

BIGMUN 2026

UNHCR: United Nations High Commissioner for Refugees

Research Report

Topic 1: Discussing the need to improve access to education, healthcare, and sanitation in refugee camps.



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Introduction

Refugee camps worldwide have grown massively in recent decades. As of mid-2025 an estimated 42.5 million people were refugees, which means they are outside their home country due to fear of persecution. Many live in camps or crowded settlements, often for years or decades. In these settings, access to basic services like schooling, healthcare and sanitation is severely strained. For example, roughly half of all school-age refugees (about 7.2 million children) are not in school. Lack of adequate water and sanitation further exposes camp populations to disease. Addressing these gaps is vital: international human rights law and the Sustainable Development Goals underscore education, health and clean water as fundamental rights for all people, including refugees. Improving these services is not only a moral imperative but also essential for refugee well-being, long-term integration and global security.¹

Definition of Key Terms

Refugee: A refugee is a person who, owing to a well-founded fear of persecution for reasons such as race, religion, nationality, social group or political opinion, is outside their country and cannot avail themselves of its protection.²

Refugee camp: A refugee camp is a temporary facility built to provide immediate assistance and protection to people forced to flee their homes due to violence, conflict or persecution. Camps are intended as short-term solutions but often become protracted settlements lasting many years or decades.

WASH: The term WASH stands for Water, Sanitation and Hygiene. It refers to efforts to ensure safe drinking water, adequate toilet and sanitation facilities and hygiene products for refugees and displaced people. WASH is critical to prevent disease and maintain dignity in camps.³

Humanitarian assistance: In this context, humanitarian assistance means the emergency aid and services provided to refugees by states and aid agencies. This includes food, clean water,

¹ (*Global Trends Report 2024 | UNHCR, 2024*)

² (*UN General Assembly, 1951*)

³ (*Water, Sanitation and Hygiene (WASH), n.d.*)

emergency shelter, medical care, education and hygiene kits, intended to save lives and alleviate suffering.

Background Information

Historically, refugee camps emerged in the mid-20th century. For example, after World War II and during decolonisation waves, millions were uprooted and housed in temporary camps or settlements. In 1950 the UN founded UNHCR and in 1951 the UN adopted the Refugee Convention which codified refugee rights. Early camps in Europe, Asia and Africa laid out basic shelter, water and health services for displaced populations. Over time, crises from the Cold War, regional conflicts and state collapse have repeatedly created new camps (e.g. camps in the 1990s for Yugoslav, Rwandan and Sudanese refugees). Notable examples include Dadaab and Kakuma in Kenya (established in the 1990s for Somali refugees), Zaatari and Azraq camps in Jordan (for Syrians), and the massive Cox's Bazar settlements in Bangladesh (for Rohingya refugees from Myanmar).⁴

Today there are roughly 120 million displaced people globally, including 31.6 million refugees. Only about 22% of these refugees live in camps (around 6.6 million) – the majority live in urban or rural non-camp settings. Conditions in camps are often better monitored, but many services remain below international standards. UNHCR finds that gross enrolment rates for refugees lag far behind global averages: only ~65% of refugee children reach primary school and only ~42% reach secondary school. Nearly 7.2 million school-age refugee children are out of school. Those who do attend tend to perform well – for example UNHCR data show that over 80% of refugee students who sit for national primary exams pass. Despite this, far too many children are excluded from learning.^{5 6 7}

Sanitation and hygiene in camps also remain critical issues. Crowded living conditions mean that if water or toilets are insufficient, infectious diseases can spread easily. UNHCR notes that “the United Nations recognises access to water and sanitation as human rights –

⁴ (UNHCR, n.d.)

⁵ (Five Takeaways from UNHCR's 2024 Education Report | USA for UNHCR, 2024)

⁶ (Refugee Camps | USA for UNHCR, 2021)

⁷ (What is a Refugee Camp? Definition and Statistics | USA for UNHCR, n.d.)

fundamental to everyone's health, dignity and prosperity".⁸ Yet in many camps basic WASH services are below these standards. In Cox's Bazar, Bangladesh, only a minority of schools for Rohingya had sufficient safe sanitation, and many refugee children lacked access to clean water.⁹ The COVID-19 pandemic further underscored these shortcomings: refugees in camps often faced heightened risk due to "overcrowded living conditions and limited access to clean water and sanitation facilities".¹⁰

Humanitarian reports also document outbreaks of disease: For instance, in 2023 WHO and UNHCR reported a measles and malnutrition crisis in refugee camps in Sudan's White Nile State, where over 1,200 children under age 5 died in a few months.¹¹ These examples highlight that gaps in healthcare and sanitation can have deadly consequences.

Over the past decade global trends show only modest improvements in these areas. For example, a UNHCR survey found increases in refugee inclusion in national health plans (77% of surveyed countries included refugees as of 2022, up from 62% in 2019). However, funding shortfalls limit progress: UN appeals for refugee assistance often remain only partially funded. Protracted conflicts (Syria, Venezuela, Afghanistan, etc.) mean refugee populations remain high.¹² ¹³ Climate change is compounding WASH challenges, since "nearly 60% of refugees and internally displaced people live in countries that are among the most vulnerable to climate change".¹⁴ The combination of these factors – growing refugee numbers, chronic underfunding, and deteriorating living environments – makes improving education, health and sanitation an urgent global priority.

⁸ (*What Is WASH?* | USA for UNHCR, 2024)

⁹ (*ECW*, n.d.)

¹⁰ (*Refugee Camps* | USA for UNHCR, 2021)

¹¹ (*WHO*, 2023)

¹² (*Woodman*, 2022)

¹³ (*More countries are including refugees in national health systems* | UNHCR, 2024)

¹⁴ (*What Is WASH?* | USA for UNHCR, 2024)

Major Countries and Organisations Involved^{15 16}

Turkey: Turkey now hosts by far the largest refugee population in the world – over 4 million registered refugees (mostly Syrians and other). The Turkish government has built camps and increasingly integrated Syrian children into its national schools.

Uganda: Uganda hosts Africa's largest refugee caseload, with over 1.5 million refugees and asylum-seekers. Uganda's so-called “refugee self-reliance” model gives many refugees land and freedom to work; the government partners with UN agencies to provide water, health clinics and schools in settlements.

Bangladesh: Bangladesh hosts over 1.1 million Rohingya refugees who fled Myanmar in 2017 – making it one of the world's largest and most protracted camp populations. Host governments like Bangladesh have relied heavily on UN and NGO support for basic services in camps, since local infrastructure is under extreme strain.

Other: Other key host countries include Jordan and Lebanon (Syrian refugees), Kenya (several million in Dadaab and Kakuma camps over decades), Pakistan and Iran (Afghan refugees), Ethiopia, Sudan, and many others.

Humanitarian organisations: The United Nations High Commissioner for Refugees (UNHCR) is the lead UN body for refugee protection and assistance. UNHCR coordinates camp administration, protection and basic services across operations. For example, UNHCR tracks education indicators globally and mobilises funding or partners to support refugee schools. UNICEF (the UN Children's Fund) plays a major role in child-focused services: It runs schooling programs, child protection and nutrition in camps. UNICEF data show, for instance, that Turkey has included 1.7 million Syrian refugee children in education efforts, and UNICEF has supported Rohingya learning centres in Bangladesh. The WHO (World Health Organisation) works on refugee health, it helps host countries incorporate refugees into national health systems and responds to outbreaks in camps. In 2023 WHO and UNHCR jointly warned of the measles–malnutrition crisis among Sudanese refugees, illustrating their collaboration. Other UN agencies also contribute: WFP (World Food Programme) provides food assistance and clean water trucking; UNESCO (United Nations Educational, Scientific and Cultural Organisation) supports accelerated learning curricula; and UN Women works on refugee gender

¹⁵ (*Global Trends Report 2024 | UNHCR, 2024*)

¹⁶ (*Global Report | UNHCR, 2024*)

issues.¹⁷ Large NGOs are also pivotal. Médecins Sans Frontières (MSF / Doctors Without Borders) often run field hospitals and WASH projects in camps. For example, MSF has provided emergency healthcare and sanitation in crises from Rohingya camps to Syrian refugee settlements.¹⁸ Save the Children, Plan International and local NGOs run schooling (including non-formal and psycho-social support) in many camps. The International Federation of Red Cross/Red Crescent Societies (IFRC) frequently build shelters and water points after mass influxes. Finally, host-country governments' education and health ministries are directly involved: e.g. Turkey's Ministry of Education oversees thousands of refugee classrooms, and Uganda's Ministry of Water liaises with UNHCR on borehole drilling.¹⁹

Relevant UN Resolutions

In recent decades the UN and partners have pursued many efforts to expand camp services, with mixed results. On education, UNHCR and UNICEF launched global strategies and funds, e.g. UNHCR's "Education 2030 Strategy" and the DAFI scholarship programme aimed at boosting refugee enrolment. At successive Global Refugee Forums (2019, 2023), dozens of countries and NGOs pledged to provide more schools, train teachers, and register refugee children in national systems. For example, at the 2023 Forum "15% by 2030" pledges were made to get 15% of refugee youth into tertiary education. In many countries these initiatives have yielded progress: Turkey has enrolled millions of Syrian children in public schools; in Kenya and Ethiopia new community schools have opened in camps. However, even with these programs, UNHCR reports that roughly 49% of refugee children remain out of school. Gender gaps also persist, as girl refugees often have lower enrolment.²⁰

In healthcare and sanitation, agencies have deployed large campaigns. UNHCR's public health teams and WHO have organised vaccination drives (e.g. measles, polio) in camps and supplied mobile clinics. NGOs have built hundreds of latrines and water points – for instance, UNHCR's WASH partners in Uganda and Bangladesh have installed boreholes and wells. Emergency cash or voucher programs have been used so refugees can buy medicines or hygiene supplies locally. Some host countries have integrated refugees into national health systems; surveys indicate that in 2022 about three-quarters of countries reported refugees in their health plans (up from 62% in 2019). These efforts have saved lives – for example, broad

¹⁷ (Global Appeal | UNHCR, 2024)

¹⁸ (Doctors without Borders, 2024)

¹⁹ (Global Compact on Refugees | UNHCR, 2018)

²⁰ (Education Report 2025 | UNHCR, 2025)

immunisation campaigns limited cholera outbreaks in several camps. Yet funding gaps have often hampered scale-up: global appeals for refugees are routinely under-funded (often below 50% of requirements), meaning UN and NGOs must ration services. In sanitation, standards often fall short – a UNHCR report noted only 53% of refugee families had safe toilets in 2024 (down from 63% in 2023).²¹

Overall, while international programs have brought gains (more classrooms, some free health clinics, increased WASH coverage), success has been uneven and crisis driven. Humanitarian responses typically focus first on acute needs (shelter, emergency care) and expand more long-term services only gradually. In many cases, aid providers acknowledge that underlying issues (overcrowding, legal restrictions, chronic funding gaps) persist despite intervention. For example, the Kutupalong camp in Bangladesh grew rapidly after 2017, and despite massive aid, a single 2021 survey found only 16% of young adolescents and 24% of children aged 3–14 had any schooling. On the other hand, the positive performance of refugee students in exams shows that when access is provided, refugees can do well. In health, some donor-backed projects (like WHO-supported malaria nets and clinics) have improved outcomes in specific camps, but the deteriorating situation in places like Sudan demonstrates that gains can be reversed without sustained commitment.²²

Proposed Solutions²³

Moving from mere survival to true resilience in refugee camps requires a fundamental shift in how the international community views displaced people—less as passive recipients of aid and more as active participants in a national economy. For decades, humanitarian work has been trapped in a "hand-to-mouth" cycle of annual grants that keep camps in a state of permanent repair. To break this loop, we need to transition toward multi-year, flexible funding that treats a camp like a developing city rather than a temporary site. By utilising innovative tools like blended finance and refugee development funds, we can move away from fragile tents and toward the kind of durable, brick-and-mortar infrastructure that can eventually be handed over to local governments.

The most successful refugee responses are rarely isolated humanitarian projects; they are national ones. When host countries integrate refugees into their own systems, the cost per person drops and the quality of care rises. Models in Turkey and Uganda remain the gold

²¹ (Global Report | UNHCR, 2024)

²² (Global Report | UNHCR, 2024)

²³ (Education Report 2025 | UNHCR, 2025)

standards here. By allowing hundreds of thousands of Syrian children into public classrooms and granting refugees land and the right to work, these nations prevent the "lost generation" effect while bolstering local markets. This policy shift must be supported by practical reforms, such as recognising foreign certifications so that refugee doctors and teachers can work in their own communities. This "task-sharing" approach not only fills critical staffing gaps but also builds a level of trust that outside organisations often struggle to achieve.

Furthermore, as climate change disproportionately affects regions hosting refugees, camp infrastructure must become climate-resilient by design. We are seeing a 2025 shift toward "green" camps where solar-powered water pumps replace expensive fuel trucking and digital hubs provide remote learning to children in the most isolated settlements. However, technology is only effective when it is inclusive. Sanitation projects, for instance, are increasingly adopting a participatory approach, involving women and people with disabilities in the planning of latrines to ensure they are safe and accessible. This is a vital protection measure, as poor sanitation planning directly correlates with increased safety risks for women and children.

Despite these clear paths forward, the reality of 2025 remains a struggle against a record funding gap. While we have reached a milestone of 9% enrolment in higher education—nearing the "15by30" goal—nearly half of all refugee children remain entirely out of school. Similarly, household toilet coverage has slipped to roughly 53% globally as aging facilities outpace limited maintenance budgets. These gaps serve as a stark reminder that even the most innovative policies and technologies cannot succeed without a sustained international commitment to "burden-sharing." Improving these services is ultimately a choice to invest in human capital today to reduce the long-term social and economic costs of displacement tomorrow.

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