

Briefing Paper

Committee: Health

Topic: The Question of Combatting Infectious Diseases in Refugee Camps

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Summary

Combatting infectious diseases in refugee camps remains one of the most pressing humanitarian and global-health challenges, particularly as displacement levels continue to rise. Several countries carry the greatest burden due to their large-scale, long-term hosting of refugee populations. Jordan, for example, hosts tens of thousands of Syrian, Iraqi, and Palestinian refugees in camps such as Za'atari (approx. 65,000–67,000 residents) and Azraq (approx. 38,000–41,000 residents). Bangladesh also hosts one of the world's largest refugee populations: approximately 930,000–1,000,000 Rohingya refugees live in the Cox's Bazar camp, following repeated waves of violence in Myanmar. These locations share similar challenges: overcrowding, unstable funding, limited sanitation, and fragile health systems, making them highly vulnerable to outbreaks.

A wide range of international and intergovernmental organisations supports health services in these camps. The World Health Organization (WHO) leads global disease surveillance, vaccination strategy, and outbreak response. The United Nations High Commissioner for Refugees (UNHCR) coordinates overall protection and camp management and ensures that refugees have access to essential health services. UNICEF plays a central role in child health, immunisation, and water, sanitation and hygiene (WASH) interventions, while OCHA coordinates emergency operations across humanitarian actors. NGOs are equally essential: the International Organization for Migration (IOM) conducts health screening and disease-prevention work, Médecins Sans Frontières (MSF) provides emergency medical care and field hospitals, and the ICRC and IFRC deliver medical services, water and sanitation, and disease-prevention programmes. Save the Children and the International Rescue Committee (IRC) strengthen child health, sanitation, and long-term health system resilience. Together, these organisations form the backbone of emergency and preventative healthcare in refugee settings.

International treaties and frameworks guide these efforts. The 1951 Convention Relating to the Status of Refugees defines refugee rights, including access to healthcare, placing a legal obligation on states to provide disease prevention, treatment, and surveillance systems. The International Health Regulations (IHR 2005) further require all 196 participating states to detect, assess, and report infectious-disease threats—making them crucial for managing epidemics in cross-border displacement contexts. The New York Declaration for Refugees and Migrants (2016) strengthened these commitments by calling for stronger vaccination systems and improved

epidemic preparedness. Following this, the WHO Global Action Plan on the Health of Refugees and Migrants (2019–2030) created a framework for improved surveillance, WASH systems, and integration of refugees into national health structures. The Global Compact on Refugees (2018), though not legally binding, reaffirmed international responsibility-sharing, emphasising public-health readiness and outbreak prevention. These commitments are tied to Sustainable Development Goal 3, which pushes states to ensure healthy lives for all—including displaced populations.

Despite decades of work, previous attempts to address infectious diseases have had mixed results. Establishing basic healthcare in camps improved survival, but it was often reactive and underfunded. Mass vaccination campaigns successfully reduced measles, polio, and cholera outbreaks, yet coverage gaps persisted due to high mobility, mistrust, and limited cold-chain capacity. WASH interventions reduced waterborne diseases but struggled to keep pace with rapid camp expansion and overcrowding. Disease surveillance systems—often aligned with the IHR—detected outbreaks earlier but suffered from inconsistent implementation and weak laboratory capacity. Meanwhile, efforts to integrate refugee health into national systems showed promise in countries like Jordan and Uganda but were limited by financial pressures and insufficient burden-sharing.

These gaps show why improved coordination remains vital. Past failures illustrate common patterns: slow outbreak analysis, delayed vaccination campaigns, funding interruptions, poor data-sharing, and fragmented monitoring. The 2011 Dadaab measles outbreak saw vaccination targeting only children even though 60% of cases were adults, while in South Sudan, cholera vaccinations often occurred after peak outbreaks. In Cox’s Bazar, sudden donor funding cuts caused clinic closures, and in Chad, surveillance systems reported data but too slowly for timely action. A future UN resolution could address these failures through clearer division of responsibilities, early-trigger vaccination protocols, protected emergency health funds, unified monitoring systems, and stronger accountability structures.

Definition of Key Terms

Refugee Camp – A designated area where refugees live temporarily after fleeing conflict or persecution. Camps often face overcrowding, limited sanitation, inadequate water supply, and insufficient medical services—conditions that increase the risk of infectious-disease outbreaks.

Infectious Disease Outbreak – A sudden increase in infections caused by pathogens such as viruses (measles), bacteria (cholera), or parasites. In refugee camps, outbreaks spread faster due to close living quarters, poor sanitation, low vaccination coverage, and limited healthcare infrastructure.

WASH (Water, Sanitation and Hygiene) – A critical public-health sector concerned with providing clean drinking water, safe waste disposal, and hygiene behaviours such as handwashing. Strong WASH infrastructure prevents waterborne diseases like cholera, dysentery, and hepatitis E.

Disease Surveillance – A system for detecting, reporting, and analysing cases of disease. Effective surveillance enables early identification of outbreaks. In camps, this includes community reporting, clinic-based monitoring, and alignment with national early-warning systems.

International Health Regulations (IHR 2005) – A legally binding global agreement requiring states to prevent, detect, and report public-health emergencies. Refugee-hosting states must assess risks within 48 hours and report potential outbreaks within 24 hours, ensuring rapid international coordination.

UNHCR (United Nations High Commissioner for Refugees) – The UN agency responsible for refugee protection and camp management. In health crises, UNHCR coordinates medical services, works with host governments, and ensures access to healthcare for displaced populations.

WHO (World Health Organization) – The UN agency leading global health. WHO establishes vaccine protocols, manages outbreak response, strengthens surveillance, and supports national health systems in refugee-hosting regions.

Community Health Worker (CHW) – A trained member of the refugee community who helps deliver basic health services, conducts disease surveillance, provides hygiene education, supports vaccination campaigns, and links households to clinics. CHWs are essential for early detection of outbreaks.

Humanitarian Health Cluster – A coordination body - usually led by WHO and UNHCR - that brings together all health actors in a crisis. The Cluster sets shared priorities, reduces duplication, facilitates information-sharing, and monitors indicators such as vaccination coverage and water supply.

Cold Chain – A temperature-controlled system required to store, transport, and deliver vaccines safely. Weak cold chains in camps can lead to spoiled vaccines and lower immunisation rates.

Burden-Sharing – A principle in international refugee policy requiring wealthier states and global institutions to help fund and support refugee-hosting countries. This is essential so host states are not overwhelmed and can safely provide healthcare.

Outbreak Preparedness – A set of measures - including vaccination plans, WASH infrastructure, stockpiles, and training - to ensure camps can rapidly respond to infectious diseases.

Preparedness reduces mortality and prevents large-scale epidemics

Major Countries and Organizations Involved

Countries with large refugee camps:

- Jordan – Hosts Syrian, Iraqi and Palestinian refugees (e.g. Za’atari Camp, approx. 65,000-67,000 residents and Azraq Camp, approx. 38,000-41,000 residents)

- Lebanon – Host Palestinian refugees (approx. 248,000 refugees living in 12 camps, largest camp is Ain El Hilweh, approx. 70,000-120,000 residents)
- Bangladesh – Hosts Rohingya refugees (Approx. 930,000-1,000,000 refugees living in the Cox's Bazar camps – recent influx in 2023 and 2024 after massive violence in Myanmar)
- Kenya – Hosts refugees in Dadaab (450,000 residents) and Kakuma (310,000 residents) camps
- Ethiopia – Hosts South Sudanese, Somali, and Eritrean refugees (approx. 950,000 individuals in 21+ active camps)

International and Intergovernmental Organisations:

- World Health Organization (WHO) – Leads disease surveillance, vaccination, and outbreak response
- UN High Commissioner for Refugees (UNHCR) – Manages refugee camps and coordinates health services
- UNICEF – Focuses on child health, immunisation, water, sanitation, and hygiene (WASH)
- UN Office for the Coordination of Humanitarian Affairs (OCHA) – Coordinates emergency response

Non-Governmental Organisations (NGOs)

- International Organization for Migration (IOM) – Health screening and disease prevention among displaced populations
- Médecins Sans Frontières (MSF / Doctors Without Borders) – Provides emergency medical care in crisis zones, including outbreak response, treatment of infectious diseases, vaccination campaigns, and running field hospitals in refugee camps.
- International Committee of the Red Cross (ICRC) – Focuses on protecting and assisting people affected by conflict, including refugees. It provides medical services, supports water and sanitation, and helps restore healthcare systems in war-affected areas.
- International Federation of Red Cross and Red Crescent Societies (IFRC) – Coordinates global disaster and health response, supporting national societies in delivering vaccinations, hygiene promotion, and disease-prevention programmes in refugee settings.
- Save the Children – Specialises in child health, nutrition, and protection. Delivers vaccinations, treatment of childhood diseases, maternal healthcare, and WASH programmes in camps.
- International Rescue Committee (IRC) – Provides healthcare, sanitation, and emergency response services in refugee camps, including disease prevention, access to clean water, mental health services, and long-term health-system strengthening.

Timeline of Events (Relevant UN Treaties)

The 1951 Convention Relating to the Status of Refugees remains the foundational legal instrument governing refugee protection. It defines who qualifies as a refugee and guarantees their fundamental rights, including access to essential services such as healthcare. This is crucial for infectious-disease control, as it places an obligation on host states to provide medical care, vaccinations, and disease surveillance systems necessary to prevent outbreaks in overcrowded camp settings. The World Health Organization (WHO) notes that refugee health entitlements are derived directly from the rights established under the Convention and associated human-rights instruments.

Another major legal framework influencing infectious-disease prevention in refugee camps is the International Health Regulations (IHR 2005), a binding agreement involving 196 countries. The IHR require states to develop the capacity to detect, assess, report, and respond rapidly to public-health threats, including outbreaks that may arise in refugee camps or spill across borders. Under these regulations, countries must assess public-health risks within 48 hours and report dangerous events to the WHO within 24 hours. This makes the IHR central to coordinating outbreak response in displacement settings, where diseases such as cholera, measles, and meningitis can spread quickly.

The New York Declaration for Refugees and Migrants (2016) was a landmark political commitment by all UN Member States to strengthen protection for displaced populations. It highlighted the urgent need to address health vulnerabilities among refugees, explicitly calling for improved access to healthcare, strong vaccination systems, and better epidemic preparedness. This declaration laid the political groundwork for the international community to prioritize infectious-disease prevention in refugee contexts, recognizing the heightened risks caused by overcrowding, limited sanitation, and restricted access to healthcare.

Building on this momentum, the WHO Global Action Plan on Promoting the Health of Refugees and Migrants (2019–2030) was endorsed by the World Health Assembly in 2019 and later extended to 2030. This plan provides a coordinated global framework to improve health outcomes for displaced people. It calls for stronger vaccination programmes, enhanced disease surveillance in camps, improved water and sanitation (WASH) systems, and better integration of refugees into national health systems. As global displacement has continued to increase, this action plan has become a critical instrument guiding how states and UN agencies work together to combat infectious diseases in humanitarian settings.

The Global Compact on Refugees (2018), while not legally binding, reinforces these commitments by emphasizing the need for international responsibility-sharing to support host countries. It directly identifies public-health readiness, outbreak prevention, and strengthened healthcare provision as essential components of refugee protection. WHO materials highlight the Compact's alignment with broader health frameworks, demonstrating its role in shaping how health systems respond to forced displacement and epidemic threats.

These global commitments are further connected to the 2030 Sustainable Development Goals, particularly SDG 3, which aims to “ensure healthy lives and promote well-being for all.” WHO emphasizes that displaced populations must be included in efforts to achieve universal health coverage, end epidemics, and strengthen early-warning systems. This reinforces the international community’s responsibility to ensure that refugee camps are equipped to prevent and manage infectious diseases effectively.

Finally, operational guidance such as UNHCR’s 2011 Epidemic Preparedness and Response in Refugee Camp Settings provides technical standards for outbreak contingency planning, surveillance, and infection prevention inside camps. While not a treaty, it remains the practical backbone through which international legal obligations are translated into day-to-day public-health action in refugee environments.

Previous Attempts to Solve the Issue

1. Basic Healthcare

One of the earliest and most consistent approaches has been the establishment of basic healthcare services within refugee camps. Under the leadership of the UN High Commissioner for Refugees (UNHCR), temporary clinics and field hospitals have been set up in camps to provide primary healthcare, treatment for communicable diseases and maternal and child health services.

Humanitarian organisations such as Médecins Sans Frontières (MSF) and the Red Cross and Red Crescent Movement have played a central role in these efforts, particularly during acute emergencies.

While this approach has saved lives and reduced mortality during outbreaks, it has often been reactive rather than preventative, limited by funding constraints and shortages of trained medical personnel.

2. Mass Vaccination Campaigns

Vaccination has been one of the most significant preventative strategies used to control infectious diseases in refugee camps. Past campaigns have targeted diseases such as measles, polio, cholera, tuberculosis and COVID19 (in recent years).

Organisations such as WHO, UNICEF, and Gavi, the Vaccine Alliance, have coordinated largescale immunisation campaigns, often prioritising children and vulnerable groups.

These campaigns have successfully reduced outbreaks of vaccine preventable diseases in many camps. However, challenges such as incomplete vaccine coverage, population mobility, cold chain limitations, and mistrust have limited their effectiveness in some regions.

3. Water, Sanitation, and Hygiene (WASH) Interventions

Recognising the link between infectious diseases and poor living conditions, previous efforts have placed strong emphasis on WASH programmes. These initiatives aimed to improve access to clean drinking water; construct latrines and waste disposal systems; promote hygiene education (e.g. handwashing).

UNICEF, Oxfam, and CARE have led many of these interventions.

In camps where WASH standards improved, there was a measurable reduction in waterborne diseases such as cholera and dysentery. Nevertheless, rapid camp expansion, overcrowding, and insufficient funding often undermined long term sustainability.

4. Disease Surveillance and Early Warning Systems

Another important attempt to address infectious diseases has been the introduction of disease surveillance systems, often aligned with the International Health Regulations (2005). These systems were designed to monitor disease trends in camps, including detecting outbreaks early, as well as to improve coordination between host states, WHO, and humanitarian actors.

While surveillance has improved outbreak detection, especially for diseases such as cholera and measles, implementation has been inconsistent. Weak national health systems, a lack of data sharing, and limited laboratory capacity have restricted the effectiveness of such systems in many refugee hosting countries.

5. Integration of Refugee Health into National Health Systems

More recently, international actors have promoted the integration of refugee healthcare into host countries' national health systems, rather than relying solely on parallel camp-based services. For example, countries such as Uganda and Jordan have piloted inclusive health policies that allow refugees to access public healthcare services.

While this approach has shown promise, it remains constrained by financial pressures on host states and insufficient international burden sharing.

Possible Solutions

1. Strengthening Existing Programmes:

Preventative Healthcare and Routine Immunisation

A key solution lies in shifting from reactive outbreak responses to preventative healthcare models. This includes expanding routine vaccination programmes for refugees upon arrival and throughout displacement. This could be implemented by improving vaccine supply chains and strengthening cold chain infrastructure, for example.

Improving Water, Sanitation and Hygiene (WASH) Infrastructure

Improving access to clean water, sanitation facilities, and hygiene education is one of the most effective ways to reduce waterborne and communicable diseases. Effective measures include investing in durable water systems rather than temporary solutions, ensuring adequate latrine to population ratios and incorporating hygiene education into community health programmes. (WASH improvements are particularly important in overcrowded camps, where poor sanitation can rapidly lead to largescale outbreaks.)

Expanding Disease Surveillance and Early Warning Systems

Strengthening disease surveillance and reporting mechanisms within refugee camps is essential for early outbreak detection. This involves integrating camp-based health data into national and international surveillance systems, in line with the International Health Regulations (2005). The use of trained community health workers and digital reporting tools can improve surveillance in resource limited settings.

2. Integration of Refugee Health into National Health Systems

Although this has been piloted in countries such as Uganda and Jordan, this solution, if fully rolled out could help to prevent the spread of diseases. Rather than relying exclusively on parallel humanitarian healthcare structures, a more sustainable solution is the integration of refugee health services into host country healthcare systems. This approach improves continuity of care, expands access to specialised treatment, and strengthens national health infrastructure overall.

International financial support is essential to ensure host states are not overburdened. Burden sharing through multilateral funding mechanisms, including the World Bank and donor states, is crucial to making this solution viable.

3. Community Engagement and Refugee Participation

Effective disease prevention requires the active involvement of refugee communities. By training refugees as community health workers (CHWs), trust in healthcare services increases, as well as compliance with vaccination and hygiene measures. Community based approaches also improve cultural sensitivity and sustainability of health interventions.

Community Health Workers would be made up of refugees selected by community workers, with an aim to recruit 50% women (with literacy preferred, but not required), who would undergo a series of training modules. These would include training on how to carry out basic but essential health functions that prevent and control infectious diseases in camps. It should include includes:

- Infection prevention skills such as handwashing promotion, safe waste disposal, and recognising unsafe water sources.
- Vaccination literacy, including explaining vaccine benefits, mobilising households for campaigns, and identifying children who missed doses.

- Disease surveillance, teaching CHWs to spot early symptoms of outbreaks (e.g., fever + rash, acute diarrhoea) and report them within 24 hours.
- WASH hygiene promotion, such as maintaining clean latrines, promoting safe water storage, and checking handwashing points.
- Risk communication, enabling CHWs to counter rumours, provide accurate health messages, and reduce fear or stigma.
- Basic home-based care and safe referrals, such as giving oral rehydration solution (ORS) and identifying serious cases that need clinic care.

CHWs would act as the eyes and ears of the health system, especially in overcrowded camps where formal staff cannot reach every household. This has been effective in Cox's Bazar, Bangladesh, where Rohingya CHWs successfully increased vaccination coverage, reduced diarrhoeal peaks, and helped detect measles cases early. And also in Dadaab & Kakuma Camps (Kenya), where CHWs strengthened cholera surveillance, improved hygiene compliance, and reduced outbreak size.

Camp leaders and faith leaders would also play a pivotal role. Camp and faith leaders should be trained to recognise the basic signs of infectious diseases and understand how they spread, so they can quickly alert health teams. They need skills in risk communication, including how to counter rumours, share accurate health messages, and reassure communities during outbreaks. Leaders learn to promote safe behaviour, such as handwashing, vaccine acceptance, and temporary changes to religious practices to reduce transmission. They also support vaccination campaigns by mobilising families, identifying unvaccinated children, and ensuring vulnerable groups are not missed. Training includes conflict mediation to prevent stigma or blame, along with guidance on working with health agencies - knowing who to contact and how to report issues in the camp. Finally, they learn key humanitarian principles, including confidentiality, fairness, and ensuring equal access to services for all groups. This has been used effectively in Cox's Bazar, Bangladesh, where Imams and community elders were trained to counter vaccine misinformation, improving measles and cholera vaccine uptake. Also in South Sudan, where church leaders facilitated safe funerals and helped identify early measles clusters.

The main aim is to make health measures more trusted and more effective by involving refugees directly. This includes helping raise vaccination coverage to at least 95%, which WHO says is needed to prevent measles outbreaks in crowded settings, and ensuring families follow good hygiene practices that meet humanitarian minimums such each person is provided with 20 litres of clean water each day (for survival and hygiene) and no more than 20 people per latrine (to mitigate the spread of diseases such as cholera, dysentery and diarrhoea). Community participation also aims to improve early detection of disease by ensuring suspected outbreaks are reported within 24 hours, which aligns with the International Health Regulations (IHR) requirement for early notification.

Community engagement and refugee participation monitoring is carried out by the Health Cluster - this is the group led by WHO and UNHCR that coordinates all health actors in a refugee crisis, including NGOs like MSF, IRC, CARE, the Red Cross, and national health ministries. These partners collect weekly data on household visits, rumours addressed, and early-warning alerts, which would be aided by reports made by community health workers. Key indicators—like vaccination coverage (target 95%), water supply (20L/person/day), and the speed of outbreak reporting (within 24 hours)—are reviewed in these meetings. Health teams also use random household checks and community feedback (meetings, hotlines, complaint boxes) to confirm that CHW reports are accurate.

4. Strengthening International Coordination and Accountability

Finally, improved coordination between UN agencies, NGOs, host governments, and donors is essential. Clear division of responsibilities, data sharing, and accountability mechanisms can prevent duplication of efforts and gaps in service delivery. Furthermore, regular monitoring and evaluation of health programmes can ensure that solutions remain effective and adaptable to changing conditions.

Although attempts for similar reforms have been attempted in the past, but not successfully. Below are identified key reforms made, why they were unsuccessful, and how a new resolution might look to solve them.

Past coordination efforts in refugee-camp health crises have often been ineffective because agencies acted too slowly or without shared strategies. In the 2011 Dadaab measles outbreak, for example, partners vaccinated only children even though 60% of cases were adults, contributing to over 1,300 infections; a new UN resolution could prevent this by requiring joint, rapid outbreak analysis so vaccination targets are adjusted immediately. Likewise, during South Sudan's repeated cholera waves, oral cholera vaccines were frequently deployed after outbreaks peaked, doubling attack rates where vaccination was late. A future resolution could ensure pre-positioned vaccine stocks and automatic early-trigger vaccination protocols to avoid such delays. In Cox's Bazar, essential clinics were forced to close when funding was suspended, weakening surveillance and referrals just as cholera rose; a resolution could address this through a protected emergency health fund that keeps critical services running despite donor shocks. Additionally, in Eastern Chad, surveillance systems like EWARS produced complete data but too slowly to guide rapid measles or diarrhoea responses; stronger coordination could enforce 48-hour investigation requirements and shared rapid-response teams. Even broader evaluations show that agencies lack unified monitoring systems, making it difficult to measure progress or prevent duplication, so a new resolution could introduce one shared results-tracking platform across all UN agencies, NGOs, and host governments.

Useful Links

1. [Access to healthcare | UNHCR](#) – Problem overview and implementation
2. [Health in emergencies | UNICEF](#) – Human Impact and Preventative Solutions
3. [Water, sanitation and hygiene \(WASH\) | UNICEF](#) – More about WASH programmes
4. [Homepage | Humanitarian Action](#) – Very comprehensive report on current global issues (conflicts which may affect the number of people in refugee camps etc.)