Study Guide

Agenda: PROTECTION AND PROMOTION OF THE RIGHTS OF REFUGEES AND INTERNALLY DISPLACED PEOPLE DURING THE COVID 19 PANDEMIC.

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Welcome letter to delegates

Delegates,

The executive board of the United Nations Human Rights Council is pleased to welcome you all to the ODM international 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, "", 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!

AYUSHMAN SINHA (Chairperson)

ANKIT CHAUDHARY (Vice Chairperson)

Introduction to the united nations human rights council.

The Human Rights Council is an inter-governmental body within the United Nations system made up of 47 States responsible for the promotion and protection of all human rights around the globe.

It has the ability to discuss all thematic human rights issues and situations that require its attention throughout the year. It meets at the UN Office at Geneva. The Council is made up of 47 United Nations Member States which are elected by the UN General Assembly. The Human Rights Council replaced the former **United Nations Commission on Human Rights.** Among them were the **Universal Periodic Review** mechanism which serves to assess the human rights situations in all United Nations Member States, the **Advisory Committee** which serves as the Council's "think tank" providing it with expertise and advice on thematic human rights issues and the **Complaint Procedure** which allows individuals and organizations to bring human rights violations to the attention of the Council.

The Human Rights Council also works with the UN **Special Procedures** established by the former Commission on Human Rights and now assumed by the Council. These are made up of special rapporteurs, special representatives, independent experts and working groups that monitor, examine, advise and publicly report on thematic issues or human rights situations in specific countries.When creating the Human Rights Council in March 2006 (resolution **60/251**), the United Nations General Assembly decided that the Council shall review its work and functioning five years after it has come into existence. It also provided that the status of the Council is to be reviewed at the level of the General Assembly.

MODUS OPERANDI OF THE UNHRC

Structure

The members of the General Assembly elect the members who occupy the UNHRC's 47 seats.The term of each seat is three years, and no member may occupy a seat for more than two consecutive terms. The seats are distributed among the UN's regional groups as follows: 13 for Africa, 13 for Asia, six for Eastern Europe, eight for Latin America and the Caribbean (GRULAC), and seven for the Western European and Others Group (WEOG).The previous CHR had a membership of 53 elected by the Economic and Social Council (ECOSOC) through a majority of those present and voting.

The General Assembly can suspend the rights and privileges of any Council member that it decides has persistently committed gross and systematic violations of human rights during its term of membership. The suspension process requires a two-thirds majority vote by the General Assembly.The resolution establishing the UNHRC states that "when electing members of the Council, Member States shall take into account the contribution of candidates to the promotion and protection of human rights and their voluntary pledges and commitments made thereto", and that "members elected to the Council shall uphold the highest standards in the promotion and protection of human rights".

Directly responsible subsidiary bodies

Universal Periodic Review Working Group

An important component of the Council consists in a periodic review of all 193 UN member states, called the Universal Periodic Review (UPR).

The new mechanism is based on reports coming from different sources, one of them being contributions from International Atomic Energy Agency, Council of Europe, International Monetary Fund, Organization of American States, International Labour Bureau, and the World Trade Organization.The first cycle of the UPR took place between 2008 and 2011, the second cycle between 2012 and 2016, and the third cycle began in 2017 and is expected to be completed in 2021.

The General Assembly resolution establishing the Council, provided that "the Council shall review its work and functioning five years after its establishment". The main work of the review was undertaken in an Intergovernmental Working Group established by the Council in its Resolution 12/1 of 1 October 2009. The review was finalized in March 2011, by the adoption of an "Outcome" at the Council's sixteenth session, annexed to Resolution 16/21.

First cycle: The following terms and procedures were set out in General Assembly Resolution 60/251:

- Reviews are to occur over a four-year period (48 countries per year). Accordingly, the 193 countries that are members of the United Nations shall normally all have such a Review between 2008 and 2011;
- The order of review should follow the principles of universality and equal treatment;
- All Member States of the Council will be reviewed while they sit at the Council and the initial members of the Council will be first;
- The selection of the countries to be reviewed must respect the principle of equitable geographical allocation;
- The first Member States and the first observatory States to be examined will be selected randomly in each regional group to guarantee full compliance with the equitable geographical allocation. Reviews shall then be conducted alphabetically.

Second cycle: HRC Resolution 16/21 brought the following changes:

- Reviews are to occur over a four-and-a-half-year period (42 countries per year). Accordingly, the 193 countries that are members of the United Nations shall normally all have such a Review between 2012 and 2016;
- The order of review will be similar to the 1st cycle;
- The length of each Review will be extended from three to three-and-a-half hours;
- The second and subsequent cycles of the review should focus on, inter alia, the implementation of the recommendations.

Similar mechanisms exist in other organizations: International Atomic Energy Agency, Council of Europe, International Monetary Fund, Organization of American States, International Labour Bureau, and the World Trade Organization.Except for the tri-annual reports on development of human rights policies, that Member States have to submit to the Secretary General since 1956, the Human Rights Council UPR procedure constitutes a first in the area. It marks the end of the discrimination that had plagued the work of the Human Rights Commission and had caused it to be harshly criticised. Finally, this mechanism demonstrates and confirms the universal nature of human rights.

Advisory Committee

The Sub-Commission on the Promotion and Protection of Human Rights was the main subsidiary body of the CHR. The Sub-Commission was composed of 26 elected human rights experts whose mandate was to conduct studies on discriminatory practices and to make recommendations to ensure that racial, national, religious, and linguistic minorities are protected by law.

In 2006, the newly created UNHRC assumed responsibility for the Sub-Commission. The Sub-Commission's mandate was extended for one year (to June 2007), but it met for the final time in August 2006. At its final meeting, the Sub-Commission recommended the creation of a Human Rights Consultative Committee to provide advice to the UNHRC.

In September 2007, the UNHRC decided to create an Advisory Committee to provide expert advice with 18 members, distributed as follows: five from African states; five from Asian states; three from Latin American and Caribbean states; three from Western European and other states; and two members from Eastern European states.

INTRODUCTION

As of the writing of this report, some 29 million people around the world are confirmed to have suffered from COVID-19. This includes some 25,000 people of concern to UNHCR— that is, refugees and other forcibly displaced and stateless persons in 98 countries, of whom 247 have died. In addition, some 280 UNHCR staff have fallen ill, of whom five have lost their lives. Countless others are suffering from the socio-economic impact of the pandemic, none more so than the millions of forcibly displaced whose lives often depend on employment in the informal sector. In line with UNHCR’s emergency policy, the High Commissioner declared a global level-2 emergency on 25 March 2020, while the IASC “System-wide scale-up protocols adapted to respond to the COVID-19 pandemic” were endorsed on 17 April 2020. The IASC Scale-Up declaration allowed for a coordinated humanitarian response, while UNHCR’s level-2 emergency declaration allowed it to scale up and adapt its life-saving protection and assistance activities across all regions, prepare and respond to the pandemic across operations worldwide in a coordinated manner, and address the needs of the most vulnerable in close collaboration with governments, partners and people of concern. Those efforts have had success, where 9.34 million refugees and internally displaced in 151 countries have accessed protection services and over 3.9 million refugees have accessed health services. In many operations, COVID-19 transmission rates amongst people of concern remain similar or lower than among host communities, a testament to the strength of UNHCR’s risk communication and public health response. Millions of articles of essential equipment such as PPE have been procured, received as in-kind support, shipped and distributed. Cash has proven essential in the response, with $338 million distributed in total. However, challenges remain. Testing and tracing remains elusive in the many remote areas in which UNHCR operates. While countries have made tremendous efforts to maintain national education programmes through radio, online and on television, including for refugees and internally displaced people, millions of children and youth are out of school due to mandatory school closures, with dramatic long-term consequences, particularly

for girls. In the early days of the pandemic, faced with extraordinary needs, UNHCR reprioritized and reallocated resources to meet the immediate needs of refugees and IDPs. As the crisis progressed, and the scale of additional needs became clearer and were articulated in the Global Humanitarian Response Plan, UNHCR did everything possible to mobilize resources from its donors—both governmental and private—who responded with generous support, including providing $161.2 million in softly earmarked funding. While the scale of global humanitarian needs grew to over $10 billion, UNHCR made deliberate efforts to ensure its appeals remained focused on the most immediate needs of people of concern and of the people who host them, supported through activities which the Office and its network of partners could reasonably undertake. While UNHCR remained modest in its assessment of needs, it nevertheless continues to suffer a shortfall in funding for its COVID-19 response, amounting to $283 million or 38% of the $745 million required to meet identified needs. With COVID-19 still a threat to health systems and populations across the world, and with its socio-economic impacts felt heavily by the most vulnerable in society, including refugees and other displaced people, UNHCR continues to call on its donors—both institutional and private—to show solidarity and support those most in need.

REGIONAL ANALYSIS OF THE ON GROUND SITUATION.

1) ASIA

China was the original epicenter of the coronavirus pandemic. The outbreak of COVID-19 there raised concerns that the virus would spread to other parts of the region, including to south Asia—home to some of the world's largest populations of refugees and IDPs. Rohingya refugees in Bangladesh, Afghan refugees in Pakistan, and millions of IDPs inside Afghanistan itself shelter in overcrowded and underserved camps and informal settlements. The coronavirus has the potential to wreak havoc in these settings.

A) Afghan Refugees and Internally Displaced People

Almost 40 years of conflict have forcibly displaced huge numbers of Afghans. Millions have fled the country and are living in neighboring countries such as Iran, representing one of the largest protracted refugee situations in the world. Iran is a hotbed for COVID-19, now reporting the fourth highest number of deaths in the world. The Iranian government faced criticism for its delay in acknowledging and responding to the seriousness of the outbreak. Not until March 26—with 29,406 cases confirmed and 2,234 deaths—did the government issue an intercity travel ban and close schools, universities, national parks, and non-essential businesses.For the more than 3 million Afghans living in Iran, the situation is most dire. Most had difficulty accessing basic services like healthcare even before the current outbreak. Tens of thousands are returning to Afghanistan. However, decades of war have devastated the health system in Afghanistan. Although more than 420 new health facilities have been established since 2014, the healthcare sector remains vastly under resourced. There are approximately three doctors for every 10,000 patients. While Afghanistan is in

the midst of fragile peace negotiations, the level of violence remains remarkably high and the population's humanitarian needs are massive. More than 2.5 million Afghans are internally displaced. Of the 120 COVID-19 cases that have been confirmed in Afghanistan, a significant number had recently come from Iran. They had entered through the city of Herat, where there is no health facility adequately equipped to deal with this illness. Government officials have recommended social distancing measures and even instituted a daytime curfew in Herat, but their recommendations have largely gone unheeded. On March 24, Afghanistan's health ministry warned that half of the country's almost 39 million people might be infected.

Rohingya Refugees

Health authorities in Bangladesh are gearing up for a possible COVID-19 outbreak in Rohingya refugee camps. There are nearly 900,000 refugees living in the camps in Cox's Bazar and more than 400,000 Bangladeshis living in close proximity to them. Cramped living conditions, poor water quality, and patchy access to healthcare in the camps leave refugees vulnerable to disease. A recent humanitarian risk assessment of the Rohingya response warned, "the potential mortality and morbidity risk associated with COVID-19 is likely to surpass global averages." Bangladesh's Ministry of Health is developing a preparedness and response plan in coordination with UN agencies. Hundreds of health workers in the camp area are receiving training to improve disease outbreak detection and prevention. However,UN officials privately warn that they anticipate major problems in managing the spread of the virus inside their own international workforce, much less across the refugee population. The government of Bangladesh is allowing only essential services to reach the camps, undermining efforts to address food insecurity and cyclone preparedness. Meanwhile, health workers there lack personal protective equipment such as gloves and masks. Donors and UN agencies must step up to supply these critical items. Communicating with displaced populations about the COVID-19 outbreak will be challenging given refugees' mistrust of authorities and the absence of formal, credible communications networks. The government continues to restrict phone and internet access in the camps while rumors and false information often spread quickly. This is likely to hinder efforts to prevent and prepare for the spread of the virus. The government of Bangladesh should therefore lift internet and phone restrictions and empower Rohingya civil society organizations that have formed in the camps in order to improve the quality and reach of essential information.

AFRICA

Countries across sub-Saharan Africa have begun taking precautions to stop the arrival or stymie the spread of COVID-19 within their borders. In many cases, this has meant blocking all incoming flights or screening and quarantining passengers of certain nationalities or arriving from specific countries. Though perhaps effective in combating the disease's spread, these measures have also prevented the delivery of much-needed humanitarian staff and cargo to respond to ongoing crises in these countries. The potential resulting shortages of goods and technical capacity could have devastating consequences in many humanitarian contexts across the continent, where there are more than 17.7 million IDPs and over 6.3 million refugees. The outbreak of COVID-19 could also

undermine critical peacekeeping efforts in sub-Saharan Africa. Many countries that contribute troops to the United Nations (UN) peacekeeping missions are experiencing outbreaks of the novel coronavirus. As a result, and in order to curb the spread of the disease, the UN recently requested that nine troop-contributing countries delay the regular rotation of their soldiers in and out of peacekeeping missions. In some cases, this could require currently deployed troops to stay in place. The pause in rotations could also lead to continued gaps in critical mission capability. Africa will be disproportionately impacted, as seven of these UN peacekeeping missions operate in conflict and humanitarian crisis zones across the continent.

Central Africa

Nigeria, where over 2 million people are internally displaced in the country's northeast, was the first central African state to report cases of the virus. As of March 29, there were 97 confirmed cases of COVID-19.28 Neighboring Cameroon had confirmed 91 cases, as it grapples with a series of crises that have forced 922,000 of its citizens into internal displacement.29 Both governments have more capacity than many of their neighbors and could play a leadership role in responding to the pandemic. The Nigerian government should be applauded for working with UN leadership in the country to coordinate response efforts there. Unfortunately, other governments across the region have not done likewise. Countries like Chad and the Central African Republic (CAR) were reporting three cases in each country as of March 29; however, given the limitations of their health systems, it is uncertain if these are indicative of the actual trend.30 The outbreak's impact could be disastrous if the 7 coronavirus spreads beyond the capital cities, especially for the displaced populations in both countries. There are more than half a million IDPs in CAR and 171,000 IDPs in Chad, as well as 468,000 refugees from neighboring countries.31 These vulnerable populations have little access to clean water or healthcare facilities.

SOUTH SUDAN

Following years of civil war, nearly one-third of South Sudan's population remains displaced— there are about 1.47 million IDPs in South Sudan and 2.2 million refugees in neighboring countries. With more than half the population facing acute food insecurity and poor health infrastructure, South Sudan is highly vulnerable to the spread and harmful effects of infectious diseases. No cases of COVID-19 had been reported in the country as of publication of this report, but several cases had been confirmed in neighboring countries. To prevent and prepare for a possible outbreak, South Sudan has suspended all international flights and locked down its land borders to all but cargo buses, food trucks, and fuel tanks. The presence of a large UN peacekeeping mission with significant staff rotations in South Sudan adds an additional potential vector for the disease to spread to the country. Almost 200,000 IDPs live in Protection of Civilian sites on or near peacekeeping bases. The UN and troop contributing countries are taking steps to limit the potential for exposure, including a temporary freeze on staff travel into South Sudan.

AMERICAS

The COVID-19 pandemic has already had significant implications for major humanitarian hotspots across the Americas. To date, the response by governments has varied widely. Countries like Peru, Guatemala, and Colombia implemented strong measures early to combat the spread of the virus. However, Mexico and Brazil have been slow to adopt mitigation measures, even dismissing the severity of the crisis.In Central America, many countries have adopted stricter border policies but have acquiesced to demands from the United States to continue receiving deported nationals. Many countries in South America have closed their borders to the movement of people, including for displaced Venezuelans.

The Venezuela Crisis

Under the regime of President Nicolás Maduro, Venezuelans have suffered years of economic collapse, institutional failure, and political turmoil. Hyperinflation, generalized violence, and political repression are rife in a country where the vast majority live in poverty. In February 2020, the UN World Food Program stated that 9.3 million people in Venezuela—about one-third of the population—faced food insecurity. As more than 4.9 million people have fled the country, over 1 million children have been left without their parents.As of March 29, 2020, there were 119 confirmed cases of the coronavirus in Venezuela. Although World Health Organization records do not indicate any deaths, Venezuelan officials have confirmed at least one death. A “social quarantine” has been established nation-wide, and 12 military forces have been deployed throughout the country to enforce restrictions on movement. Nevertheless, not all citizens are complying, as small crowds continue to line up to obtain food and other essential goods. On March 24, the government ordered stricter isolation measures in the three states—Caracas, Miranda, and Vargas—that account for 70 percent of COVID-19 cases. The country’s years-long economic crisis has left its health system and other institutions in complete collapse. Hospitals lack adequate facilities, medical personnel, supplies, and medication. For the public, face masks, soap, and even water for hand-washing are either unavailable or unaffordable. Nicolás Maduro has called on the United States to lift its sanctions on the country in order to open access to foreign investments and finance that could help fund a response. Human rights groups, and EU leaders, as well as the UN Secretary-General and the UN High Commissioner for Human Rights have echoed these calls. On March 26, the United States indicted Maduro with narco-terrorism and other serious charges in a move it could use to justify additional sanctions. Maduro also tried and failed to secure a $5 billion loan from a special emergency fund of the International Monetary Fund (IMF). President Xi Jinping of China sent 4,000 diagnosis kits, and Cuba sent a medical brigade to help. Meanwhile, Maduro’s long-held opposition to international aid organizations will further heighten the likelihood that the outbreak does outsized damage. The pandemic risks exacerbating the pre-existing humanitarian crisis inside Venezuela—a crisis that has already compelled millions from Venezuelans to seek refuge in other countries. As the situation deteriorates, more Venezuelans are likely to try to flee to neighboring Colombia and Brazil. Faced with official border closings, they may instead resort to taking dangerous unofficial routes out of the country, known as trochas, that are often controlled by armed groups. Those who are able to cross irregularly will, in turn, have trouble accessing the care they need in their host countries, and thus risk further spreading the virus.

Other Regional Countries Hosting Venezuelans

Border closures throughout the region will affect displaced Venezuelans. According to the latest official figures, Peru is host to the second largest number of Venezuelans (861,000 as of February 7, 2020). As of December 31, 2019, Ecuador is host to 366,596 Venezuelans. On March 15, Ecuador—where 1,823 cases and 48 deaths have now been reported—closed its borders to all foreign travelers. Gatherings of more than 30 people were also banned. In Peru, where 671 cases have been confirmed, Peruvian President Martín Vizcarra also declared a state of emergency on March 15 and initially shut the country's borders for 15 days. Four days later, the government imposed a nationwide curfew and ban on private vehicles. On March 25, President Vizcarra extended a state of emergency and nationwide quarantine through April 12. These border closures affect Venezuelans on the move from Colombia to Ecuador, Peru, and other third countries. For Venezuelans already inside these host countries, limited access to healthcare, loss of their livelihoods, and limits on movement and available services will put them at higher risk of infection or complications. On March 18, Brazil ordered a partial closing of its border with Venezuela for 15 days. President Bolsonaro has been criticized for his lax response to the pandemic, raising fears that the toll inside the country will be high. Already, by March 25, there were 2,271 confirmed 14 cases of COVID-19 and 47 deaths. The latest official figures indicate that Brazil was host to more than 250,000 Venezuelans as of November 30, 2019, though the current number is likely much higher. Despite the government's attempts to relocate Venezuelans who have crossed into the country, the majority remain concentrated in remote, impoverished areas along the northern border, where resources and infrastructure are sparse. The inevitable damage from the coronavirus is thus likely to affect Venezuelans inside the country even as the border closing hinders others from accessing the critical healthcare they lack in Venezuela.

EUROPE

Europe has been hard hit by the COVID-19 pandemic. At the end of 2018, there were nearly 2.5 million refugees and 646,060 asylum seekers in the European Union (EU) alone. As of March 17, just 10 cases had been reported among refugees and asylum seekers, all of them in Germany. Already, however, countries had begun to close their borders to asylum seekers. By March 16, Greece, Hungary, Belgium, and the Netherlands had shut their asylum offices.In other countries, including Italy, asylum services have significantly slowed. Due to health and travel restrictions imposed to contain the spread of the coronavirus, NGOs have had to suspend search and rescue operations in the Mediterranean Sea for those attempting to cross from war-torn Libya. Meanwhile, nationalist leaders and politicians—from Italy to Spain—have seized upon the outbreak as a false basis for xenophobic, anti-refugee rhetoric and policies.

Greece

As of March 29, Greece confirmed 1,156 coronavirus cases and 38 deaths. While this is less than several other European countries, the Greek government is concerned that if it does not act quickly, it could follow the trajectory of Italy. Greece has therefore enacted a country-wide lockdown, closing hotels and suspending most international flights.The Ministry of Migration and Asylum has suspended all administrative services until April 13 at the earliest. This includes registering asylum

seekers, conducting interviews, adjudicating cases, and reviewing appeals. The shutdown of the entire Greek asylum system leaves all asylum seekers in a precarious position. Arguably, no population in Greece is more vulnerable to the coronavirus than the more than 40,000 asylum seekers trapped on the Aegean Islands. Conditions are appalling in the Reception and Identification Centers (RICs) where asylum seekers are required to live. The official RICs and their overflow areas are squalid and overcrowded, hosting approximately eight times their capacity. These areas lack basic hygiene facilities, have very few latrines, and provide minimal medical care at best. There is no running water, making frequent hand washing impractical. NGOs on the islands report that no significant steps have been taken to prepare the camps for an outbreak of the coronavirus. Instead, the government instituted a curfew and prohibited NGOs from entering the camps for at least 14 days. These measures reduce essential services in the camps, including food distributions, childcare, and servicing latrines. Relief groups have been calling on the Greek government to evacuate camp residents to facilities across the country in order to save the lives of asylum seekers and Greek citizens alike. The EU has now echoed this call to evacuate the most vulnerable asylum seekers in the camps to other areas on the islands, a crucial first step to protect asylum seekers and limit the likely spread in the camps.

THE MIDDLE EAST

The Middle East is fast becoming an epicenter of the coronavirus crisis. Cases have escalated dramatically in Lebanon and Iran. New infections have emerged in more than half a dozen other countries in the region including Iraq and Afghanistan. At least 12 million refugees and IDPs live in Iraq, Syria, Lebanon, and Turkey. Borders throughout the Middle East are porous, with refugees, economic migrants, and others often traveling along informal routes. Another challenge to an effective coronavirus response is the region's weak or broken public health systems. However, the situation also differs significantly between countries. Turkey, with over 3.4 million Syrian refugees, has a robust healthcare system and the government is somewhat better positioned to respond to an outbreak and employ basic containment tools like contact tracing. On 16 the other hand, Iraq and Lebanon have severely weak public health systems and are not able to adequately monitor what is going on and provide a robust public health response.

The Syria Crisis Syria's brutal war entered its tenth year last month. More than 5.6 million have fled Syria since 2011, and over 6.5 million remain displaced inside the country.The majority of Syrian refugees in neighboring countries and internally displaced Syrians lack the most basic needs, including access to healthcare. Even the most basic guidance on social distancing and personal hygiene will be difficult to follow where refugees and IDPs often live in overcrowded and unhygienic camps and informal settlements. The situation in the northwest of Syria is of particular concern. It will be extremely challenging to launch an effective response to a coronavirus outbreak in places like Idlib province. While no confirmed cases of Coronavirus have been announced in Idlib, this appears to be largely due to the lack of testing kits. At least three people who showed symptoms of COVID-19 died in the past week, and there are several other patients with the virus symptoms who are quarantined inside hospitals, a doctor and a representative of a medical organization in Idlib

told Refugees International. More than 1 million people are staying in overcrowded and unhygienic camps where it is very challenging to impose social distancing. Very few people are staying home. The economic situation is such that if people do not work, they do not have the means to feed their families. Moreover, there is no authority inside Idlib that has the means to enforce preventive measures, and the various fighting factions on the ground appear to have other priorities. Much of the healthcare infrastructure in northwest Syria has been destroyed by the Russian and Syrian government bombing campaign. The facilities that remain will have little of the equipment required to treat coronavirus patients, such as ventilators, or to protect healthcare workers from infection as they go about their duties. On March 25, WHO delivered 300 testing kits to the northwest. The main challenge is that the whole area has only around 100 ventilators. Efforts to screen populations with infrared non-contact thermometers are also necessary. Any type of support for the general capacity of what remains of the medical system in northwest Syria could make a significant difference. Outside of Syria, more needs to be done now to help prepare the camps and communities that host Syrian refugees in neighboring countries. Countries like Lebanon, host to more than 1 million Syrian refugees, are already experiencing significant outbreaks that are taxing their national healthcare systems. Jordan hosts the second largest Syrian refugee population per capita in the world. Because these refugees are unlikely to be a top priority for the national authorities, 17 the international humanitarian community must step in to fill the gaps, in collaboration with host governments.

Iraq

Decades of conflict and widespread violence have wreaked havoc on the lives of millions of civilians in Iraq. According to UNHCR, more than 6.5 million people—approximately 18 percent of the population—are currently in need of humanitarian assistance, including 3 million children.113 Nearly 2 million people remain displaced inside the country, the majority of whom have taken refuge in the Kurdistan Region of Iraq (KRI). Moreover, Iraq is host to around 300,000, mostly Syrian, refugees. Many live inside camps where poor conditions and outdated infrastructure could exacerbate the spread of the coronavirus. As of March 29, 547 cases of confirmed coronavirus had been reported in Iraq. However, the real number was likely much higher. The country's health system, undermined by decades of sanctions, neglect, corruption and violence, suffers from significant gaps including shortages of supplies, equipment, and staff. To prevent further spread of the virus, the Baghdad and KRI governments imposed a curfew and cancelled all domestic flights. However, security forces are struggling to enforce the lockdown as thousands of pilgrims from across the country visit shrines in the capital. In addition, humanitarian actors have reported that curfews and movement restrictions are impacting the delivery of assistance to people in need. Humanitarian groups in Iraq have developed a COVID-19 preparedness and response planning in the camps. Moreover, UN agencies are supporting Iraq with testing capacities and the procurement of personal protective equipment for health partners. Donors and humanitarian organizations should increase their efforts to support Iraq and the KRI government's response. They should offer personnel support to fill staff shortages and provide the necessary supplies and equipment.

Yemen The WHO announced that, so far, there are no confirmed cases of coronavirus in Yemen. However, a virus outbreak will almost certainly have a devastating effect. Yemen hosts what may be the world's worst humanitarian crisis, with more than 24 million people in need of assistance, and nearly 3.65 million internally displaced. A relentless war has decimated the country's healthcare

system. In the past few years, Yemen has witnessed the worst cholera epidemic in recent history. Last week, both the Houthi rebels and Yemen's internationally recognized government banned international flights in an attempt to keep the country free of the coronavirus. The ban includes chartered medical evacuations. Despite the halt to passenger flights, the UN-led Yemen aid 18 operation continues for the moment, with the vast majority of staff being Yemeni. The UN confirmed that seaports remain open for cargo. Yemen is largely reliant on cargo arriving by sea for imports of food, fuel, and other consumer essentials critical to civilian welfare. The WHO is supporting the national health authorities to prepare for the coronavirus with medical supplies, testing kits, training, and information campaigns. However, some international relief teams have scaled back to essential staff only. A fingerprint-driven digital registration system for aid recipients to limit aid fraud has been paused. Top priority, life-saving assistance such as food, water, sanitation, and health services will continue, but some less critical aid programs will be slowed. The international humanitarian community must step in to help Yemen's medical personnel to prepare for a virus outbreak. It should particularly provide medical facilities with testing kits, medical equipment, and supplies in addition to personnel protective gear to help protect healthcare workers.

RECOMMENDATIONS.

The challenge of containing and mitigating the spread of the COVID-19 pandemic across the world's most vulnerable, displaced populations is breathtaking in scope. Each humanitarian crisis will require a strategy tailored to the specific needs and circumstances of the displaced population in question – a strategy that is workable in a context that will undoubtedly include significant resource constraints. That said, there are common elements across the countries and continents reviewed above, which lend themselves to key principles and recommendations that should be part of any effective humanitarian response to the pandemic.

The response must be inclusive: The response to COVID-19 must be inclusive if it is to be effective. International assistance to address the pandemic must reach all vulnerable populations, including the refugees, asylum seekers, and the internally displaced. Governments receiving U.S. assistance for COVID-19 should ensure that the forcibly displaced living in both camp and noncamp settings are included in prevention and mitigation efforts. By the same token, aid for refugees and internally displaced people to address the COVID-19 pandemic should be made available to host communities in refugee-hosting areas. In short, the aim should be to improve systems for all persons regardless of nationality.

Enhance communications and the flow of information: Governments and international aid groups should develop information campaigns to ensure displaced communities have accurate and current information about the coronavirus and response efforts. Where possible, they should work with local civil society and displaced persons themselves to ensure language and means of communications are easily accessible and widely disseminated. Governments should lift any phone and internet restrictions in and around displaced communities. Deploy medical personnel, supplies, and personal protective equipment: Donors and international aid groups should prioritize the deployment of qualified medical personnel to refugee, asylum seeker, and IDP-dense areas, along with personal protective equipment and other medical supplies such as gloves and masks for humanitarian health workers to ensure their safety in addressing COVID-19 outbreaks in displacement camps. Appropriate training for existing health care personnel must occur, particularly for treatment of severe cases with limited ICU access. Prioritize hygiene and other WASH-related interventions: Donors and international aid groups should improve access to water, sanitation, and hygiene (WASH) facilities for refugee and internally displaced populations – especially those living in camps or camp-like settings. This should include the distribution of essential personal hygiene items including soap and disposable towels. The response should also recognize best practices for response for particularly vulnerable populations, such as women and girls.

Focus on decongestion and isolation and quarantine capacities: Donors, host governments, and international aid groups should prioritize decongestion and building isolation and quarantine capacities in camps and camp-like settings. Services like food distribution and education should be restructured to avoid large gatherings. Donors and others should take steps now to support establishment of capabilities within displaced communities for implementation of isolation and quarantine procedures in accordance with best medical and public health advice and practices. Given the extremely high density of certain settings, novel strategies for "shielding" may need to be carefully attempted.

Build up testing and surveillance capabilities: Donors and international aid groups should prioritize deployment of rapid testing capability in adequate quantity to refugee and IDP settings.

With respect to surveillance, the good news is that many formal camps already have epidemiological surveillance systems already in place. These need to be strengthened and adapted to screen for COVID-19, especially for all new arrivals in the camps.

Stop detentions and deportations of asylum seekers: Public health officials universally agree that detention in crowded facilities increases the risk of transmission for asylum seekers and immigrants in custody, along with immigration and border officials. Governments should put in place alternatives to detention polices and ensure that all migrants have access to testing and healthcare regardless of status. Deportation of any individuals without prior medical testing risks exporting the virus into countries unprepared to deal with mass outbreaks because of pre-existing crises and substantial vulnerable and marginalized populations with little access to limited healthcare systems.

Protect those who fear persecution from forced return: Any restrictions that governments impose on travel should include provisions that safeguard individuals from forced return to 20 torture or persecution. Moreover, extraordinary policy measures that impose unusual burdens for those seeking asylum should be lifted as soon as circumstances permit. In times of national emergency, protecting vulnerable people from gross abuses of their basic rights can become far more challenging for governments, but it is at those very times when our commitment to such rights is decisively measured.

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