Study Guide

Agenda:- Strategies adopted for maintaining health and sanitation system for children including refugees during COVID-19 outbreak.

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Welcome letter to Delegates

Delegates,

The executive board of the World Health Organization is pleased to welcome you all to the ODM Model United Nations 2020. We hope, that each one of you has a rewarding experience in this conference, and have something to take away from.

The agenda for this conference, "Strategies adopted for maintaining health and sanitation system for children including refugees during COVID-19 outbreak", is an agenda, which is vast, complex, and extremely important in today's time. A successful discussion would require the mutual participation of each and every delegate. Do remember that to deliberate efficiently, this agenda needs to be analyzed from multiple angles, and the executive board hopes that they'll see multiple narratives being formed.

The following pages of this study guide aim to guide you through the nuances of the agenda. However, kindly note the fact that this guide only provides background information, and should just be the starting point of your research. It will take a lot more to survive in this committee, and we encourage you research on your own as much as possible.

We hope to see a great level of enthusiasm and participation from you all, so that we all can take a great experience.

Wishing you all the best!

Ashwath Komath
(Chairperson)

Aaditya Sharma
(Vice-Chairperson)

United Nation Children's Emergency Fund

General Introduction and History of UNICEF:-

Established by the United Nations General Assembly on December 11, 1946 and originally known as the United Nations International Children's Emergency Fund (UNICEF), the **UN Children's Fund** has employed three approaches in discharging its mandate.

For the postwar period 1946 to 1950, the "emergency needs approach" meant swift action to meet the food, clothing, and health needs of children, particularly in Europe. At an expenditure of $112,000,000, UNICEF distributed various articles of clothing to five million children in twelve countries, vaccinated eight million against tuberculosis, rebuilt milk processing and distribution facilities, and, at the climax of its effort in Europe, provided a daily supplementary meal to millions of children.

During the period 1951-1960, UNICEF continued to meet emergency needs, but at the same time moved into the long-range benefit approach. To protect the health of children, UNICEF conducted campaigns against tuberculosis, yaws, leprosy, and malaria; made provisions for environmental sanitation; encouraged maternal and child health care education. To raise nutritional standards for children, UNICEF helped countries produce and distribute low-cost, high-protein foods and fostered programs to educate people in their use. To provide for the social welfare of children, UNICEF instituted informal training of mothers in child rearing and home improvement, aided services for children through day-care and neighborhood centers, family counseling, and youth clubs. The expenditures totaled $150,000,000.

UNICEF broadened its policy during the 1961-1970 period by adopting a concept of allying aid for children to the development of the nation. In recognition of the interconnection between aspects of national policy and programs of aid to children, this approach, called the "country approach," permitted UNICEF to implement in appropriate ways the priorities established by each nation in meeting the needs of its children. Consequently, becoming concerned with the intellectual, psychological, and vocational needs of children as well as with their physical needs, UNICEF provided assistance for teacher education and curriculum reform, allocated funds for pre-vocational training in usable skills, promoted information on the uses of technology. UNICEF projects, in short, reflected a comprehensive view of the child, seeing him as "a future agent for economic and social change." In this decade UNICEF's total expenditures were in excess of $300,000,000.

In the decade of the seventies, UNICEF will attempt to elevate the quality of life of children in the developing nations, coordinating its efforts with those of the governments concerned. UNICEF hopes to increase its assistance during the decade, aiming at an annual level of $100,000,000 by 1975, and to enlist complementary support from international, multinational, and nongovernmental agencies.

Stark statistics for UNICEF's twenty-five-year history reveal only a facet of the constructive work accomplished, but they provide some indication of its scope: 71,000,000 children examined for trachoma and 43,000,000 treated; 425,000,000 examined for yaws and 23,000,000 treated; 400,000,000 vaccinated against tuberculosis, many millions protected from malaria, and 415,000 discharged as cured of leprosy; 12,000 rural health centers and several thousand maternity wards established in eighty-five countries; help given to provide equipment for 2,500 teacher training schools, 56,000 primary and secondary schools, 965 pre-vocational training schools, 31 schools for training pre-vocational instructors, 600 for training dietary personnel; equipment supplied for 4,000 nutrition centers and community gardens, and for 9,000 school gardens and canteens; equipment given to 2,500 day-care centers, 3,000 women's clubs, and 3,500 community centers; supplementary meals dispensed in the billions and articles of clothing in the high millions; emergency aid furnished to hundreds of thousands victimized by floods, earthquakes, and other natural disasters.

UNICEF's Mandate

UNICEF is mandated by the United Nations General Assembly to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential.

UNICEF is guided by the Convention on the Rights of the Child and strives to establish children's rights as enduring ethical principles and international standards of behaviour towards children.

UNICEF insists that the survival, protection and development of children are universal development imperatives that are integral to human progress.

UNICEF mobilizes political will and material resources to help countries, particularly developing countries, ensure a "first call for children" and to build their capacity to form appropriate policies and deliver services for children and their families.

UNICEF is committed to ensuring special protection for the most disadvantaged children – victims of war, disasters, extreme poverty, all forms of violence and exploitation, and those with disabilities.

UNICEF responds in emergencies to protect the rights of children. In coordination with United Nations partners and humanitarian agencies, UNICEF makes its unique facilities for rapid response available to its partners to relieve the suffering of children and those who provide their care.

UNICEF is non-partisan and its cooperation is free of discrimination. In everything it does, the most disadvantaged children and the countries in greatest need have priority.

UNICEF aims, through its country programmes, to promote the equal rights of women and girls and to support their full participation in the political, social and economic development of their communities.

UNICEF works with all its partners towards the attainment of the sustainable human development goals adopted by the world community and the realization of the vision of peace and social progress enshrined in the Charter of the United Nations.

Brief Description of Agenda

Available data and statistics show that children have been largely spared the direct health effects of COVID-19. But the indirect impacts – including enormous socioeconomic challenges – are potentially catastrophic for children. Weakened health systems and disrupted health services, job and income losses, interrupted access to school, and travel and movement restrictions bear directly on the well-being of children and young people. Those whose lives are already marked by insecurity will be affected even more seriously. Migrant and displaced children are among the most vulnerable populations on the globe.

In 2019, around 33 million children were living outside of their country of birth, including many who were forcibly displaced across borders. At the end of 2018, a total of over 31 million children were living in forced displacement in their own country or abroad due to violence and conflict. This includes some 13 million child refugees, around 1 million asylum-seeking children, and an estimated 17 million children displaced within their own countries. It is estimated that 3.7 million children live in refugee camps or collective centres. COVID-19 threatens to bring even more uncertainty and harm to their lives.

The challenges of day-to-day life Worldwide, 52 per cent of migrant children and over 90 per cent of displaced children live in low and middle income countries where health systems have been overwhelmed and under capacity for protracted periods of time. It is in these settings where the next surge of COVID-19 is expected, following China, Europe and the United States. In low- and middle-income countries, migrant and displaced children often live in deprived urban areas or slums, overcrowded camps, settlements, makeshift shelters or reception centres, where they lack adequate access to health services, clean water and sanitation. Social distancing and washing hands with soap and water are not an option.

A UNICEF study in Somalia, Ethiopia and the Sudan showed that almost 4 in 10 children and young people on the move do not have access to facilities to properly wash themselves. In addition, many migrant and displaced children face challenges in accessing health care. Half of respondents aged 14–24 years in a UNICEF poll who self-identified as migrants and refugees indicated that they did not see a doctor when needed. Similarly, in high-income countries, the safety of many migrant and displaced children is also under threat. In Marseille, France, for instance, many unaccompanied minors had been left unprotected before the pandemic as authorities failed to provide care and shelter.

Now that public child protection services have halted due to the risks posed by COVID-19, more unaccompanied migrant children have been forced to live on the streets or in unsanitary, often overcrowded squats. This has become a harsh reality for many children around the world. Children in situations like these may face the added risk of being detained by immigration authorities, potentially exposing them to violence, abuse or exploitation. Migrant and displaced children across contexts are at risk of missing out on accurate public health information, due to language barriers or simply being cut off from communication networks. Undocumented children living in foreign countries may fear contact with public authorities. Meanwhile, misinformation on the spread of COVID-19 has exacerbated the xenophobia and discrimination that migrant and displaced children and their families face.

Legal Shifts

Sudden, sweeping restrictions and regulations have been enacted to contain the virus's spread. Many further undermine displaced children's safety and security. Closed borders and restricted travel are disrupting the humanitarian supply chain and relief workers' ability to assist displaced communities. Millions are missing out on vital assistance such as food distributions and other basic medical supplies. In Yemen, where one third of children are malnourished and 80 per cent of the population depends on humanitarian aid, travel restrictions have already led to reduced relief operations.

UN agencies were forced to suspend resettlement procedures due to the COVID-19 pandemic, cutting off a "vital lifeline for particularly vulnerable refugees", leaving millions of refugees with an uncertain path ahead. In many countries, border closures have left migrants stranded, placing children and their families at risk of further harm and potentially separating families for longer stretches. As of 22 April, of the 167 countries that have fully or partially closed their borders to contain the spread of the virus, some 57 States have made no exception for access for asylum seekers.

In the United States, people seeking asylum, including children, have been turned away or deported to their countries of origin at the United States–Mexico border as part of the response against COVID-19. As countries instituted lockdowns and quarantines, in Ethiopia, 3,273 returnees have been registered and quarantined at various centres set up by the Government in Addis Ababa, including 434 unaccompanied children – 135 of them girls. Many had not gone through prior health screenings nor received child protection assistance. UNHCR has called on States to respect international human rights and refugee protection standards, including through quarantines and health checks, stating, "Securing public health and protecting refugees are not mutually exclusive"

Acronyms and Abbreviations

AMCOW African Ministers' Council on Water

CWIS citywide inclusive sanitation

DALY disability-adjusted life year

GDP gross domestic product

GRP gross regional product

GVA gross value added

GLAAS UN-Water Global Analysis of Sanitation and Drinking-Water

IDP internally displaced person

JMP WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene

O&M operations and maintenance

PPP public-private partnership

SBM Swachh Bharat Mission

SDG Sustainable Development Goal

UHC universal health coverage

UNHCR United Nations High Commissioner for Refugees

WASH water, sanitation and hygiene

WHO World Health Organization

Health and Sanitation System of the World

The Main Challenge

Sanitation is vital to health, child development, and social and economic progress. Safe sanitation is also a human right – essential for the fulfillment of child rights and the achievement of good physical, mental and social well-being recognized as a distinct right by the General Assembly of the United Nations in 2015. In the same year, Member States committed to the 2030 Agenda for Sustainable Development, including target 6.2 of the SDGs: "By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations". Progress towards universal sanitation is alarmingly off track, and uneven in its coverage, resulting in inequalities and the further marginalization of the most vulnerable. With only 10 years left before 2030, the rate at which sanitation coverage is increasing will need to quadruple to achieve SDG target 6.2. At the current rate of progress, it will be the twenty-second century before sanitation for all is a reality. This is too slow.

Sanitation suffers from chronic under prioritization, lack of leadership, under investment and a lack of capacity. While the majority of countries have national policies and plans to support sanitation, few have allocated adequate human and financial resources to actually implement them.3 Donors tend to prioritize water over sanitation. In fact, aid disbursements for sanitation were half that for drinking-water between 2010 and 2018. Within the larger water and sanitation sector (including, for example, water resources management and river basin development), aid disbursements for sanitation systems in the last nine of the total.4 The total investment in sanitation from governments and donors is not enough to provide the sustainable, resilient, safely managed services that will bring about substantive benefits to health, the economy and the environment.

Achieving universal access to sanitation by 2030 will require dramatic acceleration in current rates of progress. Global rates of progress need to double to achieve basic sanitation for all, and universal access to safely managed sanitation requires them to quadruple. However, these global averages mask the fact that some countries, and some communities within countries, are starting from a much lower baseline. In these places, the rate of change must be even greater if the pledge to 'leave no one behind', made by Member States when they adopted the 2030 Agenda, is to be honored.

Governments have a critical role to play. Sanitation is a public good in need of public funding that will allow everyone to benefit from improved health as well as social and economic development. Poor sanitation creates serious negative externalities, creating public health hazards and jeopardizing economic development for all. Conversely, good sanitation generates economic benefits and unlocks human productivity. Regulation throughout the sanitation chain is crucial to ensure that the benefits are realized by everyone. History shows it can be done.

There are many countries that have been successful in making rapid progress in sanitation coverage, transforming lives, the environment and the economy within a generation. With strong political leadership, sufficient resources and a 'whole-of-government', multi-stakeholder approach, governments can quickly transform sanitation and find ways to put the last first. In the 1960s and 1970s, Malaysia, the Republic of Korea, Singapore and Thailand produced rapid and remarkable results to achieve total sanitation coverage. More recently, India has created a mass movement which has dramatically reduced and almost eliminated

the undignified and dangerous practice of open defecation, which disproportionately affects the rural poor. Since 2000, Cambodia and Ethiopia reduced open defecation by more than 50 percentage points, and Cambodia, Indonesia, the Lao People's Democratic Republic and Nepal increased the use of at least basic sanitation services by more than 40 percentage points. Governments in many other countries are helping individuals and communities move up the sanitation ladder towards universal access to safely managed sanitation services – by mobilizing communities, strengthening markets and service providers, deploying a range of funding and financing mechanisms to build resilient sanitation services that make better use of scarce resources, recycling waste for economic and environmental benefits, and building the circular economy.

The COVID-19 pandemic has exacerbated many sanitation challenges. People have been isolated at home, where they have unsafe sanitation facilities or are forced by their lack of sanitation facilities into unsafe, communal areas, such as poorly managed public latrines or open defecation areas. Sanitation workers, obliged to keep working as they perform an essential service, add one more health hazard to what is often a long list. The pandemic has reinforced what the evidence makes clear: poor sanitation puts everyone at risk. Within the context of the recently-developed SDG 6 Global Acceleration Framework5, it presents best practices, successes and challenges. It calls on Member States, the United Nations system and other stakeholders to rise to the challenge, learn from one another and work together to achieve universal access to safe sanitation by 2030.

Progress towards universal access to sanitation

Governments are expected to localize the global SDG targets related to WASH and set their own national targets for progressively reducing inequalities in services, taking into account national contexts, capacities and levels of development, and respecting national policies and priorities. Data availability for monitoring progress towards the SDG targets on sanitation remains limited in many countries. While almost all countries have comparable data on rates of open defecation and access to basic sanitation services, fewer than half have estimates for coverage of safely managed sanitation services. Estimates for open defecation and access to basic services can be dis-aggregated by rural and urban settings, sub-national region and wealth quintile, but very few countries have the dis-aggregated data needed to identify and address inequalities in safely managed services. Furthermore, the limited availability of time-series data makes it difficult to determine rates of progress.

While JMP estimates allow international comparison, they are not a substitute for national monitoring and reporting. Governments need to establish their own systems to routinely monitor progress on sanitation, with suitable levels of dis-aggregation that allow progress to be tracked within sub-sectors of the population (urban, rural, poor, minority groups, etc.).

The SDGs challenge Member States to achieve three progressively ambitious targets with respect to household sanitation:

• Eliminating open defecation: this is explicitly mentioned in the target text, and is particularly relevant to a small number of high-burden countries.

• Achieving universal access to basic sanitation services: most countries aim to provide at least a basic level of sanitation services to their entire populations within the SDG period.

• Achieving universal access to safely managed sanitation services: for many countries reaching universal coverage with safely managed sanitation by 2030 is not a realistic target, but milestones and interim targets

can still be set. Even for high- and middle-income countries, it is a challenge to reach entire populations with sanitation services that ensure proper management of excreta along the entire sanitation chain.
The JMP uses a sanitation service ladder to benchmark and compare progress across countries on sanitation in households. The service ladder tracks how populations progress from practising open defecation and using unimproved technologies to using an improved sanitation facility that hygienically separates excreta from human contact.
Despite progress, 2 billion people still lack even a basic level of sanitation service. From 2000 to 2017, the global population increased by 1.4 billion people. During this period, the population using safely managed sanitation services doubled, from 1.7 billion (28 per cent of the global population) to 3.4 billion (45 per cent). Over the same period, the population with either basic or safely managed sanitation increased from 3.4 to 5.5 billion, which means that the number of people lacking even a basic
sanitation service decreased from 2.7 to 2.0 billion. The population practicing open defecation was cut in half, from 1.3 billion to 673 million.

For Forcibly Displaced

Achievement of SDG target 6.2 'for all' implies the inclusion of refugees, asylum seekers, stateless people and IDPs. The world is currently witnessing the highest levels of human displacement on record. At the end of 2019, there were 79.5 million people globally who were forcibly displaced as a result of persecution, conflict, violence, human rights violations or other events. Approximately 26 million of these are refugees and another 45 million are internally displaced persons (IDPs). The vast majority, 85 per cent, of displaced people live in developing countries where access to safely managed water, sanitation and hygiene services may be limited. In these situations, sanitation implementation approaches must take into consideration the weak institutional context and unique deprivations and vulnerabilities of the population to fulfil every individual's right to sanitation.
The United Nations High Commissioner for Refugees (UNHCR) and its partners manage over 220 camps and settlements globally and collect data on WASH services in them. According to data from 175 of these sites in September 2020, only 32 per cent of households at the sites used basic sanitation services.
There are considerable practical challenges to reaching the SDG targets for sanitation in camps and settlements. One challenge is the lack of sufficient space for installing household facilities.
A recent review found that globally 43 per cent of sites exceeded UNHCR population density standards. For example, in the Kutapalong camp in Bangladesh, the average population density is almost 44,000 people per square kilometre, making it one of the highest population densities on earth. In these situations, designing and installing improved sanitation systems, which are not shared between households, may not be feasible. Instead, the focus should be on minimizing the number of individuals sharing a facility, and safe excreta management (transport and treatment off-site), while ensuring that the planning, design, location and management of facilities is done with full participation of the affected population.
An estimated 60 to 70 per cent of forcibly displaced persons live outside of camps and settlements. Unfortunately very few countries have dis-aggregated sanitation data for displaced populations which makes it difficult to track whether they are being left behind the rest of the population.

Status of Health and Sanitation policy

Sustainable and effective WASH service delivery is determined not only by the state of infrastructure, but also by complex institutional, governance and financial management systems. Governance and financing systems need to be articulated in policy, and must be coordinated and aligned, ensuring the sustainability of resources and institutions to support sanitation service delivery. Recent insights into the status of policy and finance for sanitation are highlighted in the 2019 GLAAS report, which features data from 115 countries.

The majority of countries have national policies and plans for sanitation, but few have adequate human and financial resources to implement them. Of the 115 countries participating in the GLAAS 2018/2019 cycle, only three had policies and plans for rural sanitation with sufficient resources to implement them, and only six had sufficient resources to implement urban sanitation plans. Three quarters of respondent countries cited the existence of a financing plan for sanitation. However, only about one quarter said they have financing plans that have been defined, agreed and consistently used.

Households that are most in need of fecal sludge management services (emptying, transport, treatment and end use or disposal) are often located in dense urban settings. However, fecal sludge management is not addressed in a quarter of urban sanitation policies or plans. Governments need to recognize the important role of adequate fecal sludge management in achieving national sanitation targets and the SDGs by addressing the issue in sanitation policies and plans, and supporting them with sufficient resources for implementation.

In countries where open defecation is still practised, approximately three quarters have specific measures in policies and plans to address open defecation. Two thirds of these countries have established national targets to eliminate open defecation. For example, the National Open Defecation Free Kenya 2020 Campaign Framework aims to “eradicate open defecation and to declare 100 per cent of villages and Kenya open defecation free by 2020”. Zambia recently launched the Open Defecation Free Zambia Strategy (2018–2030), which aims to end open defecation, especially among populations living in vulnerable situations.

Countries are responding to the SDG imperative to ‘leave no one behind’ by establishing policy measures to reach populations living in vulnerable situations. For example, in Senegal, the Action Plan for the Implementation of the National Policy for Rural Sanitation by 2025 proposes measures to ensure that the poorest can access sanitation, with payment based on their financial capacity. However, while over two thirds of countries report they have policy measures to reach poor populations with sanitation, only one quarter have ways of financing them.

Governments are also challenged by regulation and standard setting. Over two thirds of countries have formal national standards for waste water treatment, but far fewer have national standards for safe use of waste water or fecal sludge. While 77 per cent of countries have a formal national standard for waste water treatment, only 36 per cent of countries have a standard for safe use of waste water and sludge for agriculture and other productive purposes.

The institutions tasked with oversight of sanitation standards are stretched, lacking sufficient funds and sufficient human resources to undertake the necessary surveillance and enforcement. Only 32 per cent of countries reported having sanitation/ waste water regulatory authorities that fully take corrective action in urban; and only 23 per cent in rural areas. Two thirds of countries reported that they have less than 50% of the human resources they need for waste water surveillance in urban areas.

Severely affected regions

Afghanistan- Forty years of conflict and turmoil had already taken a devastating toll on Afghanistan and its children – around 3.7 million school-age children are out of school, some 600,000 Afghan children under the age of five are affected by severe acute malnutrition, and thousands have been killed by armed conflict over the past decade. But with a weak health system and limited capacity to deal with major disease outbreaks, the outbreak of COVID-19 could make a dire situation significantly worse for Afghan children.
The threat of a respiratory disease like COVID-19 is particularly acute in the overcrowded conditions typically found in camps and settlements for internally displaced persons. UNICEF Afghanistan is working with partners to deliver safe water and hand-washing facilities, raising awareness through various activities focusing on prevention and providing other assistance for vulnerable populations.

South Sudan- Years of conflict have severely disrupted critical social services in South Sudan. Around 4.1 million children are in need of humanitarian assistance, including an estimated 1.3 million children under five years-old who are expected to suffer from acute malnutrition in 2020. Even as COVID-19 looms, it is essential to keep basic services going, ensuring children are not dying from conditions we know how to treat, even as we take precautions to prevent the virus spreading. Hand-washing stations have been installed at UNICEF-supported outpatient centres treating malnutrition. The centres, which have implemented physical distancing measures, are also providing soap to contribute to a clean and hygienic environment at home.

Ukraine- With the conflict in eastern Ukraine entering its seventh year, and with COVID- 19 spreading, the needs of children have become even more acute. For many children, schools have played a critical role in providing at least some sense of stability and a normal life – a place to learn and spend time with friends. To help children across the country keep learning even if their school has closed due to COVID-19, UNICEF has been supporting the Ministry of Education and Science with distance learning options for students to ensure continuity and to help parents, caregivers and teachers access resources and support during quarantine. UNICEF Ukraine has also delivered hygiene kits to help educational facilities adhere to safety protocols.

Venezuela- Children have been disproportionately affected by the unfolding economic and political challenges in Venezuela. Frequent interruptions in basic services, food shortages, and confinement measures have further undermined the ability of many Venezuelan families to meet their most basic needs. The COVID-19 pandemic compounds an already precarious humanitarian situation in the country, which has also recently seen the return of Venezuelans who migrated to other countries. Since the start of the outbreak, UNICEF has been delivering essential medical supplies, as well as cleaning supplies and clean water to thousands of people in Venezuela. On 8 April, a shipment managed by UNICEF arrived in Caracas with vital supplies, including personal protective equipment kits for health workers on the front-line in the battle against COVID-19.

Bangladesh- For the more than 850,000 Rohingya refugees from Myanmar living in the Cox's Bazar camps in Bangladesh, physical distancing is easier said than done. But through UNICEF's existing programmes, many Rohingya children have already been doing one of the most important things they can to protect themselves: washing their hands thoroughly and regularly. UNICEF has reached hundreds of thousands of Rohingya children with lessons on good health and hygiene, and continues to distribute essential supplies like safe water and soap through its water, sanitation and hygiene (WASH) work.

Syria- As the Syrian conflict entered its 10th year in March – and as children entered a second decade of life surrounded by war, violence, death and displacement – the region was grappling with the looming threat of COVID-19. The projected loss of jobs from lockdowns and businesses being shuttered in the Middle East and North Africa could see an additional 4 million children fall into poverty, according to the United Nations Economic and Social Commission for Western Asia, further straining already devastated health systems. UNICEF has been working with partners to reach Syrian children and their families with prevention messaging around COVID-19, and to provide clean water and distribute hundreds of thousands of bars of soap to help reduce the risk of COVID-19. With the support of partners, UNICEF has also reached hundreds of thousands of Syrian refugees living in informal settlements through a door-to-door hand washing awareness campaign which included soap distribution.

Yemen- The threat posed by a pandemic like COVID-19 is particularly acute in the world's largest emergency. More than 12 million children were already in need of humanitarian assistance in Yemen. The health system has been on the brink of collapse, with many families finding it difficult to access the health-care they need to survive. The country is also wracked by food insecurity, an economic crisis, and vulnerable communities are grappling with outbreaks of dengue, acute diarrhoea and cholera. The situation is dire, and the need to reduce the additional strain of COVID-19 spreading is urgent. UNICEF has been scaling up preparedness and response programmes across the country, including providing clean water to communities in need, and distributing basic hygiene kits – containing soap, towels, buckets and jerry cans – to empower and enable displaced families across the country to protect themselves.

Effective Measures

The COVID-19 pandemic will have broad-ranging,long-term humanitarian and socioeconomic impacts on migrant and displaced children. Many of these effects have yet to be seen. Sound policies and urgent actions are needed to put migrant and displaced children at the forefront of preparedness, prevention and response to COVID-19 – to ensure health, safety, and protection for all today, and for the long term.

Some countries are already taking action to mitigate the risks for these children: Portugal has set an example by temporarily granting residency permits to all migrants and asylum seekers with pending applications, allowing them full access to health care and social services, such as social benefits and housing. The Spanish Government agreed to release persons in immigration detention, after examining each case in light of the 60-day detention limit.Ireland introduced an unemployment payment scheme that is accessible to all, regardless of legal status. The Malaysian authorities have said non-citizens –including those who are undocumented – that come forward for testing will not be arrested or detained. To better protect vulnerable migrants, Belgian authorities are transferring them to individual accommodation or other facilities, moving families together to maintain unity; new arrivals are also being

medically screened. In Peru, where 1.2 million Venezuelans have migrated, children of asylum seekers in quarantine are being provided hygiene kits and virtual psycho-social support. The Government is implementing distance learning for all public schools, paying specific attention to rural areas and the enrolment of migrant children – 66.7 per cent of whom are out of school – while also working to provide cash transfers to at least 63,000 migrants in extreme vulnerability. And in many contexts, governments are addressing the issue of violence against children during the pandemic, including among migrant and displaced children, with UNICEF-supported efforts taking place in countries including Cameroon, Colombia, Côte d'Ivoire, Croatia and Mexico.

To increase access to remote services, child and family helplines have been set up, expanded or are being explored in many countries, such as Algeria, Bulgaria, Jordan, several Gulf States, Mauritania and Tunisia. To reach all migrants in Libya, a national hotline has been established, and multiple channels – social media, radio, television, outdoor and print materials –are being used to share key messages. These messages have been translated into French, Somali, Hausa, Amharic and Tigrinya and are being widely disseminated to health facilities, host communities, restaurants and other public spaces. With the right policies, it is possible to mitigate the risks that migrant and displaced children are facing today – and the hardships to come. The global and UN system-wide response must include a child-sensitive approach and always uphold the principle of the best interests of the child.

Policies and actions are needed to:

1. Include migrant and displaced children in preparedness, response, and mitigation efforts for COVID-19.
2. Provide accessible, timely, culturally and linguistically appropriate, child-friendly and relevant information on COVID-19 to children and families on the move.
3. Ensure access to clean water, basic toilets and good hygiene practices for migrant and displaced children and families when transiting or for those living in camps and in urban areas.
4. Ensure universal access to COVID-19 testing, health care, mental health and psycho-social support, and other essential services, for all those who need them, regardless of status.

5. Support and advocate for safer living and housing conditions to allow for social distancing, including in shelters and camps for refugees and internally displaced persons.
6. Implement education strategies for continued learning for all children – including migrant and displaced children – and make schools safe, healthy, and inclusive environments.
7. Stop refoulement, immigration, detention, push-backs, deportations and mass expulsions of migrant and displaced children and families in the context of the COVID-19 pandemic. These practices threaten children's rights and are a risk to public health.
8. Expand social protection policies and programmes to minimize the economic impact of COVID-19 on families.
9. Advocate proactively against xenophobia, stigma and discrimination – the virus does not discriminate, and neither should we.

Collaboration and unity are needed more than ever to ensure health, safety, and protection for all, especially for those in the most vulnerable of circumstances. Around the world, millions of migrant and displaced children on nearly every continent are already facing acute deprivations that will upend their growth and development as they mature into adults. COVID-19 presents even greater challenges and threatens to disrupt their lives even further. Protecting these children's well-being today is the best way to invest in their future and restore hope for a calmer path ahead.

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4. UNHCR COVID-19 preparedness, prevention and response measure- UNHCR