Ensuring Healthcare Rights for Rohingya (FDMN) in Bangladesh: An Empirical Observation

Wakila Hussain[1], Abtahee Mohammad Taha Tulukder[2]
& Shawline Jahan Shefa[3]

Abstract

The Rohingya crisis, an ongoing humanitarian challenge in Bangladesh, has created critical difficulty in ensuring adequate healthcare for the Rohingya (FDMN) owing to Bangladesh's commitments under several international legal instruments that require Bangladesh to uphold healthcare rights for everyone within its territory, including FDMN residents. However, neither the existent national legal instruments nor the existing literature has specifically addressed the issue of ensuring their healthcare rights. Bangladesh, not being a party to the Convention Relating to the Status of Refugees of 1951, has been reluctant to secure their legal healthcare rights, and the extant studies do not address the state of healthcare access for FDMN from a legal perspective, especially in the post-pandemic period. This study aims to examine the effectiveness of legal frameworks at both the national and international levels in implementing healthcare rights for forcibly displaced Myanmar nationals (FDMN). Employing a mixed-methods approach, the research involved conducting key informant interviews (KII) with stakeholders and administering surveys to gather insights into the healthcare experiences of FDMN. The key findings highlight the repercussions of the lack of specific national legislation in ensuring healthcare rights for FDMN in Bangladesh and suggest actionable strategies to improve healthcare access for this vulnerable population.

Keywords: Episodic & Thematic Framing, Crisis frames, Ukraine crisis, Bangladeshi Newspapers

1. Background of the Study

The healthcare challenges faced by forcibly displaced Myanmar nationals (FDMN) in Bangladesh reflect a critical intersection of legal, humanitarian, and socio-economic complexities. Despite the global commitment to "leaving no one

[1]Lecturer, Department of Law, Bangladesh University of Professionals.
[2]Department of Law, Bangladesh University of Professionals.
[3]Department of Law, Bangladesh University of Professionals.

behind," the lived realities of FDMN in the Cox's Bazar camps expose glaring gaps in the implementation of healthcare rights, challenging both international frameworks and Bangladesh's capacity to respond. This study emerges from an urgent need to explore these gaps and identify pathways toward more effective and inclusive healthcare delivery for this vulnerable population.

Bangladesh has historically shown remarkable compassion by accommodating successive waves of Rohingya refugees, beginning with the first wave in 1978 (Faisal and Ahmed, 2022). However, the influx reached unprecedented levels after the Myanmar military's violent

crackdown in October 2016, after the Arakan Rohingya Salvation Army (ARSA) killed nine police officers (Goodman and Mahmood, 2019). This resulted in widespread displacement and human rights violations. Today, Cox's Bazar in Bangladesh hosts nearly 975,350 FDMN, making Kutupalong the largest refugee camp in the world (Rohingya Refugee Crisis Explained, 2023; Siegfried, 2022). This humanitarian crisis has strained Bangladesh's already limited resources, particularly in the provision of healthcare. Although Bangladesh is not a party to the 1951 Convention Relating to the Status of Refugees (Sejan, 2022; Rohingya Response, 2024) or its 1967 Protocol (Sabuj, 2024), it is bound by several international legal instruments, such as Article 25 of the Universal Declaration of Human Rights (UDHR) and Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR), which enshrine the right to health for all individuals within its jurisdiction, irrespective of nationality (Nunes et al., 2017). Nevertheless, the absence of specific national legislation leaves the healthcare rights of FDMN inadequately addressed, further compounding their vulnerability.

Prior research underscores that healthcare access for FDMN is fraught with challenges, including resource shortages and systemic barriers (WHO's Transformative Initiative, 2024). During the COVID-19 pandemic, for instance, 30% of older Rohingya reported difficulties in obtaining medicines (Mistry et al., 2021), and 61.2% of the population experienced post-traumatic stress disorder (Desk, 2024). Another study revealed that 44% of households faced or anticipated problems accessing healthcare services (Limited, 2023).

However, the studies that explored the dynamics of their healthcare rights and access were conducted before and during the COVID-19 pandemic, and primarily focused on either the humanitarian aspects or the pandemic's immediate impact, leaving the legal dimension of healthcare rights largely unexplored. This paper seeks to fill this critical gap by examining the interplay

between healthcare access and legal obligations, in the context of FDMN camps in Cox's Bazar. By situating this issue within the broader framework of international law and state practices, this study aims to contribute an empirical understanding of the legal and practical challenges involved in ensuring healthcare for one of the world's most vulnerable populations.

2. Problem Statement

The Rohingya (FDMN) reside stateless in Bangladesh, and although Bangladesh has demonstrated a willingness to offer humanitarian aid, the status and adequacy of their healthcare access remains questionable. The current national legal regime does not have explicit safeguards that guarantee the healthcare rights of the Rohingya, and the national policy framework does not entirely align with international obligations. Furthermore, limited resources within this densely populated country pose hurdles for implementation. The study intends to assess the discrepancies and gaps between policies and the practices of providing healthcare services to the Rohingya community using the data collected from different stakeholders. To achieve that, *firstly,* the study explores the national and international legal and policy framework related to the healthcare rights of the Rohingya (FDMN) in Bangladesh; *secondly,* the study scrutinizes the effectiveness of existing legal and policy framework in implementing the healthcare rights of the Rohingya (FDMN) in Bangladesh; and *finally,* investigates the correlation between these access barriers and the health outcomes of the Rohingya (FDMN) in Bangladesh.

3. Literature Review

Joardar *et al.* (2020) highlighted that FDMNs are suffering from different communicable and non-communicable diseases and mental health problems in the camps. They were compelled to leave their homeland after witnessing numerous outbreaks of violence even, including murder, torture, and sexual offenses. These traumatic events resulted in various mental health problems and emotional distress. Among them, anxiety and depression affect 84%, and PTSD affects 61% of the population of the FDMN community living in Bangladesh. Such mental health problems continuously impact their functional capability and also physical health problems.

On the other hand, Rahman *et al.* (2020) showed that most of the respondents from the Rohingya community do not have basic health literacy or common treatment knowledge regarding communicable diseases like diarrhoea. The survey conducted in November-December 2017 revealed limited access of the Rohingya community to primary and preventive care, as well as obstetric care, and a high rate of injuries and assaults.

Gupta, Zaman, and Begum (2020) commented that insufficient access to medicines and hospital facilities is a significant obstacle to the well-being of this community. Psychological distress, lack of trust, inadequate facilities, and poor sanitation impede community resilience efforts and impact their adherence to health directives. The authors added that the highly corrupted relief distribution system resulted in malnutrition and held the government responsible for inadequate healthcare services and disease outbreaks. In agreement with the author, (Rawal *et al.*, 2021) emphasized that overcrowded living conditions and insufficient healthcare facilities constantly worsen the severe health crisis faced by the FDMN population. The camps are highly congested, leading to poor sanitation and a heightened risk of communicable diseases. This situation has been further worsened by inadequate water supply and hygiene facilities, increasing the incidence of waterborne diseases. Access to healthcare is limited, with a severe shortage of medical professionals and supplies. Health services are primarily dependent on humanitarian aid, often insufficient to meet the growing needs of the refugee population.

Riley *et al.* (2020) also examined the challenges faced by FDMN in accessing treatment facilities. They revealed that fungal infections are the most common in the camps, and females above 15 years get infected almost twice as many as males. This paper concluded that children are the worst sufferers here; their exposure to violence and traumatic events not only impacts their current mental health but also instigates them to indulge in future violent acts. Statistics show that over half of children aged 2-16 years' experience abnormal emotional symptoms.

Similar results were found by Khan *et al.* (2019), who also derived that FDMN children suffer from a lack of vaccination, poor education, malnutrition, etc., resulting from a lack of initiative from the government. FDMN children and women need extra healthcare, safety, and nutrition because of their long history of deprivation. Pregnant Rohingya women reported lower rates of dietary diversity and malnutrition compared to non-pregnant women. Underweight women made up 7.6% of the population, but undernourished pregnant moms made up 26.7%. Women's dietary diversity scores were low for 46% of expectant mothers and 63.8% of non-pregnant women. Children who have experienced trauma are largely ignored when it comes to mental health services.

Azad *et al.* (2022) further researched Rohingya (FDMN) and found that the population is unwilling to follow family planning as instructed by District family planning authorities. While a portion believes that using contraceptives is anti-religious activity, a big chunk of the population also thinks a large family will

help them survive and benefit financially. Superstitions and lack of education hinder the awareness of FDMN women regarding family planning. *Islam and Habib* (2024) also showed in a study conducted on 400 female FDMN participants that around 60% of FDMN women hold the misconception that permanent birth control causes physical harm, while two-thirds of them have the idea that it is under the authority of a husband. 40% consider this a subject of embarrassment, and 58% refrain from the use of contraceptives in the hope of having male children.

Islam and Nuzhath (2018) found that the health risks of FDMN are increasing day by day, which is a significant violation of their human rights. The paper suggested that to improve the quality of health services, the government of Bangladesh should produce and distribute financial resources in cooperation with national and international organizations. Nasar *et al.* (2023) explained that the role of NGOs and INGOs in protecting the right to get health services is excellent. Bhatia *et al.* (2018) showed that the World Health Organization specifically addressed the right to health under various international laws for women, children, persons with disabilities, migrants, and persons living with HIV/AIDS. There are obligations and responsibilities of states and others to uphold their rights. A monitoring mechanism is needed for states to be held accountable at national, international, and regional levels for violating the right to health.

If we compare the studies on refugees conducted in neighboring countries, Nakam *et al.* (2005) show that the situation of maternal and childcare for refugee women in New Delhi, India, is not as bad. Women can access hospital deliveries after getting official refugee status in New Delhi. Healthcare providers at clinics in Delhi offer contraceptives like sterilization, Copper-T (IUD), condoms, and oral pills, often for free, but even here, refugee women are mostly not interested in using contraceptives. He observed an insufficiency of gynecologists to ensure adequate treatment for women suffering from tract infections and menstrual and infertility issues. Although healthcare facilities are better, intrauterine mortality in Afghan refugees persists, though the healthcare conditions have improved. Myanmar women are more open about their reproductive health than Afghan women who need to seek medical care. Burns and Piorotti *et al.* (2000) also focus on the importance of the reproductive rights of refugees. Due to unstable environments and cultural barriers, both men and women refugees are not interested in using contraceptives; traditional birth attendants must be involved to address these challenges to address reproductive health. Parmar *et al. (2014) reported that free healthcare* facilities are provided to the Burmese refugees by The Indian Government, supported by UNHCR. Although no designated refugee

law exists in India, the government still hosts the refugees and ensures they have the required treatment facilities.

Freedman, L. Crankshaw, M. Mutambara, *et al. (2020) show that* refugees in South Africa face difficulties in getting sexual and reproductive health (SRH) care. Due to language barriers and knowledge insufficiency, they do not get proper treatment. Sometimes, they are denied care if they cannot show appropriate documents. Refugee women face high risks of maternal death, unsafe abortions, and exposure to diseases like HIV.

However, the literature in both Bangladesh and neighboring countries fails to discuss the legal scope and obligations regarding the healthcare access of refugees and Rohingya (FDMN) in the context of Bangladesh. The gap between international and national policy frameworks and their implications remains absent, resulting in non-coherent systematic development of the healthcare system for marginalized and vulnerable groups. Moreover, the literature does not include the present scenario of the health status and healthcare facilities of FDMN, and most of the studies date back to the COVID-19 pandemic timeline. This paper endeavors to mitigate this gap post-pandemic and highlight their access to health services in 2024 from a legal perspective.

4. Research Methodology

4.1 Research Approach: To satisfy the objectives of this research, the study has adopted a multi-sited mixed method approach to first explore the existing legal and policy framework that administers health care rights of Rohingya (FDMN) in Bangladesh and outline the national obligations of Bangladesh under the international legal regime. Next, an extensive qualitative study was carried out to narrate and synthesize the lived experiences of concerned individuals through an in-depth reflective inquiry, and the sampling, data collection methods, and analysis were guided accordingly.

4.2 Research Method: A three-stage, mixed-method approach is pursued for this study. *In the first stage,* primary and secondary data and archived studies like relevant laws, policies, rules and regulations, notifications, books, journals or articles, newspaper articles, case laws, and reports have been thoroughly studied to develop contextual and descriptive analysis. This study and analysis identify the present legal regime on health care rights of Rohingya (FDMN) in Bangladesh and the legal voids, loopholes, and potential development sectors. Secondary data analysis is also used to analyze the nature and status of healthcare rights from an international human rights perspective. *In the second stage,* semi-structured key informant interviews (KII) were carefully carried out and

interpreted to develop an insider perspective of the stakeholders on the service provider end. The participants are considered experiential experts, and their stories are presented in contingence to social and structural factors to understand their experiences and to determine their requirements to be facilitated by this policy critically. *In the third stage,* open-ended survey questions were asked to Rohingya (FDMN) participants to analyze their current status of health care access, barriers, and demands.

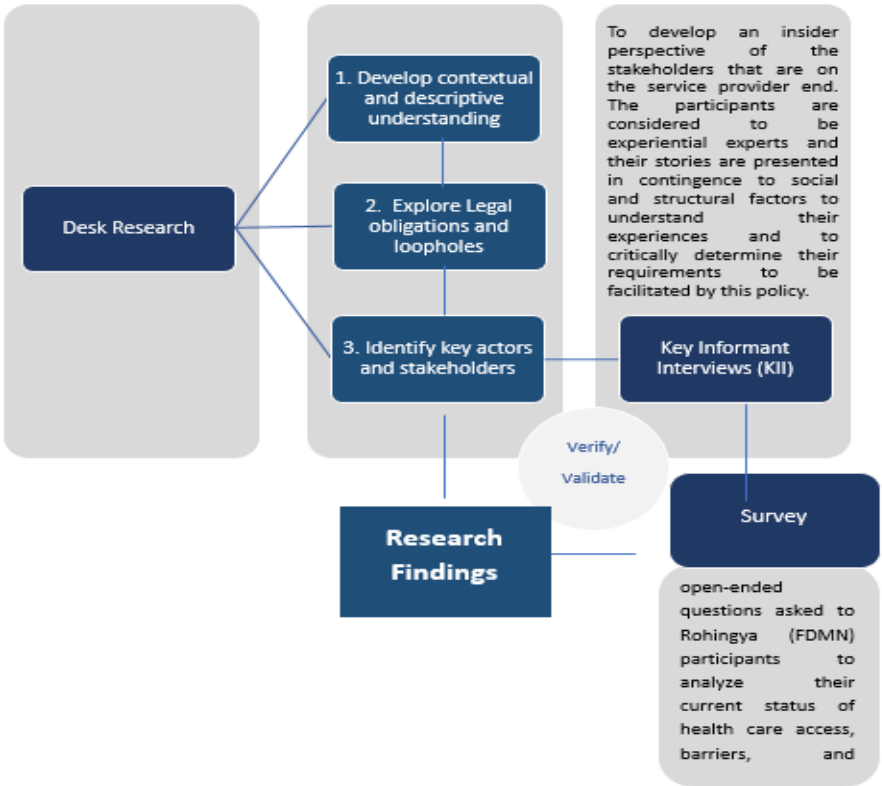


Figure 1

4.2.1 First Stage: Desk Research

It involves the systematic review and analysis of existing scholarly articles, reports, and other materials, also known as secondary research. Desk research allows this study to gain an extensive understanding of the current legal framework, scholarly debates, and policy implementations.

The most relevant articles that align best with the objective and scope of this research were chosen for the literature review. From 120 journal articles determined for initial review, 58 articles published in high-quality Q1 and Q2 journals were mainly focused. The selection criteria were based on their direct relevance to the research objectives, and the rest were excluded due to their divergence from the core focus of this study. The selected articles were thoroughly analyzed and synthesized to identify gaps in the existing literature and were crucial in formulating the research questions for this study.

In addition, a rigorous review of existing laws and policies was conducted regarding the healthcare rights of the Rohingya (FDMN). National and international legal instruments, the government's strategic plans, and the treaty committees' general comments (see legal and policy framework) were analyzed. It provided a critical context for understanding the adequacy of current legal frameworks in ensuring healthcare to Rohingya (FDMN) and for identifying the areas where legal reforms may be necessary.

4.2.2 Second Stage: Key Informant Interviews (KII)

A total of 17 semi-structured Key Informant Interviews (KII) were conducted in this stage. The semi-structured interviews allow flexibility in probing and obtaining in-depth insights, ensuring that all key topics are covered (Omolola A. Adeoye-Olatunde and Nicole L. Olenik, 2021). These were held in Kutupalong camp, camp 7, the office of the Refugee Relief and Repatriation Commissioner (RRRC), and the offices of various NGOs and INGOs. The participants, who provided their invaluable insights, had expertise in their respective backgrounds, such as government officials, journalists, advocates, and representatives of NGOs and INGOs.

4.2.3 Third Stage: Survey

A survey is a research method to collect data from a defined group of participants to gain information and insights on various topics (Ponto, 2015). Open-ended questions were administered to Rohingya (FDMN) participants for conducting a survey. Since open-ended questions allow participants to provide detailed responses with more profound perceptions of their experiences (Hansen and Świderska, 2023), it facilitates a comprehensive understanding of the current status of healthcare access, the barriers they face, and the healthcare they need.

4.2.3.1 Sampling Strategy: The snowball sampling strategy was adopted in this study, which begins with selecting initial participants, often referred to as "seeds" (Valerio *et al.*, 2016). These initial participants were interviewed or surveyed to

gather data and were subsequently asked to refer others from their social networks (Heckathorn, 2011). This strategy proved helpful because the target population, particularly Rohingya (FDMN), was vast and complex to reach, such as women. Conventional sampling methods, like random sampling, would become impractical. The target population of this study comprises several groups of individuals and stakeholders, namely, Rohingya (FDMN) residing in Kutupalong camp (registered camp) and camp 7 (unregistered camp), government officials, healthcare providers, representatives of several NGOs and INGOs, and host community.

4.2.3.2 Sample Size: The study involves 135 participants, including Rohingya (FDMN) and other stakeholders. The majority of the participants, 116 individuals, are Rohingya (FDMN), who are over 18 years old and comprise 85.9% of the total participants. The rest of the participants include three government officials (2.2%) from the Refugee Relief and Repatriation Commissioner (RRRC) and Camp-in-Charges (CIC), seven representatives from NGOs and INGOs (5.2%), four healthcare facilitators (3%), two advocates (1.5%), one journalist (0.7%), and two members from the host community (1.5%).

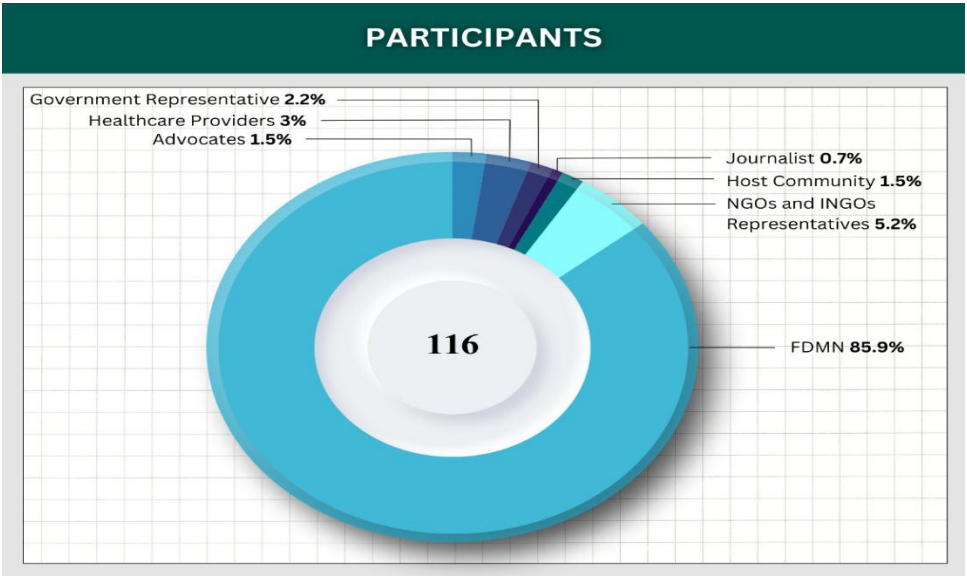


Figure 2

Among the 116 Rohingya participants, 106 are males and 10 are females, representing 91.4% and 8.6%, respectively.

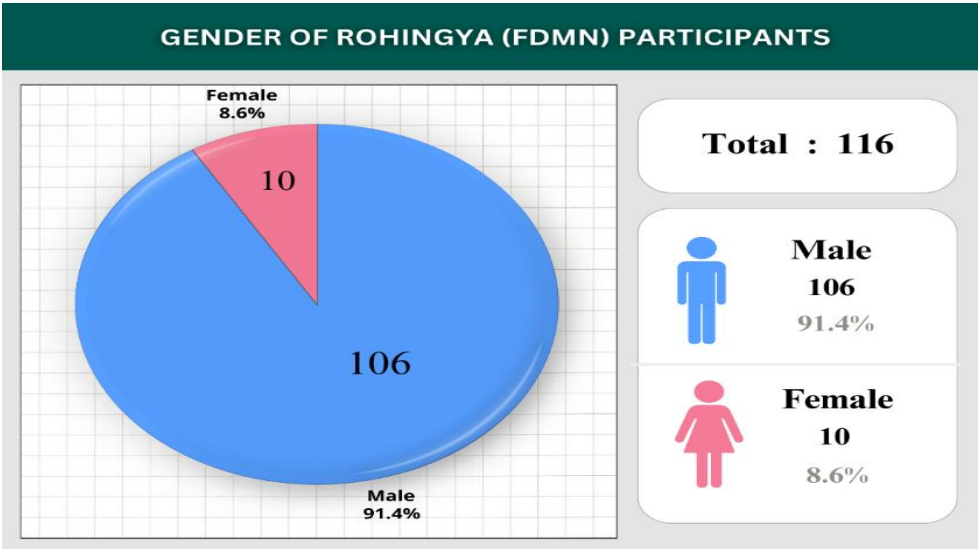


Figure 3

4.3 Data Analysis:

In the desk research stage, a thematic analysis was conducted to identify gaps in the existing literature. It facilitated the design of the Key Informant Interviews (KII) questions, which ensured the interviews were focused and relevant. The interviews of the stakeholders were meticulously transcribed, and later on, another thematic analysis was performed on the transcripts. It helped the development of questions for a subsequent survey, assuring that the study would address leading issues extracted from the interviews. All collected data were verified and validated thoroughly to ensure the accuracy and reliability of the findings.

4.4 Ethical Considerations:

The utmost consideration has been given to avoid any negative repercussions from the research. Ethical Standards have been rigorously applied during data collection and preservation. Throughout the study, the researcher has been critically concerned about unanticipated ethical issues arising from its sensitive and qualitative nature. Information consent was obtained before interviews and surveys were conducted, retaining the appropriate formal code. In both interviews and survey stages, every respondent was given enough time to give their consent and ensure they could truly reflect their views in their answers.

Confidentiality has been ensured strictly by anonymizing sensitive Data. Responses recorded in the native language have been translated with caution.

5. Legal and Policy Framework

Different legal instruments ensure all human beings' right to get health services. Section 23 and section 24 of the Refugee Act 1951 highlighted a refugee's right to access the health services provided by the states to prevent their sickness. Regarding medical care, Refugees should receive the same treatment as nationals. Rohingya (FDMN) are forcefully displaced from their own country, but they did not get official refugee status in Bangladesh (Bhatia *et al.*, 2018). As a result, the right to get health care under the Refugee Act is not applicable for FDMN.

However, under customary international law, Bangladesh is bound by certain obligations to ensure the right to healthcare for everyone within its jurisdiction, including FDMN (Wali *et al.*, 2018). Universal Acceptance**,** Indispensability, state practice, and opinion juris make the health care rights customary international law under jus cogens universally recognized norms. These norms are binding on all states (Handayani, 2019). Bangladesh is a party to several international treaties the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social, and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC), and the Convention on the Rights of Persons with Disabilities (CRPD) impose obligations to their member states to ensure their health care rights. The obligations of those treaties have become customary law in this modern era. So, Bangladesh does not need to incorporate those treaty obligations into their domestic law to ensure health care rights for all, including FDMN.

The Universal Declaration of Human Rights (UDHR) has a customary international law status because it is widely accepted in state practice and opinion juris (Hannum, 1998). **Article 25** of the UDHR ensures the right to livable standards**,** including essential services (Hannum, 1998).

The International Covenant on Economic, Social, and Cultural Rights (ICESCR) and its optional protocol are part of the International Bill of Rights, including labor rights, the right to health, education, and an adequate standard of living. Bangladesh ratified ICESCR in 1998, along with some other instruments, to recognize its constitutional commitment to human rights. **Article 12** ICESCR ensures a livable life for everyone, and the state is bound to identify physical and mental health standards for all. States parties to the covenant have to make provisions regarding the child's development and take measures to decrease the

infant mortality rate. Besides, epidemic, endemic, occupational, and other diseases have to be prevented and controlled by adopting medical measures.

According to the General comment no. Thirty-six of the UN Human Rights Committee, the state parties have an obligation to protect the right to life by taking adequate measures and ensuring effective health service and health care for everyone residing in the state. It means without access to health service, the right to life cannot be ensured.' (Point 26).

The International Covenant on Civil and Political Rights (ICCPR) is a key international human rights treaty. Historically the state obligation to enforce civil and political rights is a negative obligation in nature. ESC rights are no longer included in the state's positive human rights obligations but are classified as "private needs." The right to get health care access is one of the private needs. That's why direct provision regarding the right to health care is absent in ICCPR. Right to life, as stated in article 6 of ICCPR, states that every human being has the right to health as their human right, which is being protected by laws. The State party has an obligation to protect this right. But there is a link between The Right to Life and the Right to Health. As health became a public concern, public perceptions about health evolved. Without ensuring health services, standard life insurance is impossible (Islam, 2022). So, the right to health is recognized by the International Covenant on Civil and Political Rights (ICCPR) alongside other rights, including the right to equality and life (Islam, 2022). ICCPR recognizes every human's right to life, including health care. That's why Rohingya FDMN is entitled to health services to ensure its standard of living. So, Bangladesh, as a party country of ICCPR, has an obligation to provide standard health services to all, including the Rohingya FDMN.

Bangladesh is a state party to the **Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),** ratifying it in 1984 (Afrin, 2017). It is a widely accepted international human rights treaty that promotes equal rights for women and seeks the state parties to eliminate all forms of discrimination against women for that purpose (Khanna and Kimmel, 2016). CEDAW applies to all women in the world irrespective of their nationality, including refugees and stateless women (CEDAW Committee, 2011). Article 12(1) obliges the state parties to take steps to eliminate discrimination against women in healthcare. The steps include ensuring equal access to healthcare services for women as men. This provision also covers equality in accessing family planning services that reflect the importance of reproductive health. The same article addresses the health needs of women related to pregnancy and childbirth. It also obliges state parties under Article 12(2) to provide appropriate

healthcare services to women. It also emphasizes adequate nutrition during pregnancy and lactation. As noted in the CEDAW General Recommendation No. 24, women residing within the jurisdiction of a state, such state should ensure their nutritional needs (Committee on the Elimination of Discrimination Against Women, 1999). The said General Recommendation also provided that if a healthcare system does not provide services to prevent, detect, and treat illnesses specific to women, measures to eliminate discrimination against women are deemed inappropriate (Committee on the Elimination of Discrimination Against Women, 1999). It specifically addressed the women who were refugees and had been caught amid the armed conflict, such as the FDMN community, and recommended the state parties provide them with trauma treatment and counseling.

Convention on the Rights of the Child (CRC) is also a customary international law (Supaat, 2014) that outlines the rights and protections of all children worldwide. It was adopted by the United Nations General Assembly in 1989 (Silva *et al.*, 2016) and entered into force in 1990 (Mezmur, 2023). Bangladesh signed and ratified this convention in the same year (National Human Rights Commission, 2015). As Article 1 specifies, it applies to all persons below 18 years old, meaning adolescents (Desmet, 2012). Article 3 establishes the fundamental principle that the child's best interests must be a primary consideration in all actions concerning children (Goldhagen *et al.*, 2016). Article 3(3) provides another obligation that state parties must ensure that all institutions, services, and facilities are responsible for the care and protection of children, particularly regarding health. Article 24 is focused on providing the right to enjoyment of the highest attainable standard of health and access to healthcare services for every child. It includes physical, mental, sexual, and reproductive health (UN Committee on the Rights of the Child, 2013). This provision contains a detailed embellishment of the measures that the state parties must take to implement their obligations under this convention. Article 24(2) mandates that state parties take specific measures to ensure necessary healthcare, combat disease, and malnutrition by utilizing available technology and providing sufficient nutritious foods and clean drinking water. This convention also includes the rights of children with disabilities. Article 23 emphasizes the importance of special care and support for them, including healthcare services.

Convention on the Rights of Persons with Disabilities (CRPD) was adopted by the United Nations in 2006 (Kanter, 2022). However, it came into force in 2008 (Series, 2015). Bangladesh ratified it in 2007 (Nuri *et al.*, 2022). This convention aims to protect the rights and dignity of persons with disabilities by promoting their full and equal participation in all aspects of society, including

health. Article 25 of this convention provides a complete formulation of the health rights of persons with disabilities (Pavone, 2017). It states that they are entitled to the highest possible standard of health without facing discrimination due to their disability. The state parties must implement all necessary measures to guarantee their access to health services sensitive to gender differences. Moreover, the same healthcare services must be available to others, ensuring no difference in the quality or standard of care, including sexual and reproductive health and public health initiatives. This provision also requires state parties to offer specialized health services addressing specific needs arising from disabilities. It seeks to safeguard persons with disabilities from being denied necessary health care, services, or sustenance due to their disability.

There are existing FDMN people living in the camps who are disabled. The Government of Bangladesh, a state party to this convention, is under the obligation to ensure their right to health, though they are not accepted as refugees. The convention obliges the state parties to implement these rights for every individual residing in those countries. As such, the Rohingya community can get these rights from Bangladesh.

Bangladesh also adopted a particular strategy and plan for redressing the health issue of Rohingya (FDMN) who reside in Bangladesh. **The Health Sector Strategic Plan 2023-24** is adopted to address the healthcare system issues in several aspects, such as service delivery, human resources, medical commodities, financing, etc (Health Sector Cox's Bazar, 2022). It is designed in response to a lengthened crisis to reduce mortality, morbidity, and disability and promote the overall health of FDMN and host communities. Two strategic objectives have been adopted to achieve the goal. The first one is to strengthen the capacity of the health system for effective and efficient delivery of quality healthcare, while the second one is to ensure that essential healthcare services are equitably accessible at all levels. The strategic plan has provided many directions that must be implemented to fulfill the objectives. Some of the significant directions are deploying adequate staff who are qualified, training them on the humanitarian code of conduct, advocating for health funding, implementing health cards, working on communicable and non-communicable diseases to prevent, treat, and counseling, ensuring access to health impartially for all, monitoring the health sector performance, and so on.

Another plan is **the Nutrition Sector Multi-Year Strategy 2023-2025,** which the government has formulated through consultations and participation of key stakeholders, such as the United Nations Children's Fund (UNICEF), World Food Programme (WFP), Bangladesh Rural Advancement Committee (BRAC),

etc. (Nutrition Sector Cox's Bazar, 2023). The Nutrition Sector provides essential nutrition services to the FDMN and host communities. The main target groups are children of 0-59 months, adolescent girls, and pregnant and lactating women. There are seven strategic objectives contained in the strategic plan. These include ensuring nutrition for those main target groups and others, detection and treatment of acute malnutrition, response to emergencies, research, monitoring, and evaluation of nutrition services. The strategic plan facilitates providing essential nutrition to the FDMN and host communities.

Besides, **SRH Working Group's Strategy on Family Planning for the Forcibly Displaced Myanmar National (FDMN) Humanitarian Crisis 2022-2025** works as a guiding framework for Sexual and Reproductive Health (SRH) partners who are engaged in humanitarian efforts, particularly in family planning (Ministry of Health and Family Welfare, 2022). It has been developed to guarantee that family planning services are accessible and voluntary for all members of the Rohingya and host communities through the SRH Working Group. Mentioning several reasons for disregarding contraception among FDMN and host communities, it has documented three strategic objectives for the successful and sustainable implementation of the family planning program. Those objectives are the community-based, facility-based family planning intervention and the advocacy in favor of it. These aim to reduce social stigma, superstition, and myth relating to family planning and to increase the practice of using different methods. Various key activities have been laid down to fulfill the purpose. The strategic plan also contains a monitoring mechanism to ensure the scheme's proper implementation.

In addition, **the Relief and Repatriation Commissioner (RRRC)** is a Bangladesh government agency responsible for providing relief to FDMN and repatriating them to Myanmar. RRRC always takes need-based policy to ensure the health service for Rohingya in FDM since the FDMN community has started living in Bangladesh camp. RRRC claimed that they provided a dignified and safe life for FDMN till their repatriation to Myanmar. They supervise food security, nutrition, and health services. RRRC has made options for FDMN to choose the supervising each family over 27 dry and fresh food items at WFP outlets throughout the camp. They provided a Nutrition supplement for severe Acute Moderate acute malnutrition. They have a fixed treatment process and different treatment centers, health posts, and hospitals with more than sufficient doctors, nurses, and other health care providers. The National Committee for the Coordination, management, law, and Order of the FDMN Camp, the National Task Force, and the Executive Committee for the Coordination, management,

law, and Order of the FDMN Camp are the government supervision for ensuring the rights of FDMN.

Moreover, Article 32 of the constitution of the Republic of Bangladesh states that every person is entitled to the protection of life and personal liberty by law. That means our constitution does not permit any person's deprivation of life and individual freedom. The decisions of different case laws have already established that the right to life includes the right to health care by developing constitutional transplantation. FDMNs do not get citizen status from Bangladesh. But the constitution of Bangladesh guarantees every person's right to health. So, till the time that repatriation is possible, it is the constitutional obligation of the state to protect their health care rights to ensure their right to life. Article 18 also upholds the necessity of healthcare infrastructure to meet the medical needs of all, and the state has an obligation to provide accessible and affordable medical services. Bangladesh recognizes medical care as a basic necessity of a person under Article 15 of the Fundamental State Policy of the Constitution. Though positive enforcement of Article 15 is not possible, it holds the spirit of the Constitution. So, without fulfilling necessities, how we enforce the right to life is a big question. From the constitutional perspective, Bangladesh must ensure the FDMN's right to access health care properly.

Category of Rohingya (FDMN)	International Policy	National Policy
Female	UDHR, ICESCR, ICCPR, CEDAW	i. Articles 15, 18, 32 of the Constitution of the People's Republic of Bangladesh. ii. Need-based policy by RRRC. iii. Health Sector Strategic Plan 2023-2024. iv. Nutrition Sector Multi-Year Strategy 2023-2024. v. SRH Working Group's Strategy on Family Planning for the Forcibly Displaced Myanmar National (FDMN) Humanitarian Crisis 2022-2025.
Children	UDHR, ICESCR, ICCPR, CRC	
Disabled Person	UDHR, ICESCR, ICCPR, CRPD	
Male	UDHR, ICESCR, ICCPR	

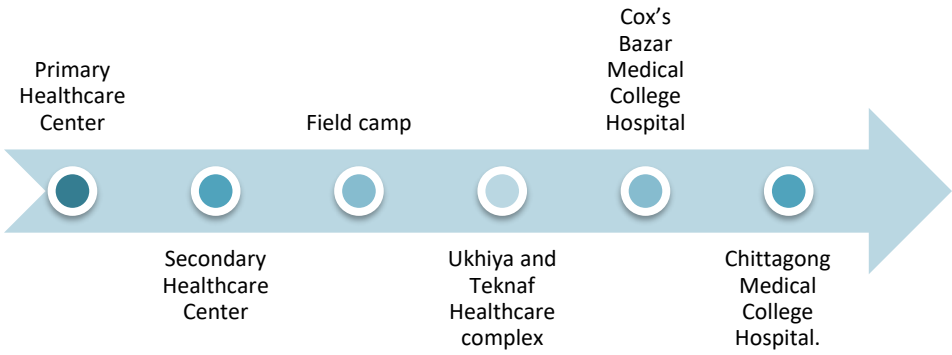
This chart shows the international and national policies ensuring that FDMN men, women, children, and persons with disabilities residing in Bangladesh have the right to access healthcare.

6. General Discussion

Ensuring health care facilities for Rohingya (FDMN) is a legal obligation and a moral duty driven by values like compassion and empathy. According to the non-discrimination principle, the right to healthcare facilities as a human right must be ensured without discrimination. Like Bangladeshi citizens, Rohingya (FDMN), as human beings, are entitled to the same healthcare rights within the territory of Bangladesh. Rohingya (FDMN) have the inherent right to get adequate health services and live free from preventable diseases and health conditions. Ensuring their right to health service is a commitment to human dignity and global solidarity. In natural justice theory, health service is crucial for preventing disease and leading a standard life. Rohingya (FDMN) possess inherent dignity and specific necessities like health services, which can preserve and protect their life. The right to healthcare facilities and services must be ensured to uphold the universal principles of justice, equality, and the common good.

FDMNs reside in camps situated in the southern part of Bangladesh. The camp in charge, the doctors, the Deputy Secretary, and the education officer were very optimistic about the health service provided to the FDMN. According to their view, FDMN gets health cards, ration cards, and top-notch health care. The education officer of Handicap International highlighted the specific attention given to FDMN daily based on their needs.

The officials and doctors of RRRC also gave a very progressive and positive vibe. They have success rates in preventing different types of skin diseases among FDMNs by providing adequate treatment and medicine. They distributed three doses of corona vaccines among the FDMNs. Doctors of the camps also claimed that FDMN gets health cards, emergency health care services, ambulances for emergencies, and available female gynecologists and physicians. He also added that There is a 24-hour friendship hospital in Baukhali. When emergencies arise, FDMNs are sent to the Cox's Bazar District Hospital and, if needed, to Chittagong District Hospital. RRRC has a well-established mechanism of referral pathway as the following:



RRRC claimed that they have 45 Nutrition centers and 451 doctors for 10 lakh FDMN while mentioning that there are only 39 doctors for 5.5 lakh Bangladeshis in the Ukhiya and Kutupalong regions. They pointed out that FDMNs receive much better health treatment than the host country's citizens. An NGO worker, Jahed Alam, Operation, Safety, and Security, Action Against Hunger, provided a similar opinion.

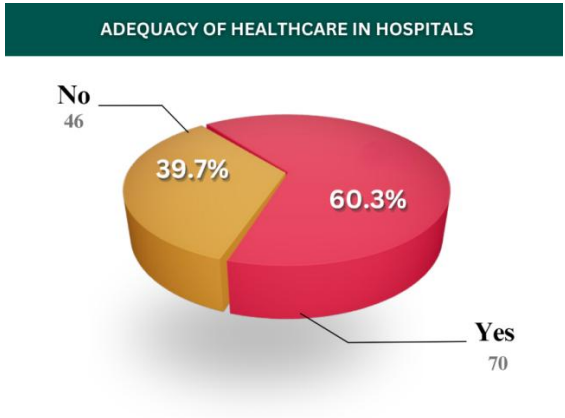


Figure 4

However, in the Rohingya camp, it was discovered that the scenarios are different for the healthcare services for Rohingya (FDMN). 60.3% of Rohingya (FDMN) interviewees argued that they do not get adequate health care from hospitals, and 38.7% of them said that they get sufficient health care from hospitals.

Sufficient healthcare and medicine were provided to them during the Diphtheriae outbreak in 2017, which they carried to Bangladesh from their homeland. Other outbreaks, such as Cholera, Dengue, etc., have been dealt with diligently, and RRRC was successful in this regard.

Only 43-44 Rohingyas died during the COVID-19 pandemic period. Many NGOs are working to create health awareness for the Rohingyas. This much medicine and medical care has been provided so they don't have to go outside the camps. Also, they have means to provide mental health support to female adolescents.

A journalist and activist for Rohingya (FDMN) has raised concern about the gradual deduction of funds by the partners. The scarcity of funds is creating a severe burden on the NGOs' work for the healthcare rights of the Rohingya (FDMN). Another INGO worker, Jahed Alam from Action Against Hunger, expressed the same concern. As a result, the standards previously followed by them have become difficult to maintain now, and generic medicines are being provided in most cases. The actual need for medicines is not being fulfilled.

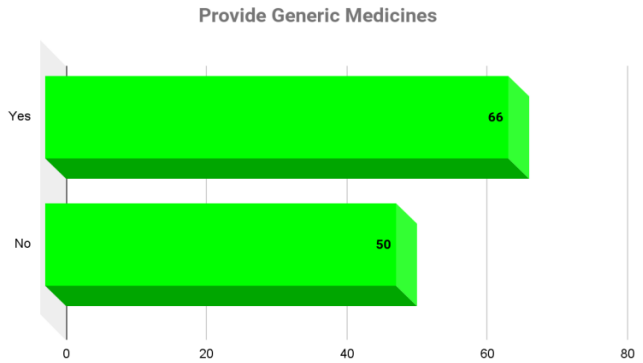


Figure 5

The Rohingya (FDMN) from camps maintained that they only get very generic and essential medicines from healthcare centers. Medicines are not available for all diseases, especially for severe diseases. According to our survey, 56.9% of Rohingya (FDMN) agree that they only get generic medicines like paracetamol, while others told us that they get all types of medicine properly.

Numerous Rohingya (FDMN) are suffering from post-traumatic and mental health disorders. The said journalist and activist informed that government and non-government organizations are working to provide mental health treatment.

RRRC has a specialized hospital where they supply 4/5 mental health issue-related medicines from the mental health unit. Even RRRC arrange monthly coordination meetings to monitor the overall mental health condition of this community. Also, they provide mental health support to female adolescents.

The camp-in-charge of Camp Seven also said that pregnant women receive special attention in terms of healthcare services. RRRC also provides pregnancy and post-maternity care to women. Besides that, RRRC claimed that they established Women—and children-friendly areas in the camps.

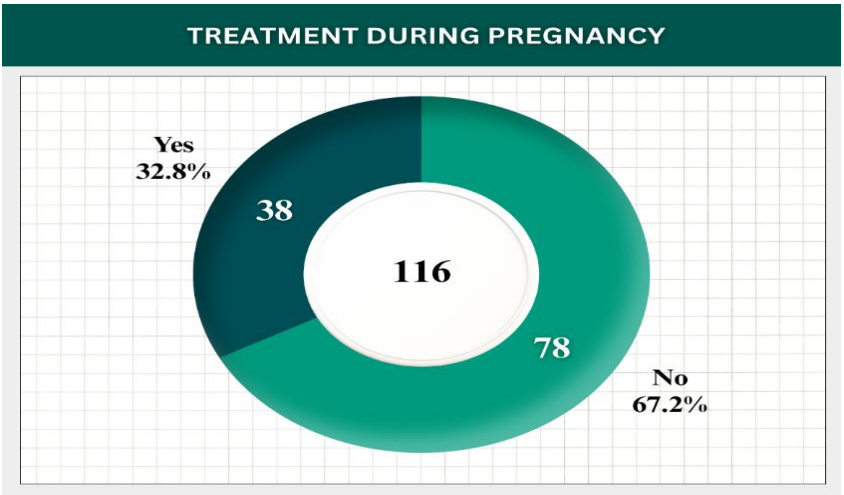


Figure 6

However, the Rohingya (FDMN) have different opinions regarding the treatment during pregnancy. Only 32.8% of participants have said that pregnant women get necessary treatment during their pregnancies, while the majority, comprising 67.2%, expressed the opposite view. They have mentioned the unavailability of follow-up treatment after childbirth. A doctor of the Kutupalong camp informed us about the 24-hour accessibility of healthcare facilities for pregnant women, including ambulance service, in case of emergency. Nevertheless, 100% of participants stated that pregnant women get treatment during childbirth, though the number of doctors is not sufficient.

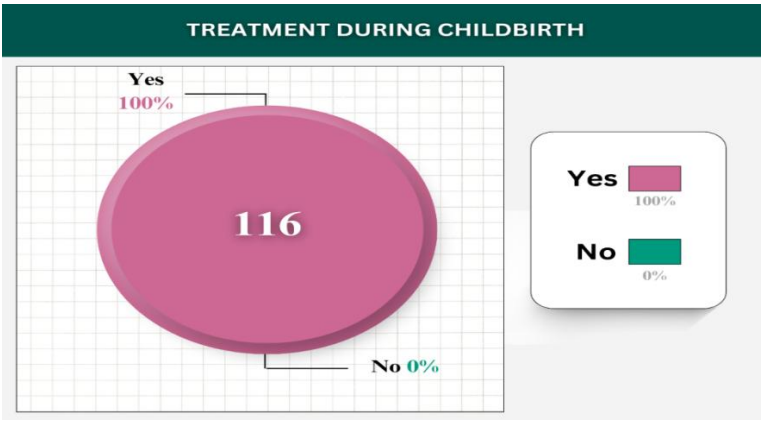


Figure 7

The Rohingya (FDMN) were ignorant about birth control and family planning methods. The camp-in-charge also claimed Rohingya (FDMN) do not care about family planning much. However, several initiatives are now making them aware of it. RRRC highlighted that the family planning awareness programs are arranged daily and Rohingya (FDMN) are becoming more positive about adopting this than before. However, a Site Manager, Amartya Galib Chowdhury, of a France-based NGO, ACTED, said there is no direct initiative of population control yet in sight, and even there is still no situation to run a birth control program here. Instead, mere awareness is created regarding the halving of prominent families through influential groups among Rohingya (FDMN) who are obeyed by all.

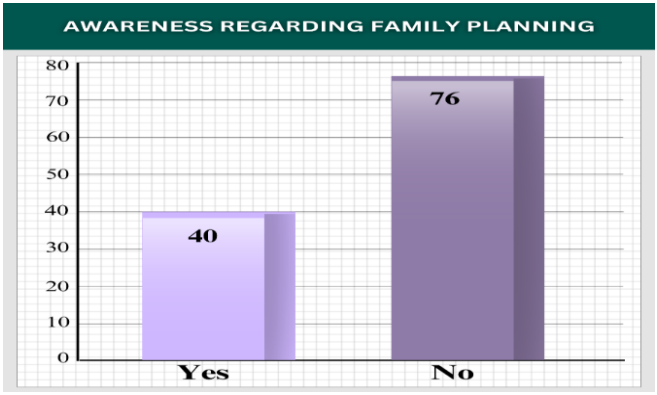


Figure 8

Though continuous awareness programs are arranged by RRRC, different NGOs, and INGOs, Rohingya (FDMN) males and females do not adopt means of family planning. Only 34.5% of the Rohingya (FDMN) are aware of the importance of family planning programs, although some do not adopt birth control mechanisms.

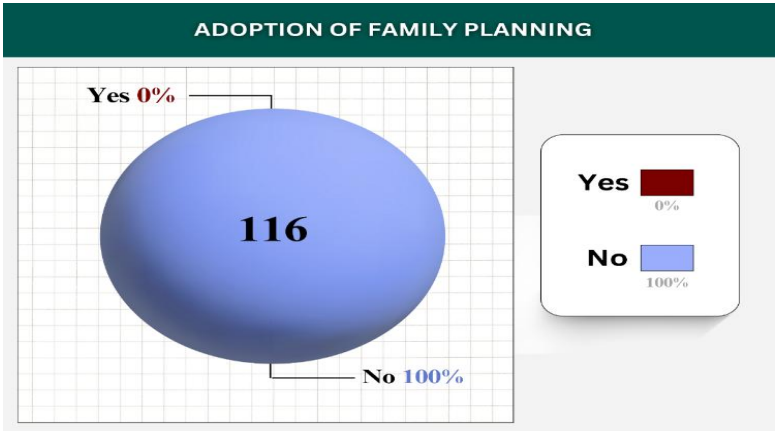


Figure 9

7. Key Findings

a) Existing international obligations not reflected in the national legal regime:

The existence of an international obligation to ensure the health care rights of FDMN is more or less absent in the national legal regime. No specific policy can address their right to get health care. The government is making a need-based policy to meet their health needs. Facilities are provided, but in some cases, all the facilities are not adequate. Due to the absence of legal policy, it is not possible to ensure access to health services and care as a whole.

b) Lack of attention for critical care:

The government claims that adequate medicines and food are provided. However, stakeholders, including the forcibly displaced Myanmar nationals (FDMN) and existing studies, argue that only generic drugs are available in the camps. Sufficient medicines for severe cases are lacking. International funding is inadequate to ensure adequate food and healthcare services.

c) Hospital facilities have been improving significantly over time:

The existing study claimed that the current hospital facilities are inadequate to meet the healthcare needs of FDMN. Doctors and health care providers are not available. However, our recent research found that most FDMN are quite happy with the hospital facilities and treatment. The government also asserts that hospital facilities are more than enough. A small portion of FDMN argued that they do not receive appropriate health care from these hospitals. In cases of severe health issues, sufficient healthcare assistance is sometimes unavailable. Most stakeholders, including NGOs and INGOs, affirm that the hospital facilities are inadequate.

d) Lack of attention to family planning:

Healthcare workers of NGOs and the Government try to make FDMN aware of family planning. However, most of the time, they show no interest in adopting this practice. Rohingya women hold the misconception that permanent birth control causes physical harm; two-thirds of them have the idea that it is under the authority of the husband, whose permission is necessary in this regard, and the rest of them do not use contraceptives due to the influence of paternal society in the hope of having male children.

e) Lack of healthcare access mainly affects women and children:

Women and children are at the highest health risk as they are considered the most vulnerable group in the community. The majority of the portion claimed that they did not get adequate care and treatment during their pregnancy and post-pregnancy period. Due to the unavailability of female doctors and healthcare workers, their menstrual hygiene and reproductive health have been compromised sometimes. Though the government claims that camps are child-friendly enough, it is found that children suffer both physically and mentally. Due to the lack of childcare support, children are not appropriately treated.

f) Neglecting the mental health of the Rohingya (FDMN) community: FDMN people are suffering from mental trauma and other psychological problems daily. The trauma arises from the moment when they are forcefully displaced from their own country. The government and NGOs asserted that they arrange psychology-supported programs and establish community health care centers to counsel them. But most FDMN people have minimal ideas about mental health care facilities, and they are not aware of it much. Only a few FDMNs are getting help from the counseling programs NGOs and INGOs conduct.

8. Conclusion

The study attempts to determine the healthcare status of Rohingya (FDMN) and their access to healthcare facilities and validate the national and legal policy to ensure the healthcare rights of Rohingya (FDMN) in Bangladesh. The current status of healthcare access for the Rohingya (FDMN) in Bangladesh is marked by notable shortcomings. Considerable gaps and challenges can characterize their right to get health care services. Though the government of Bangladesh, international bodies, NGOs, and INGOs are making efforts to ensure health services for Rohingya (FDMN), many of them are facing various obstacles to getting sufficient and adequate health services to prevent their health issues. Their hurdles and barriers to getting proper health services indicate that despite ongoing efforts, the current healthcare provisions for the Rohingya (FDMN) are inadequate and not appropriately monitored. Overcrowded camps, limited resources, bureaucratic inefficiencies, lack of coordination among various stakeholders, lack of international cooperation, corruption, and global politics all present significant obstacles to ensuring the healthcare access of Rohingya (FDMN). Due to the unavailability of specific legal instruments and the lack of a structured approach in the camp, healthcare facilities are not adequately distributed or provided. The implementation of the international obligation is not satisfactory enough to address the health issues of Rohingya (FDMN) and to ensure health care access for them. There are fewer implications of national healthcare programs for Rohingya (FDMN). It is noticeable that after the pandemic situation, the healthcare services for Rohingya (FDMN) have been improving day by day, and this community is now quite satisfied with certain aspects of the healthcare services, like hospital facilities. Systematic monitoring, comprehensive legal provisions, and practical implications should be ensured to protect their rights. As a low-income country, Bangladesh faces significant challenges in maintaining the resources and funding required to ensure adequate healthcare facilities so that cooperation and assistance are expected from international bodies to protect and ensure the health rights of Rohingya (FDMN).

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