Cerritos Advanced Conference 2020

The United Nations General Assembly Third Committee, the Social, Humanitarian, and Cultural Committee (3rd SOCHUM)

Topic A: Healthcare Inequality for Women in Developing Countries

Topic B: Humanitarian Aid Crisis in Refugee Camps

Director: Su Lee

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 Su Lee and I am extremely excited to be your 3rd SOCHUM head chair for CHSMUN 2020 As a fourth-year MUN delegate, this program has opened my eyes to discover the harsh realities of world issues discussed by the United Nations, leading me to develop a genuine passion for the environment and its inhabitants. Besides MUN, I am torturously obsessed with music (mostly R&B and hip-hop), skateboarding, binging Netflix, boba, streetwear (esp. Japanese streetwear and skate culture), and spending time with my friends. I'm also part of the varsity badminton team and am on the executive board for the Long Beach Chapter of Red Cross. I hope that by participating in this conference, you will understand the importance of the many humanitarian and human rights issues and gain experience and confidence in public speaking. Don't be afraid of stepping out of your comfort zone during the committee since this is a learning experience! If you have any questions at all before or during the committee, don't hesitate to ask me.

Sincerely,

Su Lee

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Director, 3rd SOCHUM

Committee Introduction:

As a response to the rapidly developing world after the Second World War, the third committee of the general assembly of the United Nations SOCHUM (Social, Humanitarian, and Cultural) was developed in 1945 to discuss the multitude of human rights issues that began to appear. Though the committee has no power to directly authorize action, its member states discuss prevalent issues in order to establish the goals of international humanitarian policy. SOCHUM's primary focus falls on human rights with a wide variety of topics such as women's rights, rights of the child, treatment of refugees, racial discrimination, and the right to self-determination. They address social issues such as crime, justice, drug control, family issues, and people with disabilities.

Topic A: Healthcare Inequality for Women in Developing Countries

Background:

Though met with many advances, the international community, especially developing nations, has failed to meet the standards of healthcare for women. This includes maternal care and the health of young women. Though the Global Strategy for Women's and Children's Health was launched by the UN's Secretary-General in 2010 and then renewed in 2015 to focus worldwide attention, many roadblocks stand in the way of adequate healthcare for women. Every year, 529,000 girls and women die due to preventable causes related to pregnancy and childbirth. 95% of these deaths occurred in Africa and Asia, and 4% occurred in Latin America And the Caribbean. Poverty-stricken women in remote areas are the least likely to receive health care. This was a result of the lack of infrastructure in these areas and the lack of education on the topic of maternal care. Maternal mortality in resource-poor or low-income countries has been associated with three delays. These delays include a delay in deciding to get health care, a delay in obtaining care in time, and a delay in receiving quality treatment. Due to women experiencing these delays in developing countries, the maternal mortality rate is much higher in these low-income countries. To compare developed countries and underdeveloped countries' ability to tend to maternal health, the maternal mortality rate in low-income countries is 462 deaths per 100,000 live births, whereas in high-income countries the maternal mortality rate is 11 deaths per 100,000 live. African countries, as well as the Middle East, have shown to be the most problematic when dealing with maternal health, with South Sudan, Somalia, Central African Republic, Syria, Yemen, the Democratic Republic of the Congo, Sudan, Afghanistan, Chad, Haiti, Iraq, Zimbabwe, Guinea, Ethiopia, and Nigeria all being considered to be on high alert to improve maternal health availability. Women in these remote areas are the least likely to receive adequate health care in part, due to the lack of skilled health workers. In fact, The WHO Millennium Goals Progress Report showed that 36 of 40 countries with the highest maternal mortality rates are in Africa. In sub-Saharan Africa, the maternal mortality risk is 1 : 30 compared with 1 : 5600 in the developed countries.Though the situation seems grim in the present, some strides have been made in order to combat the situation. South Asia has experienced a fall from 550 per 100,000 live births in 1990 to 190 per 100,000 births in 2013. The maternal mortality rate in Sub-Saharan Africa has dropped by almost 50%. These causes of maternal death can include severe bleeding, infections, high blood pressure during pregnancy, complications from delivery, and unsafe abortion. Most maternal deaths are preventable, and high-quality care during and after childbirth can make the difference between life and death.Access to contraceptives has also proved to be an integral part of this issue, with more than 214 million girls and women worldwide wanting to avoid pregnancy, but do not have access to modern contraceptives. Access to contraception is critical to providing adequate health care because it enables women to have the number of children they want and it allows them to have their babies safely. However, access to contraceptives has been limited especially in developing

countries due to the cultural stigmas surrounding the topic of contraception and the lack of economic stability. This inequality of health care is often a result of the social stigmas and norms surrounding women. Ingrained in the culture of many nations is the prioritization of the role of women as mothers. There is an implicit hierarchical prioritization of men in society seeing facts such as married women in 27 countries require their husband's consent for the use of contraceptives.5 Even in their own health care, despite the fact that 75% of the health workforce are women, men hold double the positions of power in public-private health partnerships and only 25% of women have senior roles. 42% of organizations offer 2 weeks or less paid leave for fathers indirectly forcing women to take up household over corporal roles. Due to factors such as arranged marriages or the duty of women to bear children, around 13 million girls under 20 give birth every year which endangers their livelihood. This is even more detrimental seeing as delaying early marriage could add $500 billion to the annual global economic output by 2030. This numbers magnitude is also related to the stigma surrounding abortions which are often illegal no matter if a woman was raped, abused, or the baby threatens the mother's life.

United Nations Involvement:

As concerns regarding maternal health have started to arise, measures have been taken by the World Health Assembly and the United Nations to improve health standards globally. On 30 September 2016, the Human Rights Council passed Resolution 33/18 in order to prevent maternal mortality and morbidity. This resolution focussed on addressing the issue specifically in developing states seeing as they lack adequate infrastructure in their health systems. It encourages developing states to adopt frameworks based on the 2030 Agenda for Sustainable Development. Despite its call to action, a majority of developing states were incapable of either adopting this framework or enforcing its actions.The Millennium Development goals were also created by UN member states as an attempt to highlight the main issues that plagued the world in 2000. Maternal Health was also included as one of these issues. Idealistically, their goal had been to reduce maternal mortality by 75% by 2015. But, lack of efficient indicators, check-ups, and medical personnel had the opposite effect. The maternal mortality rate ended up increasing during those 15 years and has not stopped since. Rather than simply focusing on laws and governmental policies regarding maternal health, the United Nations tested different methods to help reduce concerns. Security Council Resolution 1325 adopted on October 20, 2000, called for women to participate in decision making, female perspective on data collection, peacekeeping support operations, and training for new medical workers. It had also emphasized the importance of the four pillars-participation, prevention, protection, and relief, and recovery-by dividing the resolution into four distinct sections. Though a fresh approach to the issue, it only helped raise awareness. The International Federation of Medical Students Associations (IFMSA) developed a program focusing on medical students, future healthcare providers, and current healthcare professionals. Noticing its successful efforts, in March 2015 the United Nations adopted the IFMSA program into the United Nations General Assembly to expand their previous projects. This progress had tremendous positive effects, leading it to expand and create guidelines known as Maternal heald and Access to Safe Abortion. These guidelines were established in the UN

General Assembly in 2017 and addressed the stigma faced by the women surrounding individual reproductive choices and rights.More recently, Resolution A/HRC/39/L.13 was created for the same purpose but collaborated with the Center for Reproductive Rights (CRR) to engage these developing states in the creation. Focusing on sexual and reproductive health and rights for girls and women, this resolution created specific solutions to address emergency contraception and stereotypes within these developing states. With more specifications, this resolution had a more potent impact than those previous to it, but it still hasn't been enough to provide adequate maternal healthcare for women throughout developing states around the globe.The UN has taken significant action in order to account for healthcare inequality for women. One of the biggest steps has been the CEDAW which defines sex-based discrimination as well as calls for the end of gender roles and equal rights seeing the pivotal role women play.10 Moreover, in the UN's SDGs adopted by A/RES/70/1, Article 5 specifically calls for gender equality by 2030.11 The UN has also adopted A/RES/2011/1 which declares the right of women to reproductive health as well as stresses the need for education and prevention of STDs, namely HIV/AIDS.12 Additionally, the UN has implemented the Secretary-General's Global Strategy for Women's and Children's Health which supports numerous national strategies to significantly reduce the number of maternal, newborn and under-five child deaths and scales up a priority package of high-impact interventions and integrating efforts. To add, the UN has set forth a Programme of Action which advocates for gender equality and women's rights as the cornerstones for population and development and has been successful seeing as they extended the program with A/RES/ 65/234. The Beijing Platform for Action as the Cairo Programme of Action also works towards the end of healthcare inequality for women through the prioritization of education and breakdown of norms.

Case Study: North Africa

Since the past, there have been many difficulties for women to acquire healthcare in the North African region. In a 2002 speech given to the annual conference of the Middle East Studies Association, Thoraya Ahmed Obaid, executive director of UNFPA, declared that the region's health care disparities for women "…touch on issues of culture and religion, and they touch on values, traditions, and practices. They also touch the traditional patriarchal structures in the communities—structures that establish and maintain power relations between women and men, and among the community at large."These issues begin as early as when young girls are of reproductive age. "Institutional and cultural inequities limit or block their access to health services. Gender inequities are so powerful among the region's low-literacy rural populations, for instance, that women in these populations are often not able to recognize a problem when it exists." Because the lack of education on the topics of healthcare is considered the norm in these regions, many residents have proven to be ignorant on the topic. A study on women in Egypt showed that, "Although the majority of women suffered from at least one gynecological or gynecologically-related issue, they claimed that as long as they were able to have children and do their daily work, they largely ignored any reproductive health problem. The study also found little dialogue about such matters among women or between women and their spouses, reflecting

a prevailing and community-condoned fatalism about women's health problems." This ignorance shows that there must be a structural change in the healthcare and education systems in these regions so that young women would be able to take care of their bodies better. If there was a structural change, the maternal deaths in the African region may be lowered without the use of mass technology.

Bloc Positions:

Western: In the western world, women's healthcare has been polished to a fine degree especially in the most developed of western countries. In high-income countries, the maternal mortality rate is 11 deaths per 100,000 live. This statistic shows the mass developments that were made in the western sector to fight the issue of women's healthcare. Countries such as the United States have provided equal access to healthcare for women however European countries such as Finland and France have provided healthcare for women that is not only affordable but more accessible as well. The European Institute for Maternal Health has worked with governments in the past in order to create guidelines for healthcare centers to follow which has led to mass women healthcare. Countries in this bloc should focus on bringing accessibility to healthcare in countries where more mass stigma is present.

Latin America and the Caribbean: Due to the lack of financial stability in these regions, healthcare for women has not been as advanced as its western counterparts. The Latin America region consists of 4 percent of all maternal deaths, and while not as bad the African bloc, still needs development. Countries in these regions have shown to be accepting of healthcare equality however slow to act upon the topic. This was evident in Venezuela where the lack of infrastructure and crumbling economy has shown to be a detriment in providing healthcare for women as the maternal mortality has stagnated in the past 8 years.

African: Though the African bloc would benefit greatly from advanced medical care for women, the lack of infrastructure and financial security creates a large barrier for the African Bloc. The African bloc constitutes a majority of all maternal deaths (95 percent) and issues such as war and natural disasters are no strangers to the area as well, limiting the development of a proper healthcare program catered towards women. The situation in Yemen is a great example of healthcare being ignored due to the intense civil war in the area, but over one million women have reported post pregnancy depression, difficulties in motherhood, and illnesses related to pregnancy.

Asian-Pacific: Developed Eastern Asian countries have been successful in developing healthcare for both men and women, without much stigma. However, some South Asian countries have been struggling to develop adequate healthcare systems, due to the lack of proper infrastructure. Countries such as Indonesia and the Philippines have shown slow improvements in infant and maternal mortality due to the weak economy. Countries such as Thailand have shown tremendous growth however, as though one of the more impoverished asian countries,

Thailand's mortality rate fell from 58 per 1000 live births in 1980 to 30 in 1990 and to 23 in 2000. Since 2002, the government of Thailand has provided universal health coverage to al Thai citizens.

Basic Solutions:

In order to increase maternal health standards, there are a variety of solutions that can be implemented. Solutions can range from technological solutions in order to improve maternal health, to policy-based solutions in order to reduce stigmas surrounding the topics that are vital to healthcare for women, such as contraception, pregnancy, and skilled healthcare officers. For instance, the utilization of the Gates Family Planning Strategy have been aiding countries to educate their citizens on proper maternal healthcare and family planning. The Bill & Melinda Gates Foundation developed this program to assist women in families that are poor and live in areas with a strong stigma surrounding women's choice in their maternal health. Volunteers of this program would focus on identifying gaps and barriers in a community mental health system as well as testing technological inventions to see their feasibility in a certain area. They then coordinate with governments and community leaders to create partnerships and expand resources to teach women of maternal health and increase contraceptive access.

Questions to Consider:

1. What are some ways that women are able to be educated in the face of a language and cultural barrier?
2. How should governments work with ngos to create more substance around healthcare inequality?
3. What are some ways to destigmatize techniques that aid women's healthcare in countries where religion and culture play a huge factor?
4. What has your country done to explore and develop women's healthcare and how could these policies and solutions be implemented in less privileged countries?
5. How should women be educated on the use of contraceptives?

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Topic B: Humanitarian Aid Crisis in Refugee Camps

Background:

With 68.5 million individuals displaced by the end of 2017, the need for healthcare for IDPs as well as refugees is extremely evident. Refugees continue to suffer under the poor management of refugee camps. For instance, circumstances such as the overpopulation, absence of healthcare, and the lack of sanitation in camps continue to increase ongoing health risks. Health issues, such as malnutrition, physical and psychological abuse, and diseases continue to run rampant in refugee camps. Disease, in particular, continues to be the number one contributor to refugee deaths. According to a UNHCR report, "Measles, diarrheal diseases, acute respiratory infection, and malaria account for between 60% and 80% of all reported causes of death among refugees", and "'more than 80% of excess deaths were not a result of violence' and that 'the main causes of mortality [during that period] were diseases such as diarrhea,'. Issues such as mental health as well as abuse are also a big contributor to the ongoing crisis in refugee camps. It was reported in 2016, 84.1 percent of refugees in a Cambodian camp struggled with PTSD as well as depression. Also, with over 50 percent of the refugee population being women and children, this allows these refugees to be susceptible to sexual and physical abuse. In 2017 alone, over 7000 cases of rape were reported from the African block.The United Nations High Commissioner on Refugees (UNHCR) constantly deals with a displaced person incapable of finding both monetary and humanitarian aid from nations. Often, major conflicts contribute to such conditions of refugees as seen in the most recent case of the displacement of over 600,000 Rohingya refugees seeking refuge from domestic conflict and government-produced violence. The case of the Rohingya refugees in Myanmar has collected international attention as the South East Asian Bloc attempts to form a compromise of some sort to find a safe home for these refugees, despite the fact that the Myanmar government has been the leader of what the United Nations High Commissioner on Refugees referred to as the "textbook example of ethnic cleansing". The Myanmar government ordered major military crackdowns that developed the genocide of large sums of displaced Rohingya people which now represent one of the largest refugee groups discriminated from a native nation-state and without citizenship rights to any nation in the international community. This case is similar in the light of recent events in South Sudan with inter-state domestic issues forcing the displacement of thousands of South Sudanese Refugees seeking shelter in the nearby African Union States such as Nigeria. The turmoil developed by President Salva Kiir and Vice President Riek Machar in 2013 created an ethnically fueled civil war that has marked over 500,000 deaths of South Sudanese Citizens and developed what Amnesty International predicts to be the depletion of a two-century workforce GDP by 28%. Whether it is international or domestic conflict, the refugees that are displaced in the conflict are forced to require the assistance of nearby nations and the international community.Shelter also proves to be an extremely prevalent issue for refugees as adequate shelter seems to be extremely limited in refugee camps. "Poor housing has led to issues with

hygiene between camp dwellers and in camps like Poor housing led to rodent infestations and the transmission of Lassa Fever in Sierra Leone camps while conditions such as dampness and crowding have contributed to respiratory infections in camps. A study of Palestinian refugee camps in Lebanon found frequent instances of flooding, poor ventilation, and humidity, in addition to structural problems like cracks in walls and seepage in ceilings: all environmental risk factors associated with tuberculosis." Mental health is also a large issue in refugee healthcare, with many refugees being affected by post-traumatic stress disorder and many other mental health issues. PTSD is an anxiety disorder that often occurs after witnessing or experiencing an event that is personally threatening. A survey conducted among Sudanese refugees living in northern Uganda found that PTSD was prevalent among 50.5% of the refugees. A study done in 2003 on Somali refugees in a Ugandan refugee settlement found that 73.5% of those surveyed reported witnessing dead or mutilated bodies, while 69.3% reported witnessing or experiencing a shelling or bomb attack. With many more refugees being displaced since 2003, mental health has proven to be a more and more daunting problem that looms over refugee camps. Mental health disorders have proven to be a large detrimental factor due to the length of its effects as well. "Even two decades after the trauma experienced in Cambodia, studies show that 62% of adult refugees still suffer from PTSD and 51% suffer from depression. In addition, refugees frequently mention being plagued by feelings of hopelessness, fear, sadness, anger, aggression and worry." Everyday tasks have also been negatively affecting refugees, with even tasks such as waiting in line for the water tap negatively impacting the mental health of refugees.

UN Involvement:

In order to combat the constant issue of healthcare in refugee camps, the UN has put in tremendous effort to help quench the problem. In 1951, the UN Convention relating to the Status of Refugees was adopted and ratified by 145 state parties, which is the legal foundation and basic guideline of the work of UNHCR. Fast forward to 2009, this was when the first resolutions were made as an attempt to provide humanitarian assistance towards the refugee crisis. The UNHCR has also committed to countless partners as an effort to support these displaced people. Every year, the UNHCR organizes an annual consultation with worldwide NGO partners, with the global impact of an initiative of UN member states to agree on a responsive framework to the refugee crisis.Even though the UNHCR's Statute makes no reference to internally displaced persons, it does recognize in article 9 that the High Commissioner may, in addition to the work with refugees, "engage in such activities… as the General Assembly may determine, within the limits of the resources placed at (her) disposal." Based on this article and over a period of several decades, a series of UN General Assembly resolutions have acknowledged UNHCR's particular humanitarian expertise and encouraged its involvement in situations of internal displacement. In particular, UN General Assembly resolution 48/116 (1993) set out important criteria to guide UNHCR's decision on when to intervene on behalf of internally displaced persons. These resolutions, together with article 9 of the Statute, provide the legal basis for UNHCR's interest in

and action for internally displaced persons.Also, the resolution A/50/632 was made for asylum seekers who were in need of protection. This resolution was the UNHRC resolution for protecting the rights of migrants. This resolution along with A/50/632 was used to establish the rights of migrants. It outlined that migrants, regardless of their origin or their situation, should be treated equally with the rights of a safe environment and proper hospitality in their country that they seek safety to. In Latin America. The General Assembly had adopted the Declaration for Refugees and Migrants, which enacts possible situations and rights an individual has during its migrations in these developing nations. This document A/71/L.1 provides a key priority for the importance of providing assistance for many migrants, which are increasing in numbers in Latin America. The declaration also acted to stress the importance of working collaboratively with destination countries or countries where the refugees are being planned to resettle and to stress the importance of cooperation for the benefit for many of these refugees. Not only this but these resolutions aim to help integrate many refugees into the economic community through the access of reliable jobs and other sources of main income. Also, it allows many of these refugees to have access to visas and forms of transportation in order for them to feel more welcomed.In regards to helping the Internally Displaced Persons around the world, organizations such as Oxfam International has worked with local authorities within each EU member state to provide assistance and protection for refugees and migrants through clothing, hygiene kits, and water facilities. Additionally, NGOs such as World Relief partnered with local communities and churches in European nations to provide temporary shelter with food regardless of race and language. World Relief has been empowering community schools and churches to resettle refugees and migrants over the past 35 years. In addition to various humanitarian organizations focused in Europe, Handicap International based its support in the nation of Syria to assist vulnerable populations, especially people with disabilities. Various NGOs and agencies has been providing support within the European nations, but more support and assistance is needed in conflict nations like Syria, where the refugees are coming from.

Case Study: Yemeni Refugee Crisis

The Yemeni Civil War has been raging since 2015, with the two sides, the Abdrabbuh Mansur Hadi-led Yemeni government and the Houthi armed movement, along with their supporters and allies. This war devastated the surrounding area, making the residents of Yemen exceedingly impoverished and in constant danger, leading to a refugee crisis. Even before the civil war, almost half of all Yemeni residents lived in poverty, with ⅔ of all youth also being unemployed. As of March 2017, an estimated 18.8 million people, 69% of Yemen's population, needed some kind of humanitarian or protection assistance, according to the UN Office for the Coordination of Humanitarian Affairs (OCHA). That includes 10.3 million in acute need, who urgently require immediate, life-saving assistance in at least one sector. More than 3.5 million Yemenis have been displaced as of 2017. This includes 2 million refugees, as well as 1 million child refugees. Yemen currently has a nationwide food crisis, due to the multitude of blockades and naval embargos in the nation. According to the UN, “The World Food Programme has classified seven of Yemen's 22 provinces as being at "emergency" level - one step below famine on the five-point Integrated Food Security Phase Classification scale. Ten provinces are at

"crisis" level." A lack of fuel, coupled with insecurity and damage to markets and roads, have also prevented supplies from being distributed. Prices for goods have also risen due to the lack of commodities while the economy continues to fail in the area. From 2015-2017, experts have estimated that poverty rates have doubled to 62 percent. Yemeni refugees are also limited in the areas where they seek shelter with most of the refugees flocking to areas such as Saudi Arabia, Djibouti, Ethiopia, Somalia, and Sudan. These areas either lack open-door policies for refugees or have other roadblocks in the ways for these refugees. Countries such as Sudan have had open-door policies for refugees however have been rejecting refugees that are not the same race as the Sudanese people. Yemeni refugees have also begun to immigrate to Jeju Island in South Korea, visa-free. However recent petitions have been implemented to remove many refugees from South Korea, showing the struggles of refugees related to racism and Xenophobia. These petitions also removed the visa-free status of Yemeni refugees when they attempted to migrate to other countries.

Bloc Positions:

Western: Western countries just like the United States are key players within the international issue of IDPs. Contrary to the opposite regions of the globe, the United States and Canada have each established varied thriving branches and offices, comparable to the US Refugee Admissions Program (USRAP), however, faces an additional domestic problem with refugees. social phobia and Islamophobia have sparked within social media and communities, leading to a rise of hate crimes against the Middle-Eastern refugees resulting in the decrease of social and economic support of these IDPs in nations such as the middle east. For the delegates representing this region, focus on solutions that can reduce the rise of xenophobia and Islamophobia in the Western World. Nations of Eastern Europe are the key asylum centers and safe havens for refugees and migrants. Greece, Italy, and Turkey are the examples of refugee and migrant route countries in Europe, who are currently overwhelmed with the mass number of displaced persons stranded in their nation. Some European Union members, such as the Czech Republic, Poland, and Hungary have refused to accept refugees and migrants into their nation.

Latin America and the Caribbean: Latin American countries and the Caribbean has shown to be unfit places for refugees to settle as many countries in these areas also contain violence and governmental breakdowns. Many of its civilians are vulnerable to various forms of maritime piracy, human trafficking and drug dealing, and areas, where refugees would arrive such as the coast, are abundant with traffickers and gangs, who are frequent contributors to much of the kidnapping and extortion in the area. Countries of these regions should focus mainly on maintaining healthcare in refugee camps through technological solutions and with innovative ways to combat policies that include xenophobic purposes which are detrimental to refugees.

African: Most of the internally displaced persons resulting from intercommunal violence in ethnically fueled civil wars like those evident in South Sudan. With over 400,000 South Sudanese citizens fleeing their own residence into different regions of South Sudan for protection, the increasing range of internally displaced persons in Africa starts to form a need for cooperative solutions involving the African bloc itself. The amount of individuals arriving from

countries including the Federal Republic of Nigeria, Bangladesh, and Pakistan has dramatically grown in 2015 as many refugees and migrants flowed into Europe. Asylum applications from West African countries have additionally grown due to people taking advantage of the Syrian war to maneuver for economic advantages.

Asian-Pacific: The Asian and Pacific regions house IDPs are made up of Myanmar and Bangladesh because of recent government-led military crackdowns. Association of Southeast Asian Nations (ASEAN) has expressed its concern on the impact of the internally displaced persons to its member's own economic development. Recently, Myanmar has been facing a large increase of national departure from native homes in their country, and none of its neighboring countries were inclined to simply accept these refugees. Thus, nearly 63,000 internally displaced persons in Asia are in desperate need of aid and shelter and a transparent mechanism for handling this case must be found. Since this subject is more centered on the internally displaced persons as a whole, delegates representing countries in this region may utilize their country's current or past situations to produce potential solutions for the crisis in Europe.

Basic Solutions:

Recognizing the common causes for the displacement of these refugees, it is important for delegates to look at short term solutions such as easing violent conflict within the nation-state and assisting in any health-related needs for natural refugees. Delegates should be able to recognize that not only are the refugees less equipped for social standings in new environments but are now throttled by the lack of previous social support networks and still require government assistance and protection. Short term solutions can range from creating semi-permanent shelter and aid camps as well as finding facilities and vectors that promote the protection of such persons in cases of unprotected conflict such as intercommunal violence and human trafficking. However, long term solutions should include formats in creating even collection and distribution of goods and medical aid to nations that are currently consisting of large amounts of refugees who require more adequate aid from outside the government. Long term solutions generally range from projects to organizations that require a longer time and more money compared to short term solutions. An example of a short term solution would be the implementation of Tiger Toilets due to the benefits it has towards sanitation. In emergency situations, community lavatories are extremely hard to maintain, especially in an overpopulated refugee camp. These toilets utilize composting worms which are used to make toilets that turn feces into a useful fertilizer. This solution can also promote agriculture growth in these camps.

Questions to Consider:

1. What are some ways to eliminate xenophobia and racism in refugee host countries?
2. What are some ways medical supplies could be more accessible for refugee camps in countries where a blockade is present?
3. What are some ways to improve sanitation conditions in refugee camps and what are disease prevention methods that can be implemented?
4. What is your country's stance on approaching refugees and what protocols have they taken to address refugee migration?
5. What are some ways to connect health experts to refugees in areas where roadblocks such as language barriers, war zones, and blockades are present?

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