S Das Gupta, MS Zaman, & K Begum 'Rohingya children in Bangladesh: Safeguarding their health-related rights in relation to the available healthcare system' (2020) 4 *Global Campus Human Rights Journal* 25-47
http://dx.doi.org/10.25330/609

# Rohingya children in Bangladesh: Safeguarding their health-related rights in relation to the available healthcare system

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**Abstract:** *As at March 2020 Bangladesh hosted approximately 859 160 Rohingya people of which 54 per cent were children. The magnitude of their health problems is undeniable and uncertainty about the consequences of these health issues persists. Although Bangladesh is not a state party to key treaties in international refugee law, several human rights treaties to which Bangladesh is party (and some provisions of its Constitution) entail that the state should safeguard the basic human rights of the Rohingya people in its territory. This includes special protection for Rohingya children, particularly in relation to access to essential services. This article analyses whether the healthcare services and provision in one of the 34 camps set up in the Cox's Bazar district are sufficient to safeguard the health-related rights of Rohingya children. The article employs a qualitative research methodology, on the basis of field work conducted in September and October 2019. In parallel, the authors look at the healthcare system available for Rohingya children from a human rights-based approach, which should inform possible public health interventions. Their analysis illustrates that for different reasons the existing system struggles to provide adequate protection of the health-related rights of these children. In exposing the critical situation related to the ability of Rohingya children to enjoy their rights on Bangladeshi territory, the article suggests that sustainable solutions to safeguard these rights can be found only if the relief distribution, healthcare services, healthcare procedures and related conditions work concurrently in an effective way as they are all interrelated. If a single component does not function well, the affected rights cannot be secured and children's unhealthy living conditions in the camps are exacerbated.*

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The co-authors thank Dr Chiara Altafin, Research Manager at the headquarters of the Global Campus of Human Rights, who provided valuable insights and expertise that significantly improved this article.

**Key words:** *Rohingya; children; camp; health care; human rights*

## 1 Introduction

The global refugee crisis has taken a sharp turn due to a dramatic increase in the amount of forcibly-displaced populations in recent years, shifting from 65,6 million people in 2016 to 70,8 million refugees in 2018 (UNHCR 2016; UNHCR 2018a). In the midst of this crisis the Rohingya refugee crisis has become a particular matter of global and regional concern. The term 'Rohingya' has been used to introduce an ethnic minority Muslim community that for centuries has lived in the Rakhine State of Myanmar. Over the years they have faced brutal oppression based on their religious and social identity. They have essentially become a 'stateless' community, because the government of Myanmar denies them citizenship on the basis of the country's nationality law of 1982 (Ahmed 2010; BROUK 2014). In this regard, an estimated 300 000 'undocumented Myanmar nationals' have been living in Bangladesh for three decades. In addition to this, in August 2017 massive attacks on the Rohingya people, led by the military of Myanmar, have resulted in another mass exodus (UNHCR 2018b). As at March 2020 approximately 859 160 Rohingya people have taken shelter in the camps of Coxs Bazar district, Bangladesh (UNHCR 2020c); 54 per cent of these are children (UNHCR 2020c) and a staggering 4 per cent of households are headed by children (ACAPAS 2019). After these arrivals, it has been challenging for the Bangladesh government and the relevant non-governmental organisations (NGOs) to cope with the enormous and acute humanitarian needs of these people.

In order to manage such an emergency, the government of Bangladesh has built some of the world's biggest refugee camps (Première Urgence Internationale 2018). Thirty-four camps have been set up in the Cox's Bazar district in Bangladesh in order to host Rohingya people (UNHCR 2020a). Camp 4, situated in Ukhia Upazilla, is one of these camps where the proportion of men, women, children and the elderly respectively is 48 per cent, 5 per cent, 54 per cent and 4 per cent. The total area of Camp 4 is 1 155 140 square kilometres with approximately 7 014 houses providing shelter for around 29 823 individuals. The total population density is 29 per person per square kilometre. In this camp the authorities (supported by 37 partner organisations) provide services in the areas of site management, protection, shelter/site infrastructure, access to water, sanitation and hygiene (WASH), nutrition, food security, health, education, energy and environment. In the child protection and health sector, a total of 14 partner organisations work along with the camp authorities (UNHCR 2020b). In total, 132 health posts are run by the partners in Camp 4. Furthermore, 29 out of 32 primary health centres run 24/7 services. Additional health facilities are under construction or planned in order to address the gaps existing in healthcare. From 1 January to 30 April

2019 more than 2 million outpatient consultations (35 per cent for males and 65 per cent for females) were reported to the health sector, and more than 30 implementing partners provided services to people in the camp. Significantly, healthcare services were provided to 69 per cent of adults and children of five years and over. The final 31 per cent who received health care were children younger than five years. Overall, field hospitals, diarrhoea treatment centres, specialised SRH delivery facilities, and other specialised health facilities, including eyecare facilities, rehabilitation facilities, and age-friendly centres, were run by the health sector partners.

However, specialised health services have not been widely available for everyone in need in these camps (Health Sector Cox's Bazar 2019), including Camp 4. Bangladesh authorities have established the *Majhi* system as an emergency response arrangement to handle the sudden and large influx of people since August 2017. The *Majhi* has been appointed primarily to estimate the population, identifying immediate survival needs and linking Rohingya refugees with emergency assistance from various providers. However, the *Majhi* system has not been established with the participation of Rohingya communities and thus lacks representation and recognition of accountability towards the refugees. Moreover, from the Rohingyas' perspective this system is deemed unreliable for the distribution of humanitarian aid, mostly because the needs of people and the respect for minimum humanitarian standards such as representation, impartiality, transparency and accountability have not been properly adhered to in the past (Protection Sector Working Group Cox's Bazar 2018).

It is worth highlighting that Rohingya people should receive the status of 'refugees' after arriving in Bangladesh. In fact, they have taken shelter in the country due to the fact that they faced grave human rights violations in Myanmar. They were forced to flee due to discrimination, persecution and violence because of their religious, cultural and social group identity. This certainly falls under the broader definition of 'refugee' that has been expanded by state practice (Harvey 2013), if not also in the narrow definition set forth in article 1 of the 1951 Convention Relating to the Status of Refugees. Nonetheless, Bangladesh authorities have formally identified them as 'forcibly-displaced Myanmar nationals' (FDMN), because Bangladesh has not yet acceded to the 1951 Convention or its 1967 Protocol (UNHCR 2019b). Serious gaps in assistance have thus emerged, as these refugees lack formal legal status and face restrictions on movement. However, as a corollary of the customary nature of the principle of *non-refoulement* embodied in article 33(1) of the 1951 Convention, all states (including Bangladesh) are prohibited from denying temporary asylum to refugees who arrive at their borders, and from sending them back to their country of origin until the threats they face there have ceased (Kaur

2016: 8-9).[1] Notably, Bangladesh recently underlined that, although it is not a state party to the 1951 Refugee Convention, it 'has long been hosting refugees and forcibly displaced Rohingyas from Myanmar with full respect to international protection regime' (UNHRC 2018b: para 125). Moreover, Bangladesh is neither a state party to the 1954 Convention relating to the Status of Stateless Persons nor to the 1961 Convention on the Reduction of Statelessness. Its accession to these two conventions, however, would set up 'a framework to prevent and reduce statelessness and avoid the detrimental effects of statelessness on individuals and society by ensuring minimum standards of treatment for stateless persons' (UNHCR 2012: 5). The Rohingya people have been coming to Bangladesh since 1970 (Tompson 2005), but have been exposed to severe risks and human rights abuses due to the absence of national legal and administrative frameworks for refugee and asylum seekers or stateless persons. Certain constitutional provisions apply to everyone inhabiting in the territory of Bangladesh (Aktarul 2018: 59-60; Banerjee 2019), but there is no specific domestic mechanism safeguarding the rights of refugees in statutory law or state policy.

In the context of the Universal Periodic Review (UPR) of 2012, the United Nations High Commissioner for Refugees (UNHCR) indeed addressed the need to create 'a refugee protection framework' in the country, with a clearer basis to provide international protection to refugees, recommending Bangladesh to accede to the 1951 Convention and its 1967 Protocol, while also taking concrete steps towards the adoption of national refugee legislation (UNHCR 2012: 3). For the UNHCR, this would have been an official acknowledgment of the hospitality and solidarity Bangladesh for decades has shown towards Rohingya people. It would also have underscored the significance of being committed, together with the international community, to find solutions to the struggles faced by refugees. It would have finally allowed the government to deal with asylum issues in a structured manner, thus complementing its obligations stemming from binding international human rights instruments and the provisions of its own Constitution (UNHCR 2012: 3). It is also worth noting that article 23 of the 1951 Convention guarantees to all refugees lawfully staying in a state's territory the same rights to public relief and assistance as is accorded to nationals of the host country; it is meant as the same material benefits with the same minimum of delay (Commentary 1997, citing E/AC.32/SR.38: 5). Although the right to health care is not mentioned in the Convention, article 23 has been given a wide interpretation, covering areas such as medical assistance and hospital treatment, emergency relief, and relief for those who are blind, unemployed, suffering from physical or

1 According to the principle of non-refoulement a state cannot expel or return refugees in any manner whatsoever to countries or territories where their life and freedom may be threatened because of their race, religion, nationality, membership of a particular social group or political opinion.

mental disease, incapable of earning a livelihoods for themselves and their families, and also children without support (Commentary 1997, citing E/AC.32/2: 39; E/AC.32/SR.15: 5-8).

It must be highlighted that Bangladesh is a state party to various core international human rights treaties, such as the International Covenant on Civil and Political Rights (ICCPR); the International Covenant on Economic, Social and Cultural Rights (ICESCR); the Convention Against Torture and other Cruel Inhuman or Degrading Treatment or Punishment (CAT); the Convention on the Rights of the Child (CRC); the Convention on the Rights of Persons with Disabilities (CRPD) and its Optional Protocol; and the Convention on the Rights of Migrant Workers and Their Families (CRMW). These entail that the state should safeguard the rights of Rohingya people while they are sheltered on Bangladeshi territory. The state is bound to respect their basic rights, especially by guaranteeing equal benefits and protection under the law as well as access to essential services. Moreover, Rohingya children are specifically entitled to special protection under some of these treaties.

Despite these key considerations, ensuring these rights has been a real challenge for Bangladesh and in many cases there have been social, political, economic and managerial shortcomings, which tested the humanitarian aspirations of the state regarding the management of refugee children (Lawrence et al 2019). The inadequacy of the services provided is particularly apparent with respect to health care for the Rohingya children from birth up to the age of 17, who in total make up around 298 700 of the population in all camps in Bangladesh (UNHCR 2020b). On this basis, this article analyses whether the healthcare services and provision in the aforementioned Camp 4 are sufficient to safeguard the health-related rights of Rohingya children. Since the welfare of children entirely depends on such services, investigating the state of the healthcare system is indicative of the critical human rights situation these children are facing. Inadequate health care provided to Rohingya people, especially to children, can determine violations of the rights concerned.

After explaining the qualitative inquiry followed as main methodology, we elaborate preliminary considerations in relation to the CRC in order to question the healthcare system available to Rohingya children also from a human rights-based approach. Our subsequent analysis provides insights into the existing situation. We illustrate that in the process and procedure of relief distribution in Camp 4 Rohingya people struggle to meet their basic needs such as food needs, of which the proper supply is functional to safeguard children's health-related rights. We then discuss the healthcare services, procedure and condition separately, also addressing their direct connection to children's rights. We argue that the effective combination and practice of these three components of health care has the potential

to ensure the rights of Rohingya children living in Bangladesh. After looking at pertinent positions expressed by the state concerned as well as international monitoring bodies, we make some concluding remarks.

## 2 Research methodology

For 23 days in September and October 2019, we carried out qualitative research to investigate the Rohingya children and parents' healthcare-seeking process in Camp 4, Ukhia, Cox's Bazar, and its relationship with the health-related rights of these children. Our research departs from the CRC definition of a child (namely, an individual under 18 years of age) and takes into consideration children up to 17 years only. In fact, in Camp 4 we selected block C (out of seven blocks) for the field work, since there the availability of children is high. We found a high concentration of 17 year-old children. This is why the Rohingya children from birth to 17 years and their parents were selected. In order to understand the notion of the healthcare-seeking process and their perception in this regard, it was done on the basis of existing healthcare programmes implemented by governmental and non-governmental organisations. A purposive sampling strategy was used to select the 24 potential participants. A total of 16 in-depth interviews with Rohingya children and their parents were conducted, combined with eight key informant interviews of healthcare service providers from governmental and non-governmental organisations. In particular, we conducted 10 in-depth interviews with the parents of children from birth to 12 years; six in-depth interviews with 13 to 17 year-old children; a further three key informant interviews with doctors and health officials; two key informant interviews with community health workers; three key informant interviews with health officials from NGOs. Qualitative tools for in-depth and key informant interviews, based on the WHO guideline, were used for data collection (Dawson et al 1993). Relevant literature, including journals, books, reports and news reports, was reviewed to collect data from secondary resources. Our inquiry adopted Neuman's three-phase coding system to analyse the qualitative data (Neuman 2003).

## 3 Preliminary considerations in relation to the Convention on the Rights of the Child

The four guiding principles (non-discrimination; the best interests of the child; the right to life, survival and development; the right to be heard) as enshrined in articles 2, 3, 6 and 12, provide specific safeguards for all children, including those seeking international protection such as the Rohingya children on Bangladeshi territory. A particularly relevant provision for our study is article 22. Article 22(1) requires Bangladesh to take legislative, administrative or other measures to effectively ensure

that refugee children and children seeking refugee status (whether unaccompanied or accompanied) receive '*appropriate* protection and humanitarian assistance in the enjoyment of applicable rights' (emphasis added). This entails to consider measures that are tailored to specific vulnerabilities and developmental needs of the intended beneficiaries in order to make them able to actually enjoy their rights in the existing circumstances. The textual reference to both 'protection' and 'assistance' means that the state not only has to refrain from acts that hinder children's capacity to enjoy their rights, but also that the state has to take steps to secure their enjoyment (Pobjoy 2019: 836-838). In this regard, the aforementioned guiding principles should inform the measures required as well as the content of proper levels of protection and humanitarian assistance to which these children are entitled. Article 22(2) also enjoins the state to provide cooperation in any efforts by the United Nations (UN) and other competent organisations to protect and assist all these children, as well as to trace family members of any child refugee in order to gather information needed for reunification. If this is not possible, the child should be accorded the same protection as any other child permanently or temporarily deprived of family environment. Children (with or without parents or family members) who have left their country of origin to escape war, persecution or natural disasters have to undergo a very helpless situation as a child and as a 'refugee' (Vaghri, Tessier & Whalen 2019).

Another provision of critical importance for our study is article 24. The right of the child to the highest attainable standards of health care and to access to facilities for the treatment of illness and rehabilitation must be respected during all periods of displacement. The state has to make every effort 'to ensure that no child is deprived of his or her right of access to such health care services'. For the related implementation, article 24(2) expressly requires the state to take 'appropriate measures' to reduce infant and child mortality; to guarantee the provision of necessary medical assistance and health care to all children (with the emphasis on the development of primary health care); to combat disease and malnutrition (through, *inter alia*, the provision of clean drinking water, adequate nutritious food and a clean environment); to ensure proper pre-natal and post-natal health care for mothers; to ensure (in particular for parents and children) information, access to education and support in the use of essential knowledge of child health and nutrition, hygiene and environmental sanitation; and to develop preventive healthcare services. The UN Committee on the Rights of the Child (CRC Committee) has elaborated on the normative content of these obligations in its General Comment 15, and some points are particularly relevant for our study. In terms of article 24(2)(a) state parties should take effective interventions such as community-based treatments which include 'attention to still births, pre-term birth complications, birth asphyxia, low birth weight, mother-to-child transmission of HIV and other sexually-transmitted infections, neonatal infections, pneumonia,

diarrhoea, measles, under- and malnutrition, malaria, accidents, violence, suicide and adolescent maternal morbidity and mortality'; 'strengthening health systems to provide such interventions to all children in the context of the continuum of care for reproductive, maternal, new-born and children's health' are also recommended (CRC/C/GC/15: para 34). According to article 24(2)(b) priority should be given to universal access for children to primary healthcare services to be provided in community settings (para 36). In terms of article 24(2)(c) state parties have to take, according to the specific context, necessary steps to guarantee access to nutritionally adequate, culturally appropriate and safe food and to combat malnutrition (para 43). According to article 24(2)(e) children need information and education on all aspects of health to permit them to make informed choices about their access to health services (para 59). According to article 24(2)(f) preventive healthcare strategies should address communicable and non-communicable diseases and incorporate a combination of biomedical, behavioural and structural interventions (para 62).

In line with a joint reading of articles 22 and 24, supplementary healthcare services may be needed for refugee children and children seeking refugee status, due to the heightened health risks that they may face, including rehabilitation services to promote their physical and psychological recovery and social reintegration under article 39 (Pobjoy 2019: 846). Moreover, in situations of limited resources and facilities, especially in connection with large-scale influxes such as in the case at issue, the state must consent and support the assistance offered by the UNHCR, the United Nations Children's Fund (UNICEF) and other relevant agencies to fulfil the healthcare needs of these children. The level of cooperation is left to the discretion of state parties under article 22(2), but it must be performed in good faith.

## 4 Relief distribution among Rohingya people

Rohingya people have entered into Bangladesh for having been forcefully displaced from Myanmar. They did not have any kind of belongings to meet up their basic needs. The government, with the aid of the UNHCR and other national or international organisations, has given shelter and undertaken many projects under the programmes Food Security and Nutrition, WASH, Shelter and Non-Food Items, Health and Education to support them, providing humanitarian aid to meet their basic needs. According to one of the interviewed humanitarian workers, 'the distribution of humanitarian aid to this kind of vulnerable people, considering the children, is very crucial because it is very tough to ensure that every Rohingya family has got their basic relief or not'. The lack of manpower, relief, a proper relief distribution system, and a management system for maintaining such a huge influx are the main reasons behind the mismanagement in the delivery of humanitarian aid. Critically, a shortage

of basic relief and a lack of clarity in relief distribution represent the main problems that hinder Rohingyas' ability to enjoy their basic rights. According to one of the interviewed humanitarian workers, 'delivering relief properly to this large population is becoming difficult day by day, because, on the one hand, the amount of relief is decreasing continuously, and, on the other hand, corruption is happening in the relief distribution'.

Humanitarian aid in the form of relief distribution has been supplied through the *Majhi* which is considered the representative of Rohingya people. The *Majhi* stands for the total population of a block of around 120 to 130 families. The *Majhi* takes the responsibility of delivering relief to every family of that block. However, the Rohingya people have expressed some complaints against the *Majhi* as well as the humanitarian workers, since they do not properly receive the relief. The father of one Rohingya child aged three years stated:

> The *Majhi* misuses his power to distribute relief. He gives priority to people known or close at the time of relief distribution. In many cases, some portion of the relief is sold outside. They even sell the milk powder and nutritional food of the babies from the relief.

This clearly is not in line with the aforementioned obligations stemming from article 22 of CRC. Moreover, it must be emphasised that under article 3(2) of CRC state parties 'undertake to ensure the child such protection and care as is necessary for his or her wellbeing … and, to this end, shall take all appropriate legislative and administrative measures'. Importantly, article 3(3) of CRC also requires states to 'ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision'. Accordingly, in the case at issue, in order to ensure child safety, the care and protection of Rohingya children need to be safeguarded through the appropriate supervision of collaborating staff. However, in the case of camp management the adequacy of staff is limited. In fact, the *Majhi* is in charge of distributing all the powdered milk or nutrients that come as relief or nutritious food, especially for children. Around 120 to 130 families live in each block and one *Majhi* is assigned by the camp authority to each block, with the responsibility to deliver the relief to the families of the block. A system is in place to monitor whether these components are properly distributed, but this is not functioning correctly. As a result, corruption is on the rise and the children increasingly become the sufferers. Children are being deprived of care and protection from camp authorities, although the state is bound to ensure protection and humanitarian assistance through adequate staffing and proper supervision so as to enable children to effectively enjoy their health-related rights.

## 5 Healthcare services in the Rohingya camp

As a consequence of the deprivation of basic needs due to corruption and shortage of relief, Rohingyas have become so vulnerable that they have to think only about food, shelter and safety. Thinking about health issues seems to them to be a luxury. An interviewed mother of a seven year-old child stated:

> We have to fight to manage our food daily. The environment we live in and the ration we get from the authority is not suitable for us. Our children do not get proper food and that is why they are suffering from malnutrition, which leads them to many sicknesses. Medical treatment cannot cure this health problem of our children.

In this regard two main considerations may be highlighted.

First, the situation in Camp 4 illustrates that the food and nutrition needs of children have not been sufficiently met, with implications for their health-related rights, because the degree of relief that has been provided by the camp authority is not sufficient, which means that the available resources are not being used properly. This is not in line with article 4 of CRC, which enjoins the state to undertake appropriate (legislative, administrative and other) measures to implement the rights enshrined in the Convention, to the maximum extent of its available resources, and even taking actions at the national level within the framework of international cooperation. In this regard, the CRC Committee has agreed that 'even where the available resources are demonstrably inadequate, the obligation remains for a state party to strive to ensure the widest possible enjoyment of the relevant rights under the prevailing circumstances' (CRC/GC/2003/5: para 8). Some of the preliminary considerations that we made on articles 22 and 24(2) are also relevant in this respect.

Second, healthcare services are crucially important to address nutritional and health risks faced by the Rohingya people, especially the children, in such a situation of protracted displacement. The Ministry of Health and Family Welfare of Bangladesh, *Médecins Sans Frontières* (*MSF*) and other NGOs have provided such services in Camp 4 through a range of collaborative medical assistances. In this regard, national and international organisations – such as Research, Training and Management International (RTMI); Humanity and Inclusion (HI); Partners in Health Development (PHD); Gonoshasthaya Kendra (GK); OBAT Helpers; and HOPE foundation – work to provide these services to Rohingya people. Nonetheless, one of the health service providers stated that '[w]hen it comes to medical treatment, it is very difficult for doctors to provide a good check-up to every patient because the pressure of patients remains very high and we doctors are very few in number'. The pressure on healthcare providers to give treatment to Rohingya people, especially the children, regularly increases, also resulting in a drop in quality standards

in healthcare services. The scarcity of available doctors is evident in Camp 4 and is not in line with the reasonable implementation of articles 22 and 24 of CRC, even in light of article 4 of CRC.

## 6 Healthcare procedures in the Rohingya camp

In Camp 4 there is a hospital named 'Refugee Health Care Centre', which is jointly run by the government of Bangladesh and the RTMI. In this hospital there is a medical team composed by one leader, two medical officers, one medical assistant, one health advisor, one EPI health assistant, a pharmacist and community health workers, who have been appointed to provide health services to Rohingyas. The community health workers have the duty to disseminate the information and knowledge about primary health care and hygiene (as provided from this centre) among Rohingya people as well as to motivate them to take treatment from this centre. The other members of the medical team provide services to Rohingyas on a shift basis. There also is a specialised delivery sector that is run by some NGOs. However, according to the interviewed health officials, the manpower is not adequate to serve the existing enormous population and there is no child care specialist for the treatment of Rohingya children. The latter suffer from many diseases such as diarrhoea and diphtheria because of their unfortified situation, and are infected with some communicable diseases which can turn into an epidemic situation.

According to one of the interviewed health service providers, 'the Rohingya people live in a very congested shanty and in crowded living conditions, and because of that they are so much unprotected to water and airborne diseases. They have come from Myanmar with lots of health complications that are contagious as well.' He added: 'Children are the most sufferers of these diseases and remain unprotected from them, which is why they are susceptible to new diseases and has been kept separated from the local people, and also their movement is being restricted into the camp.' In recent times chickenpox and diphtheria outbreaks have occurred in the Rohingya camps, which have raised public health concerns in the region. One of the interviewed health service providers in the government hospital stated:

> Recent health problems which the Rohingya people are suffering from are diphtheria and chickenpox. Rohingya children are the main sufferers. The parents come with their children who are suffering from these two diseases daily in a large number. We are facing tough situations to treat the patients properly.

Rohingya children are the pivotal victims and have been advised to remain at home and not to go outside. An interviewed 14 year-old Rohingya boy said:

> When the chickenpox outbreak happened, then the community health worker came to us and provided some suggestions to be aware of the chickenpox. I behaved according to those suggestions and I have not faced any problems. But my friends did not follow the suggestions and three of them have been affected with chickenpox.

They were seen as 'untouchables' by the health service providers and even by their community members. One of the interviewed Rohingya parents of a five year-old child stated:

> When my baby was affected with chickenpox, I took her to the hospital. The doctors did not seem helpful, and examined my baby with a behaviour that was not good. My baby and I were treated like we come from a very dirty place or the doctors will be affected with chickenpox.

In compliance with articles 22 and 24(2) of CRC the state is bound to take 'appropriate measures' to combat disease and malnutrition (for instance, through access to clean drinking water and adequate nutritious food), also possibly developing and/or supporting programmes to ensure general immunisation and primary health care. In the case at issue, however, Rohingya people, especially the children, have come to this country with many health complications. The camp authorities have taken the necessary steps to support them in such a protracted displacement crisis by providing humanitarian assistance, but these steps have not been proven sufficient. Regarding the procedure for the delivery of health care services and the healthcare-seeking process, the community health workers have been selected from the Rohingya community so that they can make their own people aware about health concerns, because Rohingyas were not introduced to the medical facilities and often did not know such facilities, nor the process of treatment, while they were in Myanmar (where they depended on their traditional healing). One of the interviewed healthcare providers stated that '[t]he parents are not conscious about the management of diseases and health, and for this reason, they are unable to take care of their children's health'. Their inexperience continued after arrival in Bangladesh and the current situation has made them and their children even more vulnerable. As they are not familiar with the healthcare facilities, they have to adapt to such processes and gain awareness about health issues, especially children's health. One of the interviewed doctors stated: 'Rohingya parents do not have enough knowledge about the health of children. They do not want to come to us when their children become sick. They come to us when the situation becomes worse. The lack of awareness harms them a lot'. A further serious matter for concern is that there is only one community health worker available to provide services to approximately 650 Rohingya people in Camp 4.

## 7 Condition of healthcare services in the Rohingya camp

The scarcity of healthcare service providers and the pressure for the large number of patients in the healthcare centre have made the situation even more critical. According to the interviewed health officials, this pressure has increased day by day, with the result that it has become difficult to manage it and to provide the patients with proper services. Rohingya people have expressed objections regarding healthcare services. They have to wait a long time for check-ups, but when they get their appointment to go for a check-up, the doctors do not dedicate proper time to it, even when examining the children. In emergency cases they also have to ask permission from several authorities. The Rohingya father of an eight year-old child stated that, when his daughter had a sudden onset of severe pain in her stomach, he took her to the camp hospital for treatment and, after a 20-minute delay the doctor did the examination on her and provided a prescription in which the possibility of appendicitis was mentioned, advising him to take her to the district hospital by the name of Cox's Bazar government hospital. To get his daughter to the district hospital he asked permission from the CIC office, security forces and the camp management authority, a process that required much time in such a critical situation. He also faced two check posts on the way to Cox's Bazar, which took more time, and in the meantime his daughter fainted. After all f these formalities, when he reached the district hospital the doctors and nurses took a long time to start the treatment because of his identity as Rohingya. Although his daughter recovered from the appendicitis, they faced many problems to obtain the treatment.

This example reflects a practice in Camp 4 where the security process and the permission of the camp management – rather than the children's health protection – are the main concerns. This means that the Rohingya children's best interests in health care are not primarily considered in every decision or action regarding them, which is not in line with article 3(1) of CRC. As highlighted by the CRC Committee, to determine and assess the best interests of the child, the perspectives and views of the child should be taken into account along with the specific circumstances, including any vulnerabilities or protection needs that the child may have (CRC/C/GC/14: paras 48, 75). A child suffering from a certain medical condition or a disability is an example. A further critical point is that, after maintaining all processes and rules of admitting patients to the hospital, their medical services are being interrupted or delayed because of the identity of these children, who were introduced as 'Rohingya children'. As a result, their health conditions gradually deteriorate, while the state is bound to supervise the service providers, the staff, and also the suitability of the organisations that are supposed to offer health care, in compliance with article 3(3) of CRC. In practice, these children are deprived of

healthcare services and security due to the lack of proper action and/or supervision by the state.

Moreover, basic healthcare services are provided by international and national non-governmental organisations in the camps according to the system of referral to government hospitals in cases of emergency. However, government healthcare officials do not encourage formal or regular access by Rohingya refugees to the public healthcare system of Bangladesh. One of the interviewed officials stated: 'We do not want to refer them to the district hospital as they have to face several issues to get proper treatment in that hospital. We try our best to provide treatment within the camp.' Informational mistakes regarding treatment have also been discovered in the medical reports or prescriptions issued by the doctors of the healthcare centre in Camp 4. The interviewed health officials informed us that these types of errors were caused by the pressure due to the large numbers of patients as they have limited manpower and resources.

Therefore, it has become very difficult to provide healthcare services to Rohingyas in Bangladesh. One of the interviewed health officials stated:

> The Ministry of Health and Family Welfare, with the support from WHO, IOM, UNFPA, UNHCR and UNICEF, have done a mapping of the distribution of health services in the Rohingya camps. Around 210 health facilities have been identified in Cox's Bazar Refugee Camps. In this mapping, primary health centres, health posts and hospital for completeness and to assist in referrals planning have been mainly included. We have found that the distribution of health services result to be far from equitable due to limited land availability and poor road access, as well as that the health services provided to Rohingya people are not standardised.

## 8 Upholding the health-related rights of Rohingya children in view of the positions by Bangladesh, international monitoring bodies or other stakeholders

Interviewed health officials have identified some common physical health conditions of the Rohingya children, namely, high pervasive malnutrition and chronic malnutrition or stunting, prevalent among 60 per cent of the Rohingya refugee children in Bangladesh (Prodip 2017; Milton et al 2017; Mahmood et al 2017). New-born Rohingya babies suffer from low birth weight and poor nourishment, which continues throughout the lives of infants. Rohingya children suffer from poor nutrition and anaemia as a result of the lack of food diversity and proper counselling on nutrition by healthcare service providers (Prodip 2017; Tanabe et al 2017). Because of the inadequate coverage of vaccination, malnutrition, overcrowding, unsanitary conditions and lack of access to safe water, the prevalence of infectious and communicable diseases, such as respiratory tract infections, diarrhoea, skin diseases, measles and water-borne diseases, are high

among Rohingya children in Bangladesh (Hossain et al 2019). There are also psychological and social effects of the emergency, with thousands of children in need of urgent psychosocial care, the lack of which can impair a child's emotional, mental, social, and physical development (Word Vision 2018).

Our qualitative inquiry into Camp 4 illustrates that, for different reasons, the existing healthcare system does not ensure adequate protection of the health-related rights of Rohingya children. The standard of services has been questioned, as it is not adequate, also due to the lack of a child-care specialist. The system has been found to be a complicated process when Rohingya parents go for the treatment of their children. In addition, the lack of health information management and awareness among Rohingya parents and children during the whole treatment procedure hinders their health-related rights. Furthermore, Rohingya children and their families have to face the problem of identity at the time of their treatment in both the camp hospitals and district hospitals.

Our findings shed light on some health-related challenges from the perspective of children or their parents. Rohingya people, especially parents, generally are not aware of the health and health care of the children, including possible medical treatment, assistance and medicines, and cannot generate awareness among their own children. The factors behind this are the continuous displacement, the poor living circumstances, the limited access to healthcare services and system, which have resulted in poor health outcomes and violations of their rights. These factors work together interdependently, with basic policy and rights issues and, therefore, healthcare service accessibility and utilisation by Rohingya children and their families are exacerbated.

We previously addressed how under international law Bangladesh is bound to respect and protect the rights of asylum-seeking and refugee children, especially as a state party to CRC and ICESCR. In this context, it is worth considering the positions expressed by the CRC Committee and other UN bodies or relevant organisations as well as by the state, in dealing with the health-related rights of Rohingya children on its territory.

In its fifth periodic report submitted to the CRC Committee under article 44 of CRC in 2012, Bangladesh specifically referred to Rohingya refugee children by underlining, among other things, the following relevant aspects: children born in refugee camps were registered (14 867 children residing there at that time); all children aged between six to 23 months were brought under a blanket feeding programme; special care for improving the nutrition and therapeutic feeding programmes; children and their families had easy access to healthcare services inside the camps, also in the local and secondary medical facilities; community management and protection against violence was strengthened through

special management; regular awareness-building sessions were conducted to develop their understanding on the consequences of violence (CRC/C/BGD/5: para 286). However, in the context of the UPR of 2012, the UNHCR addressed the large number of Rohingyas living in Bangladesh without access to asylum procedures and refugee status determination, recommending to the state to consider the establishment of such procedures to identify those genuinely in need of international protection. The UNHCR further supported previous recommendations by the CRC Committee that Bangladesh provide the unregistered population from Rakhine State with 'at minimum, legal status, birth registration, security and access to education and health care services' (UNHCR 2012: 3-4). In its Concluding Observations of 2015, the CRC Committee welcomed the adoption in 2013 of a national strategy on Myanmar refugees and undocumented Myanmar nationals, which for the first time acknowledged that undocumented Rohingyas (many of whom are children) who are in Bangladesh have fled persecution and need humanitarian assistance. However, despite the decision to provide birth certificates to children born inside two refugee camps, the Committee expressed concern that refugee children born outside the camps did not have birth certificates and had limited access to basic services, recommending to the state to 'provide birth registration and access to basic rights, such as to health and education … irrespective of their legal status' (CRC/C/BGD/CO/5: paras 70-71). Regarding respect for the views of the child, it was also recommended that Bangladesh guarantee the active involvement of children in vulnerable situations, such as minority children and refugee children, in the preparation and implementation of laws, policies and programmes affecting them and have to give proper attention to the active involvement of refugee children (CRC/C/BGD/CO/5: para 33(b)).

In its 2018 national report submitted for the UPR, Bangladesh underlined that the realisation of its 'human rights commitments faced setbacks in the face of sudden influx of nearly one million forcibly displaced Myanmar nationals (Rohingyas) to Bangladesh' (UNHRC 2018a: para 3). As recently acknowledged by Professor Yanghee Lee (Special Rapporteur on the Situation in Myanmar), 'the people of Bangladesh have shown the world the definition of humanity as they continue, despite their own hardships, to host the Rohingya people'. Bangladesh also specified that its government 'has allocated 4 707 acres of land including forest areas to build the shelters for the Rohingyas' and has provided them with 'food, medical and WASH facilities, and other basic services'. It has also established '11 additional police check posts' to ensure the smooth distribution of relief and to maintain security of the Rohingyas. It has further deployed 'more than 1 200 law enforcement officials and 1 700 military personnel' in Cox's Bazar, besides building roads and other infrastructures in the district in order to facilitate timely delivery of humanitarian assistance to the Rohingyas (UNHRC 2018a: para 126). Bangladesh reportedly

conducted the biometric registration of all displaced Rohingyas living in its territory, also planning to issue documentation to the Rohingya children born in the country. It has provided full access to all international partners and agencies including UN, INGOs, humanitarian actors, the media and other civil society organisations to work in Cox's Bazar and support the Rohingyas. In this context, the government openly affirmed remaining 'sensitised about the rights of the Rohingyas', primarily the right to safe, dignified, voluntary return to their homes in Myanmar, and to that end concluded bilateral arrangements of return (UNHRC 2018a: para 127). Being mindful of the critical conditions for safe return, it negotiated 'to include *voluntariness, non-criminalisation, livelihood, resettlement, reintegration* and other universal elements of human rights in the bilateral return arrangements' and involved UN agencies (particularly the UNHCR) in the return process.

Nonetheless, critical considerations are included in the 2018 summary of 29 stakeholders' submissions on Bangladesh to the UPR. STEPS was concerned with 'the limited access to health for many Rohingya women and girls living with HIV/AIDS', and JS15 reported that 'many Rohingya new-born babies will perish if no action is urgently taken to ensure access to better hygienic conditions' (UNHRC 2018b: para 54). In addition, JS7, AI and NHRC reported that 'more than 500 000 Rohingya refugees live in Bangladesh without any protection, and are considered to be illegal immigrants'.[2] JS6 reported that since 25 August 2016 more than 60 per cent of the Rohingya refugees are children under 18, recommending to ensure that unaccompanied and separated children are reunited with their families, and to provide assistance to all vulnerable children in need.[3] In this case, JS7 urged the support of the international community (UNHRC 2018b: para 74). In the 2018 report prepared for the UPR by the Office of the United Nations High Commissioner for Human Rights, the UNHCR commended Bangladesh for its continuing efforts in view of the fact that as at 28 September 2017, more than half a million Rohingya refugees had arrived in Bangladesh and that the massive influx of people seeking safety had outpaced response capacities. Noting the lack of an 'institutionalised approach' for addressing the protection needs of asylum seekers and refugees, it recommended that Bangladesh develop a national asylum mechanism and enact national refugee legislation (UNHRC 2018c: paras 69, 72). The significant percentage of children in the Rohingya population that had fled to Bangladesh and the challenges in ensuring their rights have led to the recommendation that the state appoint an ombudsperson

2 Joint submission 7 (JS7) of the Institute on Statelessness and Inclusion (Eindhoven, The Netherlands), the Statelessness Network Asia Pacific (Selangor, Malaysia), Amnesty International (London, UK) and the National Human Rights Commission (Dhaka, Bangladesh).

3 Joint Submission 6 (JS6) of the Child Rights Advocacy Coalition in Bangladesh (CRAC, B), Dhaka (Bangladesh), Actionaid, Dhaka (Bangladesh), and Save the Children, London (UK).

for children (para 56). Moreover, children are more exposed to HIV if their parents are HIV positive, and the organisations must ensure children's health safety without showing any disparity, by removing the social stigma or the superstition. To eradicate the disparities in the process of health services, Bangladesh has to develop and implement policies to elevate health infrastructures (UNHRC 2018c: para 47).

As far as specifically ICESCR is concerned, in 2018 the UN Committee on Economic, Social and Cultural Rights (ESCR Committee) expressed deep concern for the fact that Rohingyas do not have legal status in Bangladesh, which limits their movement outside of the camps to access healthcare services and other basic services. It was also concerned about the safety and habitability of the shelters in the camps (such as Kutupalong and Nayapara) where the risks of landslides and flooding are high, and about possible outbreaks of diseases such as diphtheria and cholera, particularly in light of the imminent monsoon season (E/C.12/BGD/CO/1: para 27, citing articles 2(2) and 11 of ICESCR). In this regard, it was recommended that Bangladesh take effective measures to recognise the legal status of the Rohingya in order to guarantee 'their access to livelihoods, healthcare, particularly emergency medical treatment, education and other basic services provided outside of the camps'. Bangladesh was also advised to take necessary steps (with the humanitarian assistance of the international community) to ensure their safety and to protect against possible outbreaks of diseases such as diphtheria and cholera (E/C.12/BGD/CO/1: para 28). Further concern was expressed about the low birth registration rate, despite significant improvement, because it has had the effect of limiting the access of refugee children to healthcare services, social security benefits and other basic services. In this regard, Bangladesh was recommended to intensify its efforts to register the Rohingya refugee children born and living in the country (E/C.12/BGD/CO/1: paras 47-48, citing articles 9-14 of ICESCR).

## 9 Concluding remarks

In the current world, Rohingyas are among the most oppressed and ill-treated minority communities. They have had to take shelter in the makeshift camps of Bangladesh to escape discrimination, violence and persecution in Myanmar. Due to such displacement, they are living a life without any ray of hope. Bangladesh should seriously consider acceding to the 1951 Convention and its 1967 Protocol, and urgently elaborate a national legal and institutional framework to advance an effective and adequate protection mechanism for coping with the multiple issues (including healthcare issues) affecting them, also clarifying the functions and responsibilities of national actors (that is, government, the judiciary, the National Refugee Commission, the Human Rights Commission, and so forth) as well as coordination and cooperation with international and

regional actors. In any case, as party to several human rights treaties, Bangladesh is already bound to safeguard the basic rights and dignity of the Rohingya people residing in the camps in its territory. In particular, CRC enjoins it to ensure appropriate protection and humanitarian assistance to Rohingya children, with measures to be tailored to their specific vulnerabilities and developmental needs, in order to enable them to enjoy their rights in the existing circumstances of critical health, safety and security.

Healthcare services and benefits are crucial for every human being, particularly for children, but, like other factors, there are many conditions involved in providing and receiving such services. Our analysis of Camp 4 illustrates that for different reasons the existing system struggles to secure Rohingya children's ability to enjoy their health-related rights. In this regard, regrettably the concepts of 'nation', 'state' and 'identity' have acquired relevance: when providing emergency medical assistance and healthcare, the origins and identity by which they are known (such as 'forcibly-displaced Myanmar nationals', 'Rohingya', 'refugee', 'inhabitants of Rakhaine State') have been specifically considered, and such an approach has been undertaken in and outside the camp.

Arrangements have certainly been made for health services along with other basic needs when Rohingya people came out of their country of origin with empty hands. Since their movement has been strongly restricted, everything has been arranged inside the camp concerned. In the case of health care, doctors and medical staff provide services inside the camp, but there is no arrangement to provide emergency and necessary services apart from a few pre-determined services. Similarly, there is no specialist doctor for children. If they have to go to the government hospital in the case of critical medical conditions, they have to undergo several fixed referral arrangements, which is complex in nature. No matter how severe the conditions may be, the process does not allow any exceptions.

Although the Bangladesh government, along with the support of the UNHCR and other partner organisations, has tried to provide necessary assistance in the healthcare sector for Rohingya children, they have been suffering from a lack of funds and resources as well as coordination. The health-related rights of these children have been compromised mainly because of the complex healthcare system in place and Rohingyas' lack of knowledge about health and health care. We suggest that sustainable solutions to safeguard them can be found only if the relief system, healthcare services, healthcare procedures and related conditions work together effectively, because they are all interrelated. If a single component does not function well, then the affected rights cannot be secured and children's unhealthy living conditions in the camps are aggravated. In this vein, healthcare services should be intensified and be more accessible.

Community health workers should be effectively trained to guarantee adequate health and hygiene promotion, also undertaking home visits. Information should be amply provided to these children and their parents or other relevant caregivers; mental health service in primary health care settings should be increased. A prompt response against disease outbreaks is needed and reliable health statistics are vital, and therefore organisations should give more consideration to data collection and dissemination. At the same time, more collaboration among the government, private sectors and partner organisations is needed.

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