How can you counter any political or societal narratives that enable the unfounded fear that refugees pose an economic threat? What are some ways to demonstrate to host communities that refugees can make a positive contribution to their society when allowed to live outside of the camp?
4. How can you assist nations who have large amounts of refugees better balance the needs of their citizens and the needs of their refugees? What can be done to support areas that are struggling with poverty especially?
5. What solutions can be implemented to address the problem of the lack of documentation and the language barrier for refugees?

Sources:

1. Abdo, Nour, et al. *Quality-of-Life among Syrian Refugees Residing Outside Camps in Jordan Relative to Jordanians and Other Countries*, vol. 7, 2019, doi:10.7717/peerj.6454.
2. Aburass, Samer. "Syrian Refugees' Documentation Crisis." *NRC*, Norwegian Refugee Council, 26 Jan. 2017, www.nrc.no/news/2017/january/syrian-refugees-documentation-crisis/.
3. Asylum Access. "Latin America." *Asylum Access*, 1 July 2019, asylumaccess.org/about/latin-america/.
4. Asylum Access. *Refugee Work Rights Report Refugee Access to Fair and Lawful Work in Asia*. Host International, 2019, *Asylum Access*, asylumaccess.org/wp-content/uploads/2019/11/Asia-RWR_FINAL.pdf.
5. Bahar, Dany, and Meagan Dooley. "Venezuela Refugee Crisis to Become the Largest and Most Underfunded in Modern History." *Brookings*, Brookings, 10 Dec. 2019, www.brookings.edu/blog/up-front/2019/12/09/venezuela-refugee-crisis-to-become-the-largest-and-most-underfunded-in-modern-history/.
6. Connor, Phillip. "Europeans Support Taking in Refugees – but Not EU's Handling of Issue." *Pew Research Center*, Pew Research Center, 20 Aug. 2020, www.pewresearch.org/fact-tank/2018/09/19/a-majority-of-europeans-favor-taking-in-refugees-but-most-disapprove-of-eus-handling-of-the-issue/.
7. "Economic Inclusion of Refugees." *UNHCR*, UNHCR, www.unhcr.org/5df9f0bc7.pdf.
8. "Frequently Asked Questions: Work Permits for Syrian Refugees in Jordan (Valid as of December 2018) [EN/AR] - Jordan." *ReliefWeb*, OCHA, 10 Jan. 2019, reliefweb.int/report/jordan/frequently-asked-questions-work-permits-syrian-refugees-jordan-valid-december-2018.
9. Garcia, Raphael Tsavkko. "Is Brazil No Longer Safe for Refugees and Immigrants?" *Brazil | Al Jazeera*, Al Jazeera, 16 Aug. 2017, www.aljazeera.com/indepth/opinion/2017/08/brazil-longer-safe-refugees-immigrants-170809113330259.html.
10. Global Compact on Refugees. "Refugees' Self-Reliance: The Dilemma of Implementing the Global Compact on Refugees in Africa." *Refugee Law Initiative* , School of Advanced Study University of London, 3 Apr. 2019, rli.blogs.sas.ac.uk/2019/04/03/refugees-self-reliance-the-dilemma-of-implementing-the-global-compact-on-refugees-in-africa/.
11. Grierson, Jamie. "Refugees Missing out on Jobs in UK, Say Humanitarian Groups." *The Guardian*, Guardian News and Media, 2 May 2019, www.theguardian.com/world/2019/may/02/refugees-are-missing-out-on-jobs-in-uk-charities-warn.
12. Halpern, Peggy. "Refugee Economic Self-Sufficiency: An Exploratory Study of Approaches Used in Office of Refugee Resettlement Programs." *ASPE*, U.S. Department of Health and Human Services, 21 Feb. 2017, aspe.hhs.gov/basic-report/refugee-economic-self-sufficiency-exploratory-study-approaches-used-office-refugee-resettlement-programs.

13. Harrell-Bond, Barbara. vol. 29, UNHCR, 2000, pp. 1–11, *Are Refugee Camps Good for Children?*
14. Henry, Brandy F., et al. NASW, *Challenges of Refugee Resettlement Policy and Psychosocial Factors*, www.socialworkers.org/LinkClick.aspx?fileticket=X2QaNfEuJUk%3D&portalid=0.
15. "International Covenant on Economic, Social and Cultural Rights." *OHCHR*, 1976, www.ohchr.org/en/professionalinterest/pages/cescr.aspx.
16. Kanso, Heba. "Poverty Forces Syrian Refugee Children into Work." *Reuters*, Thomson Reuters, 12 June 2018, www.reuters.com/article/us-lebanon-child-labour/poverty-forces-syrian-refugee-children-into-work-idUSKBN1J82CY.
17. Klitgaard Weirsoe, Eva Cecilie, and Roque Gil Sato. 2020, pp. 1–7, *Creating Economic Inclusion and Financial Opportunity for Refugees*.
18. Krogstad, Jens Manuel. "Key Facts about Refugees to the U.S." *Pew Research Center*, Pew Research Center, 30 May 2020, www.pewresearch.org/fact-tank/2019/10/07/key-facts-about-refugees-to-the-u-s/.
19. Momodu, Sulaiman. "Africa Most Affected by Refugee Crisis | Africa Renewal." *United Nations*, United Nations, Mar. 2017, www.un.org/africarenewal/magazine/december-2016-march-2017/africa-most-affected-refugee-crisis.
20. Moon, Katharine H.S. "Why Is Asia MIA on Refugees?" *Brookings*, Brookings, 22 Sept. 2016, www.brookings.edu/blog/order-from-chaos/2016/09/22/why-is-asia-mia-on-refugees/.
21. Norwegian Ministry of Foreign Affairs. *Shared Resilience for Syrian Refugees and Host Communities in Jordan*. Norwegian Refugee Council, reliefweb.int/sites/reliefweb.int/files/resources/nrc_jordan_case_study_web.pdf.
22. Norwegian Refugee Council. NRC, 2017, *Syrian Refugees' Right to Legal Identity: Implications for Return*, www.nrc.no/globalassets/pdf/briefing-notes/icla/final-syrian-refugees-civil-documentation-briefing-note-21-12-2016.pdf.
23. Reintegration and Local Settlement Section Division of Operational Support. *Handbook for Self-Reliance*. UNHCR, 2005.
24. Robila, Mihaela. United Nations Department of Economic and Social Affairs (UNDESA), 2018, pp. 1–14, *Refugees and Social Integration in Europe*, www.un.org/development/desa/family/wp-content/uploads/sites/23/2018/05/Robila_EGM_2018.pdf.
25. Sleiman, Dana. "Debt a Growing Burden for Syrian Refugees in Lebanon." *UNHCR*, 20 Nov. 2015, www.unhcr.org/en-us/news/latest/2015/11/564f1baa6/debt-growing-burden-syrian-refugees-lebanon.html.
26. "The Truth about... Refugees." *Amnesty International UK*, 18 May 2020, 05:36 PM, www.amnesty.org.uk/truth-about-refugees.
27. UN. "Refugees." *United Nations*, United Nations, www.un.org/en/sections/issues-depth/refugees/.

28. UNHCR, and World Food Programme. *Enhancing Self-Reliance in Food Security and Nutrition in Protracted Refugee Situations*. UN Refugee Agency, *United Nations High Commissioner for Refugees*, www.unhcr.org/5c3c6d584.pdf.
29. UNHCR. *Promoting Livelihoods and Self-Reliance Operational Guidance on Refugee Protection and Solutions in Urban Areas*. UN Refugee Agency, 2011, *The UN Refugee Agency | USA*, www.unhcr.org/en-us/publications/operations/4eeb19f49/promoting-livelihoods-self-reliance-operational-guidance-refugee-protection.html.
30. United Nations High Commissioner for Refugees, UNHCR. "Identity Documents for Refugees." *UNHCR*, 20 July 1984, www.unhcr.org/en-us/excom/scip/3ae68cce4/identity-documents-refugees.html.
31. United Nations High Commissioner for Refugees. "Asylum in the UK." *UNHCR*, UNHCR, www.unhcr.org/en-us/asylum-in-the-uk.html.
32. United Nations High Commissioner for Refugees. "Comprehensive Refugee Response Framework." *UNHCR*, www.unhcr.org/en-us/comprehensive-refugee-response-framework-crrf.html.
33. "Venezuelan Nationals Now Require a Visa to Enter Chile." *Fragomen*, 25 June 2019, www.fragomen.com/insights/alerts/venezuelan-nationals-now-require-visa-enter-chile.
34. Vicuña, José Tomás. "At This Inflection Point in Politics and Migration, Chile Can (Re)Imagine Its Future." *Migration Policy Institute*, Feb. 2020, www.migrationportal.org/insight/inflection-point-politics-migration-chile-can-reimagine-future/.
35. WEForum. "Europe's Refugee Crisis Is Making Headlines, but Latin America's Is Just as Alarming." *Instituto Igarapé*, 28 July 2017, igarape.org.br/europes-refugee-crisis-is-making-headlines-but-latin-americas-is-just-as-alarming/.
36. Wike, Richard, et al. "Europeans Fear Wave of Refugees Will Mean More Terrorism, Fewer Jobs." *Pew Research Center's Global Attitudes Project*, Pew Research Center, 20 Aug. 2020, www.pewresearch.org/global/2016/07/11/europeans-fear-wave-of-refugees-will-mean-more-terrorism-fewer-jobs/.
37. "The World's Swelling Refugee Population Has Shrinking Options." *Council on Foreign Relations*, Council on Foreign Relations, www.cfr.org/refugee-crisis/#!/a-system-under-strain.