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Rohingya Women in Bangladesh: Health Challenges among Marginalizing Refugees

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Dedication

To my parents who bring me in this world and support me in every possible way.

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Hasina Zannat Nadia

Abstract

My research interest intends to distinguish, portray, and investigate minority Rohingya women's health situation and Bangladesh's health policy towards them after their huge departure from Myanmar to Bangladesh on 25 August 2017, from an indigenous perspective. The neighborhood reconciliation of Rohingyas in Bangladesh is certainly not a feasible choice, considering the difficulties and the frail state limit of Bangladesh. Thinking about Rohingyas' local coordination, the state and society will bomb/explode because of the tremendous Rohingya populace's additional load. Since 2012, more than 159 000 individuals, the majority of whom are Rohingya, have fled from Myanmar in ineffectively built boats for ventures enduring a little in neighboring countries, causing many deaths. As immigrants, they experience various freedom issues every day, and the degree to which human rights approaches towards general health programs isn't well recorded. I outline the historical phenomenon leading to this intricate crisis in Rohingya women's Health and human rights. The Rohingya minority people, especially the women, young girls, and infants, are suffering from various health issues such as child wellbeing, malnutrition, waterborne diseases, and the absence of medical facilities. In December 2014, a UN determined request to conclude the emergency. Observing various wellbeing hazards and expanding the infection epidemic's opportunity, all government, private sector, and worldwide community partners must work together to help the displaced people in their desperate condition improve their health status. This deliberate research aimed to achieve fundamental human rights and essential medical facilities for the indigenous people and build up an ideological common liberties system to educate current arrangement practice and programming corresponding to the necessities of the medical facility of Rohingya refugee women in Bangladesh.

Keywords- Rohingya History, Women, Refugee, Health, Marginalizing people, Minority rights, Human rights, Indigenous people.

Contents

1 Introduction

The Rohingya, an ethnic minority in Myanmar's Rakhine state, has a long history of suffering from fundamental freedoms and identifying specific secessions, prompting re-elected patterns of limited removal between Myanmar, Bangladesh, Saudi Arabia, Pakistan and Malaysia, India, Thailand, Indonesia, and other neighboring Southeast Asian countries over the past few decades. (Tay, A. K., Islam, R., Riley, A., Welton-Mitchell, C., Duchesne, B., Waters, V., & Ventevogel, P. (2018) The Rohingya have established the most significant Muslim minority group in Myanmar. The Myanmar government has systematically denied the Rohingya people's fundamental rights for a long time, barring young people from marriage, alternative tolerance, voting or participation in community life, training, freedom of movement, and access to equity. (Parmar, P. K., Jin, R. O., Walsh, M., & Scott, J. (2019). Since August 2017, more than 700,000 Rohingya refugees from the northern municipalities of Rakhine State, where most of the Rohingya minority lived, have been persuaded to flee to the Bangladesh Border due to mischief and military action escalation. It was creating a significant crisis that exacerbated the current difficulties in providing assistance to the nation's 200,000 to 300,000 refugees at that time. One of the central issues that have come together is health issues. This thesis will focus on the health of Rohingya minority women from the indigenous perspective. In order to address the underlying cause of Indigenous medical conditions, there must be full recognition and exercise of Indigenous rights to common resources and self-determination. Numerous psychological well-being issues such as depression, substance abuse, and self-destruction have been recognized, which can be associated with the colonization and deportation of refugee people, leading to the disintegration of minority cultural, social, economic, and political foundations. (UN)

According to a UNICEF review, the Rohingya minority are being devastated in Bangladesh's south-eastern district, where the most critical sufferers are women. The state of the camp is overflowing, unhealthy and risky. Due to the huge population size, Rohingya women are facing health difficulties, and there is a wave of higher mass exploitation in the camp. Of the more than 900,000 Rohingya refugees living in exile camps in Bangladesh, 52% of them are women and young girls. About 42,000 pregnant women are giving birth at home, and others are facing ill health. Because of the large population, Rohingya women face health problems, and there is a risk of recovery in the refugee camp. (Islam, M. M., and Nuzhat, T. (2018). Between

September 2017 and August 2018, there were 52 maternal deaths in these camps out of 82 pregnancy deaths. (Learson, C., 2018). In 2015, 61% of the 303,000 maternal deaths worldwide occurred in fragile and conflict-affected states. Maternal death and fragile conditions are common scenery among the minority people in a humanitarian crisis. Many women affected by conflict face the grips of wickedness and extinction, such as sexual barbarism, unwanted pregnancies, and conceptual treatment provide helpless access to care. For example, evidence-based mediation, the Minimum Primary Service Package (MISP), can reduce maternal mortality among displaced people through its implementation may be hampered by complex refugee and host nation factors. The UN fact-finding mission in Myanmar has ordered an investigation into the attack. It needs to convict veteran Mian-Defense military pioneers for destruction, crimes against humanity, and war crimes. Psychiatric problems remain another concern as they are traumatized by their past. There have also been several rapes that have affected women's mental health. (Islam, M. M., and Nuzhat, T. (2018), Parmar, P. K., Jin, R. O., Walsh, M., & Scott, J. (2019).

1.1 Indigenous human rights and feminist theory

This research paper calls for more significant interdisciplinary interventions among the most comprehensive levels of social investigation and refugee studies among women. I am convinced that the women's worker hypothesis can make considerable assumptions and practical commitments in refugee studies. Alternatively, that refugee study provides a rich, usually undiscovered experimental space for women activist requests. The study also argues that ongoing calls to speak of human rights as human rights can only be effective by misrepresenting the geographical location of human rights internationalism and its nationalism. This research paper argues that training is needed for localization and transnational characteristics for techniques and activities that create gender imbalances. Indeed, even in the national context, in Myanmar, the appeal for women's human rights has not been valued because of the harsh treatment meted out to women from such minority communities under the guise of religion and culture. Concepts of economic and social equality, as opposed to rights, can work better in numerous such cases. To describe Indigenous Human Rights and Feminist Theory, I study two articles by *Ethnic Human Rights and Feminist Theory: Gender Implications for Refugee Studies and Practice* by Doreen Marie Indra and *Women and Migration: Incorporating Gender into International Migration Theory* by Monica Boyd & Elizabeth Grieco.

There has been minimal coordinated exertion to consolidate gender into worldwide relocation theories. In the migration context, it is challenging to understand gander. Building up a gendered hypothesis of migration has been troublesome because the controls of human studies, social aspects, political theory, economics, demography, law, and history have would, in general, the spotlight just a couple of sorts of movement and stress various clarifications. Since the hypothesis of the movement generally underlines the causes of global migration, it has often been neglected in the face of explicit activities of the gender. It is difficult to say clearly without a clear hypothetical view, for example, the conditions under which women move or the strength of women in specific workflows and not between others. Moreover, the conventional hypothesis neglects to understand the requirements that call for women to become transnational visitors, go through trafficking channels, or seek refugee resettlement. (Boyd, M., & Grieco, E. (2003)

In her article, Monica and Elizabeth wrote that, during the 1960s and mid-1970s, the expression "migrants and their families" was a code for "male migrants and their wives and children." The women's development, in any case, with its accentuation on the circumstance of the woman, made some inquiry the close intangibility of women as migrants, their assumed lack of involvement in the movement procedure, and they are expected to stay in the home. Research during the 1970s and the 1980s started to incorporate women; however, it didn't cause a sensational move in contemplating who migrated, how migration was clarified, or the possible results. One of the primary inquiries concerning women during this period was whether the movement "modernized" ladies, liberating them from their expected customary qualities and practices. (Boyd, M., & Grieco, E. (2003). In the neoclassical currency model and the models of the push-pull segment of the 1970s and 1980s, the transition space resulting from individual selection was viewed to influence women's liability as wives and mothers (and men's work as provider) to control women's choices. These gendered obligations were adopted to clarify why women were more uncertain than men when it came to relocating their spouses or participating in the work of the host nation. (Boyd, M., & Grieco, E. (2003)

The massive framework for refugee assistance, refugee reassurance, and resettlement that has progressed since World War II has been thoroughly thought out and predicted on the refugee rights proposal - with the notion that displaced people belong to a class whose fundamental human rights are genuinely political, economic and environmental—tested by which induced

after their flight. As such, travel with universal limitations regularly allocates to certain prescribed benefits that may request either an actual temporary status of rights (asylum) or the restoration of absolute social equality (such as citizenship of a sheltered nation). (Indra, D. M., 1989). Unknowingly, however, the bureaucratic tools set up to manage displaced people have become thunderous and any contribution from refugees regarding these rights and benefits. The opportunities for the self-assurance of the people have given more than a minimum of empty talk. Organizations and governments operating from large sources of power often help refugees talk about their benefits without being allowed to represent themselves, often for deportation. Topical spotlights were mainly among the wonders of considerable size: demographics, public development, structural foundations, program evaluation, and so on, and at the same time, the deliberate separation of information or significant edges by sexual orientation. Naturally, the sexual aspect is not relevant by any imagination. It was only considered as one more factor like age or profession. Women's issues were differentiated from men's equivalents. At the moment, however, the problem of how to remove pundits before the 1980s is too much for women. Regularly planned to have either applied work or some used effect of work, its general benefits were additionally closely linked to approaches and projects. Such research was usually thrown into the form of a social problem, which guaranteed that (looking at other social issues such as alcoholism), it usually shared an inseparable basic philosophical premise and a significant number of recent concerns from program executives. Women's issues have not been widely publicized as 'refugee issues'; Thus, minimal academic research on women was distributed. (Indra, D. M., 1989).

1.2 Previous research

The Rohingya minority is a controversial issue in Myanmar and a predicament for Bangladesh. There has been a lot of literature and a ton of conversations related to Rohingya refugees based on autonomous opinion and significant discussions. It was clear that the parliamentary entrance to Myanmar opens up new elements of research. For my inspiration, part of this research has been used to understand Rohingya refugee women's health concerns, its credibility, state boundaries, and the human rights or needs of the Rohingya minority. As I am researching the health emergency situation of Rohingya minority women, I will discuss the Bangladeshi situation for the treatment of Rohingya beyond the indigenous rights. As a result, I have gathered my target region-based data from Cox's Bazar, Bangladesh. Since the state of

emergency remains firmly on the Myanmar side, excluding the necessary information, secondary sources are essential. Thus, the academic articles are my specific spotlight for this research. I also review online articles and newspapers for the most recent news from various sources. While researching, I have focused on online articles mainly as secondary data. For example, “Rapid behavioural assessment of barriers and opportunities to improve vaccination coverage among displaced Rohingyas in Bangladesh” by Jalloh, M. F., Bennett, S. D., Alam, D., Kouta, P., Lourenço, D., Alamgir, M., ... & Vandenent, M. (2019)., “Medical and health risks associated with communicable diseases of Rohingya refugees in Bangladesh 2017” by Chan, E. Y., Chiu, C. P., & Chan, G. K. (2018)., “Humanitarian disaster for Rohingya refugees: impending natural hazards and worsening public health crises” by Ahmed, B., Orcutt, M., Sammonds, P., Burns, R., Issa, R., Abubakar, I., & Devakumar, D. (2018), “Marriage and sexual and reproductive health of Rohingya adolescents and youth in Bangladesh: a qualitative study” by Ainul, S., Ehsan, I., Haque, E., Amin, S., Rob, U., Melnikas, A. J., & Falcone, J. (2018), “One Year On: Time to put women and girls at the heart of the Rohingya response” by Sang, D. (2018), “Culture, Context and Mental Health of Rohingya Refugees: A review for staff in mental health and psychosocial support programmes for Rohingya refugees” by Tay, A. K., Islam, R., Riley, A., Welton-Mitchell, C., Duchesne, B., Waters, V., & Ventevogel, P. (2018) and Rohingya refugee response gender: Recognizing and responding to gender inequalities,(2018) etc. I also focus on lots of articles and journals mentioned in my thesis and the reference part. All those articles tend to highlight the women's health situation in Bangladesh. Most of the data surveyed by fieldwork, focus group discussion. The primary purpose of my thesis to spotlight the Rohingya women refugee situation in Bangladesh with the help of secondary data.

1.3 Relevance of the study

I was born and raised in Cox's Bazar, Bangladesh. It is a world-renowned destination for hosting large numbers of Rohingya refugees from Myanmar. The world knows and feels for the rise in their midst; Only individuals in the unfortunate refugee camps learn the regular battles and the ‘subhuman’ tolerance of the network. The dynamic experience of watching them struggle every day since my youth has left a lasting impression on my psyche. I constantly need to achieve something for those who are in difficulty. This idea led me to explore the Rohingya issue, mainly around gender themes. After understanding the health status of Rohingya women, this

research will help the host country, the public, and NGOs worldwide come up with some plans to develop health strategies. I would objectively identify myself as generally internal because of the criticism of understanding the situation with their perspective. My essential concern is with precise ideas and data. I will contribute to myself as a researcher by analyzing my research studies and personal experience. I will try to be as neutral as possible and not judge any issues from my perspective. This research is solely based on the available studies and data. As I am a student of the master's program on indigenous studies at UIT and in part of my master's Thesis, I need to recognize indigenous strategies for researching Indigenous issues and finding myself a researcher.

Beginning with Indigenous Knowledge, "Indigenous knowledge can be specific to location, region, and a group of peoples, for instance, indigenous knowledge for a woman, the deaf community, the poor, and so on." (Chilisa, 2012). For example, here, Rohingya women can be classified as indigenous people or minority communities. On a long-term basis, it is found that indigenous peoples were fighting for their freedom because of the colonization and abuse in those regions. (Oskal. N, 2008, Chilisa 2012). Rohingya people are no exception. Like other indigenous regions, they are deprived of their basic rights and tried to cope with the situation. Chilisa has similarly used Shawn Wilson's perception to convey ideas about the worldview of indigenous exploration, "we have tried to adopt a dominant system research tool by including our perspective into their views. We have tried to include our cultures, traditional protocols, and practices into the research process by adopting and adapting suitable methods. The problem with that is that we can never really remove the tools from their underlying beliefs." (Chilisa 2012). In this way, it helps build relationships with the person who interacts with them and thus connects the member and the researcher. Apart from these, land and climate have a good relationship with indigenous people, and it is an ideal way to gather information in the context of research. The connection of other geographic nations or locations with other countries allows scientists to talk about expert items and topics related to effective research. Verifiable knowledge, oral history, and information are similarly seen as profound items. (Chilisa, 2012). Nils Oskal expressed in his article that Indigenous people consider epistemology from a hypothetical logical point of view. (Oskal. N, 2008). Knowing or understanding or doing something socially or culturally is the underlying attitude among the aborigines. Using epistemology in indigenous research techniques, illustrate the experiences, social and environmental perceptions, stories, and various topics of their own sets. (Oskal. N. 2008,

Chilisa, 2012). Judicial literacy in Chilisa's view is "research guided by the principles of accountable responsibility, respectful representation, reciprocal appropriation and rights of regulation." Giving an example of the African perspective, the guideline of a rational philosophy is I and we, living and non-living and deeply connected with love, affection, and network building. (Chilise 2012). According to Oskel's perception, the 'individual' is the core of sociological and humanistic exploration and focuses on the individual's activities, practices, and action outcomes.

1.4 Scope of the thesis and research questions

The health policy on the situation of Rohingya refugee women provides limited information on the gathering's culture, mental health, and psycho-social well-being. The purpose of this paper is to assess the mental health and socio-economic condition of Rohingya refugee women so that minority rights can be spotlighted for further steps. The ultimate goal is to provide a socially applicable health system to sympathetic actors and offices and assist the Rohingya refugees in Bangladesh. The survey sought to explore the legitimate rights of ethnic minorities.

To examine this, I have planned the question with this and detailed test:

a) What is the situation of Rohingya Refugee Women’s Health in Bangladesh?

On-premises of this exact inquiry, there are two territories that I need to analyze.

b) As the Rohingya are a minority people who are refugee in Bangladesh, how does it affect Rohingya women in Bangladesh?
c) What is the affords and aim of the Bangladesh government to improve women's health conditions according to minority rights?

This research addresses the health conditions and situations of Rohingya minority women, and it is the primary concern of my examination. The main reason is to get legitimate data regarding the medical care administration within the camp from the perspective of Rohingya minority people. This implies that during the investigation and conversation, the administration will support the private sector and global networks to improve the health status of refugee women and try to maintain minority rights by following the findings of the study.

1.5 Method, and structure

To address the research questions, a qualitative research is conducted to investigate the necessary discussions based on the relevant topic for Rohingya refugee women, which helps

get a picture of health policy in the Bangladeshi health system. The critical investigation is important to my research as it reveals how those habits affect the social structure. While taking a gender issue, these records affect the refugee women, their families in Bangladesh, and the legal administrative system. It is interesting to investigate the health strategy to see which health structures have been rebuilt in these archives, especially among the Rohingya refugees in the minority health-centric situation. The research structure is based on the assumptions starting from the four regions. These four regions will be presented here in a few seconds and will be discussed in more detail in the following chapters. The primary domain is to research the historical background of the Rohingya and their present condition in the host country Bangladesh, focusing on Rohingya deportation from Myanmar. Then, the health strategy taken for them is also discussed in this paper. The third is minority women's health status, in which case test results are available. The fourth is the gender interface, an idea derived from indigenous research aimed at understanding diversity in health policy. Thus, these four points provide a predictive system, which enables the answer and discuss of research questions.

1.6 Thesis structure

In the second chapter of this paper, I will describe the history of Rohingya History which will discuss the historical background of Rohingya minority people. Rohingya refugee has a long history of suffering from fundamental freedoms and identity crisis. The third chapter is set up with the methodology, data, and methods. The fourth chapter is followed by the main thesis concept of Rohingya Refugee women's health. There are mainly two parts, the first part is the concept of indigenous people and minority people, Health and Migrants, The Health Right as an international Human Right Law. Moving forward, I analyze women's health, the general overview of Rohingya refugee women, and their health. Finally, the last part concerns the challenges faced by Rohingya refugee women in Bangladesh while living in the refugee camp. The fifth chapter is an analytical section discussing the outcomes presented in the previous part, clarifying some proposals to improve the Rohingya women's health issue.

2 Historical Migration and Situation of Rohingya

In this chapter, I will discuss Rohingyas' reality, a Muslim ethnic group living in Rakhine province in western Myanmar, which is the threat of genocide in the first part. The Rohingya keep on experiencing a few types of limitations and freedoms in Myanmar because of them being denied Myanmar citizenship. They are survivors of different kinds of abuse. Since the 1970s, various crackdowns on the Rohingya in Rakhine have constrained them to escape to neighboring nations. More than 1,000,000 Rohingyas have moved to evacuee camps in the Bangladeshi locale of Cox's Bazar. This chapter manages the Rohingya source, the type of their citizenship, and late persecution in the Rakhine State of Myanmar. Later they flee to Bangladesh. The next part expects to break down the unfavorable impacts of the Rohingya refugee on Bangladesh in recent years. Since Bangladesh's autonomy, it has been experienced many good and bad times in the nation's set of experiences. Despite the fact that the demographic weakness and the socio-economic state of Bangladesh not accepting additional responsibility, more than 1,000,000 Rohingya displaced people stay in Bangladesh. Accordingly, Bangladesh faces numerous difficulties and issues, alongside social, ecological, lawful, and economic effects. This chapter plans to distinguish the effects and problems for Bangladesh because of the mass inundation of Rohingya exiles.

2.1 History

Setting apart the history of Arakan from Burma is important because the Arakan region in the west has always been separated by a high and difficult-to-cross coastal mountain range from the rest of Burma. The antagonistic behavior towards the Rohingyas established by Myanmar creates an impression that the Rohingyas have no legitimate place in the state. However, the land shares a typical history like most other regions in the world which have seen a sequence of ethnic shifts, invasion, expansion and collapse which is why it is no wonder that around one-third of the population of Myanmar was made up of distinct ethnic groups than the Burman majority by the mid-1990s. This is a natural reflection of the history of interaction with China to the north, Indonesia and Malaysia to the south, Thailand and Laos to the east and India to the west. A diverse range of non-Burmese ethnicities lived, especially in the mountainous regions to the north and east of the central Irrawaddy region for a very long time. Though most of these groups live on both sides of various borders, some live exclusively in modern-day Myanmar.

Some proofs point to the fact that up to the nineteenth century, there was a degree of ethnic and religious tolerance through Buddhism's domination in the Burmese regions. At the same time, marginal groups retained animist beliefs or adopted Islam or Christianity. (Ibrahim, A., 2016).

2.2 Burma and Arakan history

The earliest human settlements supported by the archaeological evidence in modern-day Myanmar date back to 11,000 BC. There is evidence of a more established culture that mastered cave paintings by around 6000 BC. Agricultural evidence was found near Mandalay which dates to about 500 BC. The styles of pottery, burial practice, ironworking all show resemblance with those practiced in Thailand and Cambodia concurrently. This suggests that the earliest settlers were related to the ethnic groups prevalent in South Asia. (Ibrahim, A. (2016). Around 200 BC, the first walled cities in the region appeared. The design features were common both to India and to Thailand which indicates the diffusion of Indian culture and norms in that period. Hinduism and Buddhism arrived in the region at this period and mixed with the older indigenous beliefs. At this stage, central Myanmar was ethnically split between the Pyu and the Mon, who lived in the north and the south, respectively. (Ibrahim, A. (2016). The Mon is accredited with bringing Theravada Buddhism to Myanmar. Still, the independent Mon kingdom reached a conclusion as the city was conquered by the emerging Pagan kingdom at the beginning of the eleventh century AD. Though the Mon retained their language, they were largely absorbed into the new Burmese Buddhist culture. (Ibrahim, A. (2016).

It appears that the northern Pyu city-states have been ethnically related to the wider Burmese-Tibetan group and it is not surprising that the Pyu and the Burmese languages seem to have similar linguistic roots. Around 500 BC, Buddhism was first recorded in the Pyu dominated region. This region was linked with India and China for trading purposes which made it wealthy and simultaneously vulnerable to the more powerful neighbors. A series of wars took place between China and Pyu city-states in the nineteenth century AD leading to an invasion of Burmese from Tibet who eventually took advantage of ethnic ties. Provided with inconspicuous and complicated evidence, one probable explanation for this incursion is that the northernmost Pyu cities were already occupied by people of Burman ethnicity as early as 900 AD. So, this might not be a conquest from Tibet rather a process of the intermingling of two closely related groups as their power shifted. In the ninth century, the Pagan kingdom absorbed the minor cities

and following the collapse of the Pyu city-states, the Burmese people spread along the Irrawaddy valley. By 1100, the Burman ethnic group gradually became more influential in central Burma leading to the emergence of the Burmese Pagan Kingdom. Earlier divider Mon and Pyu areas were unified under the first Pagan king, Anawrahta (1044-77 AD) of the dynasty and this regime adopted Theravada Buddhism but there was no movement to remove other religious beliefs prevalent in the region. In 1286, a small Mongol incursion caused the rapid collapse of the kingdom into smaller city-states. Irrawaddy Valley was unified by about 1636 by the Ava Kingdom (1287-1752) and this led to the end of the Shan Dynasty in northern Burma. Succeeded by the Konbaung Dynasty (1752-1885), Mandalay emergence as the capital of the new state. This dynasty annexed Arakan in 1784 but they lost it to the British by 1826, after a series of wars. The annexation of the entire territory by the British occurred in 1886. The British avoided the religious disputes and took a secular view which eventually took some decisions which caused Theravada Buddhism to fall apart. (Ibrahim, A. (2016)

The earliest settled kingdoms leaving archaeological record were Indo-Aryan groups arriving from the Ganges valley around 3000 BC. Some other minorities were already living in those remote hilly regions. It is suggested by Gutman that whoever lived in Arakan before the ninth century AD had ethnic links to Indian groups. The earliest ones who ruled Arakan were mostly Hindus. Islam arrived via trading links to India and Arabia in the seventh century, but the region remained multi-confessional. Around 1000 AD, the Rakhine ethnic group crossed the Arakan mountains and settled in the region. From 1000 AD, Arakan met the rest of Burma as it did with Bengal and northern India. (Ibrahim, A. (2016).

The Rohingyas' dominance came to an end with the arrival of the largely Buddhist Rakhine from central Burma around 1000 AD and Pagan power reached its height following that. Arakan regained its independence followed by six centuries of war, dispute and trade with neighboring Burma and Bengal. There were periods of Burmese dominance, periods of Arakan independence from the thirteenth to the end of the seventeenth century. Though the Rakhine retained their Buddhist identity, Islam became prevalent among the Indo-Aryan descendants (seems, the Rohingyas). By the early nineteenth century, the existence of Rohingyas in Arakan was supported by plentiful evidence in a sequence of work published at that time. (Ibrahim, A. (2016).

2.3 Colonial-era (1824-1948)

The histories of Burma and Arakan were separated up to this point in time but from 1784, the two were inexplicably linked. As tensions were intensifying among the Burmese kings, it led to the Second Anglo-Burmese War in 1852 followed by British control over southern Burma resulting in upper Burma completely isolated from the rest of the world. In 1885, the Third Anglo-Burmese War ended, and the British created a formal division between `Ministerial Burma` and the `Frontier Areas`. As a separate administrative state, Burma was recognized by India in 1937 and based on earlier state borders that had existed just before the war of 1824-26, the borders were drawn. Thus, the new administrative unit incorporated Arakan which in turn shaped into the newly independent country of Burma. (Ibrahim, A. (2016).

British rule was resented by Burmese nationalists as they failed to meet the political and cultural demand along with a lack of willing support towards Buddhism. Moreover, the British preference for employing Indians in the colonial civil service and administrative structures worsened the situation. As a result, ethnically Burman communities were carrying Anti-British feelings while many minorities ethnic groups like the Muslim Rohingyas and the Christian Karen were pro-British. This had immediate consequences, for instance, the anti-colonial riots of 1938 were aimed at both British power and the Muslim community. During World War-11, the Japanese invaded Burma in 1942 and initially, they were welcomed by some Burmese nationalists, but the Rohingyas remained loyal to the British. As a result, noteworthy strife between the Rohingya and Rakhine ethnic communities broke out. Estimation says that about 307 villages were destroyed along with 100,000 Rohingyas becoming homeless and a further 80,000 fled the region consequently. The Japanese also carried out multiple massacres of the Rohingyas for their pro-British stance. This led to ethnic segregation between a largely Muslim north and a Buddhist south. (Ibrahim, A., 2016). The British recruited soldiers from among the Rohingyas and in exchange for their contribution to the war, they were promised relative independence but once the Japanese were defeated, the British reneged the promise. (Ibrahim, A. (2016); (Bari, M. A., 2018)

In 1947, some Rohingyas formed their army and tried to seek the incorporation of northern Arakan into the newly created East Pakistan, now Bangladesh. This initiative was in vain, yet some Arakanese Muslims went on to petition the Constituent Assembly in Rangoon for the

integration of Maungdaw and Buthidaung districts into East Pakistan after Burma achieved its independence in 1948. Consequently, the Burmese authorities were driven to consider the Muslim population of Arakan as hostile to the new regime whose loyalty lay with a different state. These events aided a belief that only Buddhist could be the real part of the new state, an attitude strengthened by the attempt of the Burmese Communist Party to bring down the new state after 1948. (Ibrahim, A. (2016); (Bari, M. A., 2018). The other side of the liberation struggle was even more complex in this period. The Burmese Independence Army (BIA) was formed to help the Japanese against the Chinese who were allied with the British and Americans. Intending to weaken the British, Aung San visited Japan in 1941 and became chief of staff when the Japanese declared the independence of Burma in

1943. By 1944, the Japanese were losing the wider war and Aung San started to negotiate with the British. Thus, the independence movement switched its sides, and, on March 27, 1945, it was revolted against the Japanese. This day was celebrated as `Resistance Day` and later became `Armed Forces Day`. (Ibrahim, A. (2016). Following the Japanese surrender, the BIA waged a low-level insurgency against British rules from 1946 to 1948 (up to independence). After being independent, it became the core of the new national army. (Ibrahim, A. (2016).

2.4 Constitutional period (1947-62)

In 1947, with the assassination of Gen. Aung San and some of his colleagues, a parliamentary federal union system was introduced. Following independence, multiple insurgencies nearly caused the complete collapse of The Union of Burma. Prime Minister U Nu still managed to remain in power, but the country remained unstable. Democracy took root and began to grow during this thunderous period. In 1958, unity among the ruling AFPFL leaders disbanded. Prime Minister U Nu came with the proposition that the parliament should decide which group would govern the country. U Nu won by such a tight edge that he had to resign within a few months and suggested that Gen. Ne Win should conduct a new election. Gen. Ne Wins's provisional government lasted only 16 months. U Nu led fraction won when the promised elections were held and after that U Nu called a meeting for February 1962 where he planned to find out a solution discussing with all ethnic leaders. But before U Nu could inaugurate his recommendations for peace, Gen. Ne Win led a military coup and seized the power on 2 March

1962. (Human Rights Documentation Unit (HRDU) (2007). In independent Burma, Rohingyas were betrayed after the death of Aung San.

2.5 Military rule (1962-88)

A military dictatorship replacing the parliamentary federal system was established by The Revolutionary Council in the constitution. In 1962, The Revolutionary Council founded itsparty, The Burma Socialist Program Party (BSPP). Though it retained the same military rulers, the BSPP transformed itself into the governing structure in 1971. In 1974, with additional centralized powers, a new constitution was adopted. The second constitution of independent Burma differed significantly from the earlier one. U Ne Win, the head of the BSPP, became the president and The Pyithu Hluttaw or People's Assembly, became the highest governing structure in the country. Freedom of the people of Burma was largely repressed under the one-party regime. The ruling regime faced popular unrest during this regime. Violent strikes were staged by the workers in 1974 and 1975. After a struggle between the students and the regime, a particularly serious student protest emerged in 1974. Ne Win ventured down from the administration in 1981 but continued as head of the BSPP. The economy suffered severely due to political instability. (Human Rights Documentation Unit (HRDU), (2007)

In March 1988, after the intervention of riot police, a student from the Rangoon Institute of Technology (RIT) died following a teashop brawl. The riot spread among the other universities leaving several students dead and missing. As the people of Burma unified in their demand for political change, the wave of social unrest escalated. Declaring a state of martial law, the BSPP appointed Gen. Sein Lwin as the new party head and later president in July 1988. In August 1988, students and activists organized a peaceful protest nationwide. The 8888-uprising led to the death and arrest of thousands of demonstrators and protestors at the hand of the regime. Following this, Gen, Sein Lwin was replaced by a civilian lawyer but on 18 September, through a bloody coup, the military regained power. Under the name `State Law and Order Restoration Council`(SLORC), The military dictatorship forcefully took control and suspended the 1974 constitution leading to the brutal suppression of all oppositions, resulting in death tolls and arrests. (Human Rights Documentation Unit (HRDU), (2007)

Up until 1965, the Rohingyas were not attacked directly but they were constantly losing their existing rights and ethnicity-based identity cards were imposed in 1974, with the Rohingyas

being only eligible for Foreign Registration Cards (non-national cards). The next legal step was the 1982 Burmese Citizenship Law. Based on their residence in Burma before 1824, different categories were assigned to different ethnic groups. Who did not belong to these categories, especially the Rohingyas were deemed to be foreign? Due to the ethnic classifications used in 1948, the Rohingyas were denied full citizenship under the 1982 legislation. ((Ibrahim, A. (2016). Denial of citizenship led to the loss of land holdings, imposed restrictions on movement along with access to education. Faced with increasing violence by the state, there was a growth in the number of refugees fleeing to Bangladesh. The 1977 Nagamin campaign (also known as dragon king) was designed to distinguish every individual's status as a citizen or a foreigner which subsequently was interpreted by the Rakhine Buddhist community and the army as a license to attack Rohingya communities. By 1978, Bangladesh saw more than 200,000 refugees most of whom were returned to Burma. (Ibrahim, A. (2016); (Bari, M. A., 2018)

2.6 SLORC'S military rule (1988-1997)

Gen. Saw Maung. The head of the SLORC assured the public that the military intervention aimed at the restoration of law and order. With the advent of new election law, parties began to register, and The National League for Democracy (NLD) led by Daw Aung San Suu Kyi, rapidly emerged as the leading opposition party. The military tried to discredit her as her popularity rose with various allegations. Unable to influence her supporters, SLORC placed Daw Aung San Suu Kyi under house arrest and disqualified her from taking part in the elections in 1989. Despite these, the NLD achieved a landslide victory in the elections in May 1990. The junta refused to implement the results and SLORC maintained control over the country through martial law. As SLORC consistently refused to hand over the power, members of the elected parliament set up the National Coalition Government of the Union of Burma (NCGUB). (Human Rights Documentation Unit (HRDU), (2007); (Bari, M. A., 2018)

On 10 July 1995, Daw Aung San Suu Kyi was released but there was no improvement in the human rights situation in Burma rather the political arrest and persecution increased after November 1995 when the NLD withdrew and in response, SLORC expelled the NLD permanently from the convention. Hostility between the ethnic resistance groups and the SLORC continued throughout the whole period. To pressurize opposition groups into one-sided ceasefire pacts, the SLORC heightened aggressive tactics and a range of human rights

violations and abuses against the ethnic minority villagers living within the conflict zones took place. (Human Rights Documentation Unit (HRDU), (2007)

Political instability saw an increased deployment of the Burmese military in northern Rakhine. In the period 1991-92, the renewed attacks saw 250.000 Rohingyas flee to Bangladesh following the use of forced labor, beatings, rape and land theft. The latter incorporated the construction of villages in northern Rakhine for non-Rohingyas built on the land forfeited from older Rohingya settlements, even often built with forced Rohingya labor. Subsequently, this led to more refugee flow to both Bangladesh and Malaysia. (Ibrahim, A. (2016); (Bari, M. A., 2018) There was a repatriation agreement between Bangladesh and Myanmar under the international pressure on which around 230,000 Rohingyas returned to their homeland from 1992-1997.

2.7 SPDC's military rule (1997-Present)

The SLORC was renamed the State Peace and Development Council (SPDC) on November 15, 1997. Replacements and reshuffling started to take place within a very short time of its formation. On 16 September 1998, in response to the military regime's failure, the Committee Representing the People's Parliament (CRPP) was formed. (Human Rights Documentation Unit (HRDU, (2007) Suu Kyi was arrested and released several times. The military leadership experienced a constant flux. International pressure went on to reform the junta as there was no real progress towards democracy. Regardless of that, the regime continued to commit a severe violation of human rights and harassment against political organizations (Human Rights Documentation Unit (HRDU) 2007). The 8 November 2015's elections followed by a landslide victory of Nobel Peace Prize laureate Aung San Suu Kyi's party reflected the huge popular mandate for her and came with the expectations that she and the NLD would deliver the needed political and economic changes. Though the Rohingyas were repatriated, they were not given their expected rights or any compensation. Enraged Myanmar government arrested a Rohingya MP in 2005 for helping his community. (Ahmed. S & Ali, A.B (2019). Myanmar's third constitution was framed in 2008 where nothing good was preserved for the Rohingya community as it reinstated the denial of the constitution of 1982. (Ibrahim, A. 2016).

In early 2012, there was blame that a Rohingya Muslim raped a Buddhist woman which infuriated the Rakhine Buddhist and state-patronized anti-Muslim propaganda during the past

two decades instigated them which led to the massacre in 2012. 10 Muslims were murdered on the contrary which triggered a severe clash and turned into a deadly communal riot between Buddhists and Rohingyas in June continuing up to October. More than 200 deaths occurred and around 150,000 became homeless. Following this, a state of emergency was declared in the Rakhine state. (Ahmed. S & Ali, A.B, 2019). President Thein Sein said in his interview to the UN that, “The million Rohingya people in Rakhine state are simply not welcome in Myanmar. They would be placed in camps or, preferably, deported.” (Bahar, 2010). This statement made it clear that it was a state patronized systematic attempt to force the Rohingya leaving the state behind which the main motive was ethnic cleansing. Myanmar directed its first census in over 30 years in 2014, but Rohingyas were not included. Even Suu Kyi refused any Muslim contestant from the NLD platform in 2015’s election. (Ahmed. S & Ali, A.B (2019). Burmese state media claimed in October 2016 that 300 Rohingyas attacked border posts in Rakhine State and killed 9 police. Myanmar military scrambled on unarmed Rohingyas, killed many and drove around 90,000 to Bangladesh. Myanmar army started a series of attacks naming ‘Clearance Operations’ on 25 August 2017 showing an allegation of a so-called attack by ARSA (Arakan Rohingya Salvation Army) on the military of Myanmar. Different international organizations’ reports highlighted the fact that the persecution of Rohingya was at that point in progress even fourteen days before the assault of the ARSA. But the recent violence in Rakhine state crossed all previous records. On 25 August 2017, an estimated 655,500 Rohingyas were driven to Bangladesh escalating the total Rohingya population living in Bangladesh to some 800,000. (Ahmed. S & Ali, A.B (2019).

Despite all these massacres and exodus, Suu Kyi denied any sort of human rights violation in a television speech on 19 September 2017 but the violation of all sorts of human rights was reflected in the report of the UNHCR. Many scholars termed these acts of brutality as a state-patronized crime and Genocide. This attitude of the Myanmar government clearly states that they are not willing to let the Rohingya community live in Myanmar. (Ahmed. S & Ali, A.B (2019).

3 Methodology

This chapter discusses the research methods used for data collection and addresses the research objectives related to the research process. Gerring (2006) claims that researchers face a choice between knowing little or nothing abroad in the practical sense. (Gerring 2006). This section will be instantly proceeding on how I want to answer the proposed specific research question.

3.1 Research design

The study used for this research is the qualitative methodology to collect information. The study is solely dependent on secondary data. One of the patterns of Qualitative research which analyses data from written documents. (Patton, M. Q. (2005). According to Fossy, Harvey, and Mcdermott & Davidson, "Qualitative research aims to address questions concerned with developing an understanding of the meaning and experience dimensions of humans' lives and social worlds." Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Qualitative technique utilized to respond to inquiries concerning experience, meaning and point of view, especially opinion from the member. This information is generally not manageable to check or estimate. Subjective exploration procedures incorporate 'small group discussion' for examining trust, attitude and ideas of regularising behaviour; 'semi-structured interviews,' to investigate on a particular point, information, background history or an institutional viewpoint; 'in-depth interviews to comprehend a condition, insight, or event from an individual point of view; and' investigation of writings and archives, for example, government reports, media articles, websites or journals, to find out about circulated or personal information. (K. Hammarberg, M. Kirkman, S. de Lacey (2016).

I will focus on qualitative research methods for my data collection. It is important to note that, in indigenous research methodologies, indigenous knowledge plays an important role. In short, indigenous knowledge is a reflection of language, history, culture, and historical oppression. (Chilise). It gives the researcher new ideas, topics, and methods of analysis and makes him curious about the history of colonialism and imperialism previously ignored. Indigenous knowledge has also driven the cultural decolonization process demands and conducted research methods respectfully and ethically. According to Olson, the term 'indigenous method' is based on interests that support indigenous premises and rights. He emphasized the concept of research

for indigenous studies, "reciprocity, humility, and rationality. Research on the indigenous issue should be done respectfully, sympathetically, and benevolently." mutual behavior, humility, and rationality. The 'Indigenous Research paradigm' discusses the distinct epistemology, ontology, and ethics of Indigenous peoples. In the Indigenous context, the concept of 'paradigm' was widely used. Paradigm is reflecting of the researcher's approaches and methods. (Olson). The research strategy chosen to answer my particular research question mentioned in my previous chapter is a theoretical, descriptive study, which provides secondary information sources such as scholarly articles based on qualitative research, survey, as well as relying on journals, newspapers, and documents, etc. In order to make my research successful and to find the answer to my objective question, I have tried to look into the several projects and survey. The report, I collected focuses on previous surveys that included adult Rohingya refugee women, married and unmarried Rohingya adolescent girls, and children. In some cases, this data is collected from international report,service contributors and program staff from the government, NGOs who are working with Rohingya refugee in Bangladesh.

3.2 Study location

There are a total 34 Rohingya refugee camps in Bangladesh. Most of the Rohingya refugees live in Ukhia Upazila, and the rest of the Rohingya people live in Teknaf. My secondary data were surveyed from Balukhali, Kutupalong, Unchiprang, and Nayapara camp areas. Among all the camps, Kutupalong camp is the largest. So, these are the primary research locations of my thesis.

3.3 Research method

I focus on lots of articles and journals, which mentioned in my thesis and the reference part. All those articles tend to highlight the women's health situation in Bangladesh. Most of the data surveyed by fieldwork, focus group discussion. The primary purpose of my thesis to spotlight the Rohingya women refugee situation in Bangladesh with the help of secondary data. As my research is dependent on secondary data, I tried to investigate the different articles, journals, books, etc., to collect my data. For this purpose, I was careful about not biased from my indigenous studies ethics. First of all, I focus on the refugee women's situation in Bangladesh and collect my data with a survey conducted by the primary authors. Then organized the

collected data into a subchapter to present a clear idea about the minority women, which is the main aim of the thesis. After managing the data, I focus on the objective of my research questions and give some idea about the further steps which will be beneficial for both minority people and the host nation.

3.4 Challenges and limitation

The primary purpose and plan of my research is for interviewing Rohingya women, which I am supposed to conduct by myself. But because of Covid 19 situation, I can't be able to go to the refugee camp in Bangladesh. Thus, my research has depended on secondary data, which is not satisfactory enough. It affected my quality of research and didn't fulfil the research goal. The study was thoroughly dependent on secondary information. In my research, there was no primary data included. The primary source of the study were articles, books, journals and online newspapers, and annual reports of international organizations. As I must depend on secondary sources, I feel the most challenging phase is accurate information. Different sources show different numbers and percentages which is the most challenging part of sorting out. I can't be able to verify and investigate the data.

3.5 Indigenous Ethics and the position of the researcher

I am belonging from Bangladeshi, which does not make me a Rohingya refugee or tribal. It is not controversial to study indigenous studies as non-indigenous individuals. The connection between indigenous individuals and non-indigenous analysts in groups was previously very disproportionate, and its effects are still evident today. All in all, Indigenous analysts were leading researchers in Indigenous folk groups when considering their advantages and adding colonial legacy to the study. (Chilisa, (2012, 2016), Olsen, (2017), Smith, (2012).

"The word itself, 'research,' is probably the dirtiest in the Indigenous vocabulary" Linda Tuhiwai Smith (2012) discusses the decolonizing procedure in the presentation of her compelling book. Although my research has focused on strategy archives, as mentioned earlier, these records influence the day-to-day reality of Rohingya refugee women in Bangladesh. Moreover, strategies that rely on incorrect research adversely affect the lives of indigenous peoples. This means that I have a much more important responsibility as a researcher. In order to identify indigenous peoples directly, ‘4R’ qualities have significance: respect, reciprocity,

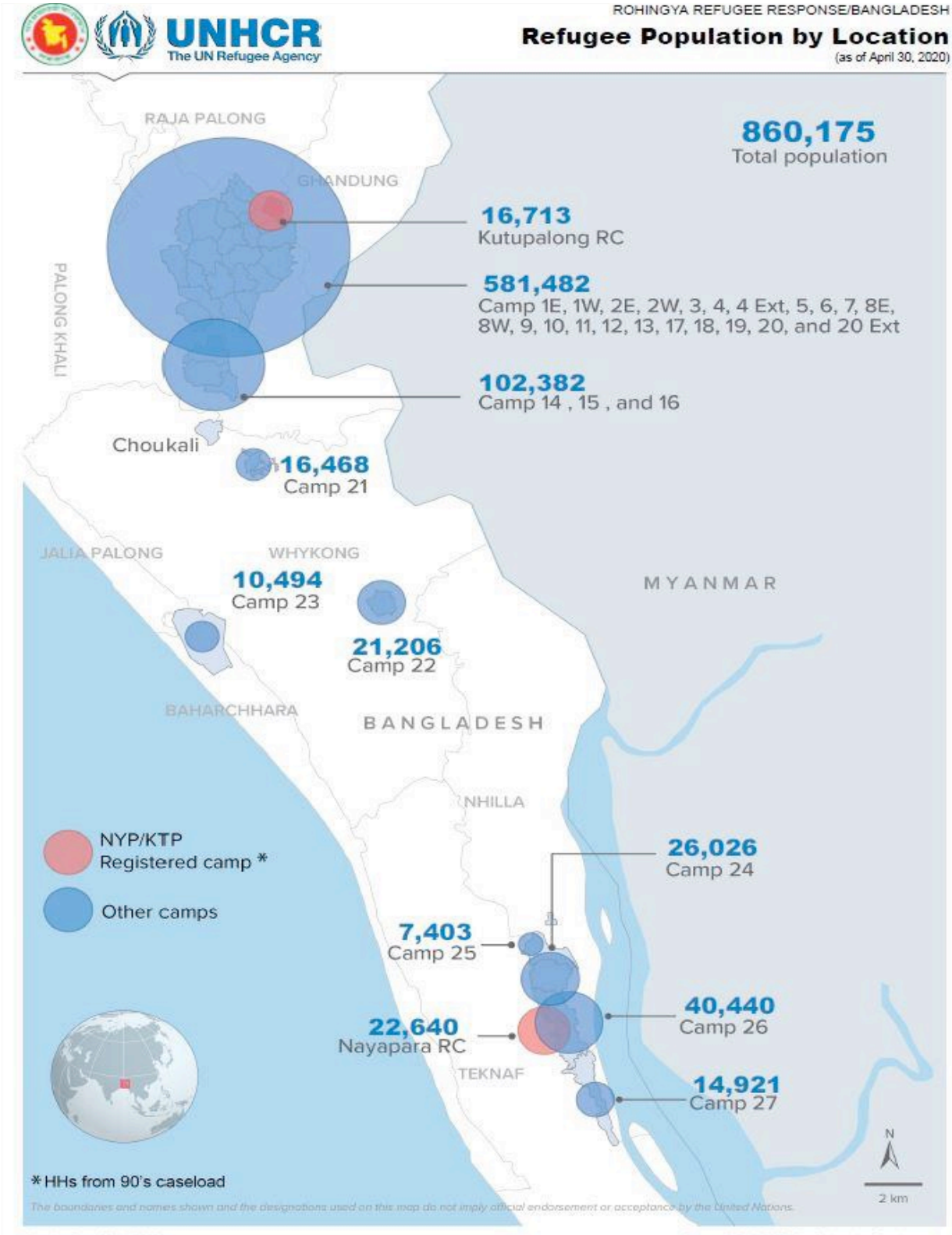
relationality, and responsibility (Olsen, 2016). This ‘4R’ will work as a guideline in the research and as a researcher, I am responsible for consequence of my research. My aboriginal tendencies should be kept in focus and returning to the network should be necessary for my research. My situation as a researcher has similarly taken on a real job (Chilisa (2012), Olsen, (2016, 2017), Smith, (2012). Thus, it will be more challenging to portray myself as like as an outsider, which is usual for me. Being external means, I will miss out on some relevant information that is just known to insiders. This information may also be necessary for me to work. There was talk of a way to maximize the lost data impact, although my initiative can be reasonably expected with insiders. Then again, not being a Rohingya implies that I did not have to face the same Rohingya situation as others experienced in Myanmar. This means that I can see from a different angle the position of the current program in Bangladesh, seeing what people living in Myanmar can experience as expected for a longer stretch of time. As a researcher, countless factors have contributed to my situation. Compared to the top experiments on indigenous themes, I will continue to become desirable for the required larger terms. There are several factors that can capture a part of my thesis. It highlights the significance of the progressive demonstration of image of my opinion and its impact on my research. As a researcher, I will put myself both colonizer and colonized. As below, I can take the data and take the intensity of the connection between the research and the researcher. The situational position is a sensitive, related, and ethical issue. Truth, duty, calmness and tranquility, justice, and community are the five ordinances that signify perfection. As a researcher, I will try to disclose the investigator as the subject.

At this point, I need to follow the imperialist plan. There is a lack of such knowledge about colonization in history, so there is a lot of uncertainty about certainty and good decisions. This approach generates practical arguments which force me to examine, evaluate, and thoroughly consider positive advances for research. (Chilisa, 2012). Known as the social interface by Martin Nakata (2007a, 2007b), which it is firmly identified. He illustrates the cultural interface where specific information structures meet, for example, indigenous and Western. It is not like direct resistance, yet in this place, these two data structures are involved with other political, financial, historical, and social elements.

I need to know the duties and responsibilities of an expert, which reflects ethics. Rohingya individuals who had a clear historical, social, and political format should take a position in the

surrounding networks to represent the Rohingya people in a global context in the surrounding networks. (Olsen, 2016). From a systematic point of view, the researchers introduced themselves to Lifeworld and are working on refinements. Researchers additionally see the reality. In matters of morality, I should follow the subject and purposeful duties. Abstract responsibilities include age, sexual orientation, social class, nationality, or research, and many more and more objective responsibilities are quality research, variable interest, individual integrity, and commitment to members. Members recognize their function during the investigation. They preserve the option behind the research to understand the motivation, sponsor identity, personality, material data, and ultimately the significance of the research. (Chilisa, 2012, Olsen, 2017) Both the researcher and the member have to show respect to each other, and so the relationship is effective. (Chilisa, 2012, Olsen, 2017). Basically, considering my position and the many reasons can affect this thesis. I need to guarantee, this thesis can be elegantly integrated into research and information about Rohingya women's health strategies. Thus, considering my position has been important for the study and composition of this thesis.

Figure - Rohingya camp location in Bangladesh



Source-(Reliefweb, 2020).

4 Rohingya Woman Health Analysis

This chapter will present the concept of Health, Indigenous and Ethnic Minority people, and Human rights. To present this, I am going to introduce and discuss the Indigenous and Ethnic Minority and migrants. After that, I will give the idea about the concept of the Indigenous Health Right from the perspective of international Human Rights Law. In this chapter, I analyze women's health, Rohingya refugees, and the challenges of Rohingya women's health in Bangladesh, which is the primary purpose of this study. This part analyses women's health, which can be seen as a fundamental human right. As part of this, I focus on the importance of women's health. After that, the focus will be on the general overview of Rohingya refugee women and their health. For this reason, I look at the ways and methods mentioned and justified in the literature and previous research. Finally, the last part is about the challenges faced by Rohingya refugee women in Bangladesh while living in the refugee camp.

4.1 Indigenous and ethnic minority people

"Minorities" do not have the proper meaning in global law. The structure of the United Nations is to help the people from any ethnic, religious, and linguistic minorities and groups enjoy their own way of life, mother tongue and claim and practice their own religion. As per definition by Special Rapporteur of the United Nations Sub-Commission on Prevention of Discrimination and Protection of Minorities, a minority is: *"A group numerically inferior to the rest of the population of a State, in a non-dominant position, whose members - being nationals of the State - possess ethnic, religious or linguistic characteristics differing from those of the rest of the population and show, if only implicitly, a sense of solidarity, directed towards preserving their culture, traditions, religion or language."*

To understand the definition of indigenous people, as per ILO Convention 169 on Indigenous and Tribal peoples 1989, *"Peoples in independent countries who are regarded as indigenous on account of their descent from the populations which inhabited the country, or a geographical region to which the country belongs, at the time of conquest or colonisation or the establishment of present state boundaries and who, irrespective of their legal status, retain some or all of their own social, economic, cultural and political institutions."*

There are few characteristics that Indigenous people and minorities usually share: a non-privileged position, differences of their societies, dialects or religious beliefs from the dominant part, and struggle to hold their identity. Individuals from minority or indigenous communities who are refugees are likely to be affected by their relocation and segregation. This acute isolation may affect some people from the local area more than others, especially women, children, people with disabilities, older people, and lesbian, gay, bisexual, transgender, and intersex (LGBTI) people. (UNHCR). Minority and indigenous groups are regularly among the most undervalued networks in numerous social activities: they often refrain from participating in socio-economic life, have no access to politics, and are habitually barred from showing their personalities. These barriers are multiplied by the limited transfer time and increase the insurance risks they face. (UNHCR). In different parts of the world, these groups have survived serious general liberties, brutality, struggle, ethnic or religious persecution, and even genocide. Accordingly, they left no choice but to flee regularly. There is a chance that the refuge of the people who took their place with the lion's share in the country of origin may end up in a minority-like circumstance in the asylum. They may now be in danger of being rejected and marginalized.

More individuals are moving now than at any other time. There are an expected 1 billion migrants in the world today, of whom 272 million are worldwide migrants and 763 million internal migrants – one of every seven of the total populaces. An expected 70.8 million of the world's inside and worldwide migrants are persuasively dislodged today. (WHO 2020). Another recent evaluation of the United Nations High Commissioner for Refugees (UNHCR) shows that 65.3 million individuals have been persuasively displaced worldwide. Approximately 34,000 individuals are compelled to escape their homes each day because of abuse. (Tay, A. K., Islam, R., Riley, A., Welton-Mitchell, C., Duchesne, B., Waters, V., & Ventevogel, P. (2018). Migrants come from territories influenced by extraordinary poverty and war and leave on long and depleting ventures. This may bring about expanded weakness to irresistible sicknesses and non-transmittable illnesses, such as cardiovascular infections, diabetes, cancer, persistent lung infections, and psychological wellness issues. The suggestions for worldwide general health are too critical to be in any way overlooked. (Zumla, A. and Abubakar, I. (2018).

4.2 The Indigenous health right as an international human right law

Indigenous women are the worst sufferer when it's time to use medical services. So, before starting my main analysis part of my thesis, it is important to understand how important health rights from an indigenous perspective view is. The privilege of the most noteworthy achievable health norm is a fundamental right known in global human rights law. The International Covenant on Economic, Social and Cultural Rights, broadly considered as the main instrument of insurance for the privilege to wellbeing, perceives *"the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."*. International Covenant on Economic, Social and Cultural Rights, art. 12:

1. *The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*
2. *The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:*
    a) *The provision for the reduction of the stillbirth rate and infant mortality and the healthy development of the child.*
    b) *The improvement of all aspects of environmental and industrial hygiene.*
    c) *The prevention, treatment, and control of epidemic, endemic, occupational, and other diseases.*
    d) *The creation of conditions which would assure all medical service and medical attention in the event of sickness.*

According to the UN Declaration on the Rights of Indigenous Peoples, Article 24 is stated that,

1. *Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.*
2. *Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right*.

Towards the end, the entitlement of migrants to wellness is firmly identified and depends on their work and daily environment, and legal status. States must find ways to better understand immigrant treatment problems, among other things, satisfactory housing, safe and stable working conditions, a unique form of life, food, data, freedom, and protection. As well as states to understand their benefits, freedom from slavery and forced labor. (OHCHR, 2008)

4.3 Women and health

A woman's privilege to enjoy the highest standard of health must be ensured throughout her lifetime. Both biological and gender-associated differences have a remarkable impact on women's health. Physical, psychological, and socio-cultural aspects must be considered in women's health and disease. Many of the same health-related issues affect women, but they experience them differently due to both genetics and social construction. Often social realities have disadvantageous effects on women's health, including financial restrictions and dependency, gender-based violence and discrimination, limited freedom in life-decision making, especially sexual and reproductive life. Sound health is the key to lead a productive and fulfilling life of dignity and the right to control all the aspects of their health, especially their fertility, which are fundamental to their independence and empowerment. As in many societies, women are underprivileged by discrimination rooted in sociocultural factors; women's health and well-being are of particular concern. Some socio-cultural factors responsible for preventing women from benefiting from quality health services and obtaining the best possible level of health include:

a) Dissimilar power relationships between men and women
b) Social norms that deteriorate education and paid employment scopes
c) Exclusively focusing on only women's reproductive roles
d) Actual and potential experience of physical, emotional, and sexual violence.

Some noteworthy fact sheets about women's health are discussed below:

4.3.1 Female genital mutilation

Female genital mutilation includes all systems which lead to incomplete and add up to the evacuation of external female genitalia or some other injury to the female genitalia because of

non-clinical purposes. Above 200 million girls and women experienced this in 30 countries in Africa, the Middle East, and Asia. (Genital, F. (2016). It has no medical advantages, just damage. Immediate complications can include serious pain, excessive bleeding, genital tissue swelling, fever, infections, shock, and even death. Long-term complications can consist of vaginal problems, urinary problems, menstrual problems, sexual problems, increased risk of childbirth complications, psychological issues, etc. It is recognized as a complete violation of human rights, and this practice additionally violates an individual's privileges to wellbeing, security, and physical integrity. (Genital, F. (2016).

4.3.2 Adolescent pregnancy

An expected 21 million young girls matured 15-19 years in developing nations become pregnant, and around 12 millions of them give birth. (Darroch J, Woog V, Bankole A, Ashford LS,2016). In 2018, in South-East Asia, the overall fertility rate was 33 ranging from 0.3 in the Democratic People's Republic of Korea to 83 in Bangladesh. (Ganchimeg, T., Ota, E., Morisaki, N., Laopaiboon, M., Lumbiganon, P., Zhang, J., ... & Vogel, J. P. (2014). An adolescent who experiences unwanted pregnancies may not be able to prevent it due to knowledge gaps and misconceptions about contraceptive methods. Among girls aged 15-19 years, pregnancy and childbirth-related complications are the leading cause of death globally. (Neal, S., Matthews, Z., Frost, M., Fogstad, H., Camacho, A. V., & Laski, L. (2012). Additionally, among girls aged 15-19 years, some 3.9 million unsafe abortions occur each year, resulting in maternal mortality, morbidity, and lasting health problems. (Darroch J, Woog V, Bankole A, Ashford LS,2016)

4.3.3 Maternal mortality

Still today, maternal mortality is unacceptably high, and approximately 94% of these deaths occur in low-resource settings, among which most could have been prevented. (World Health Organization, 2019). As a result of complications developing during and following pregnancies, maternal death occurs. The primary complications are severe bleeding, infections, pre-eclampsia and eclampsia, complications during delivery, unsafe abortions, etc. Mainly poverty, distance to facilities, lack of knowledge, inadequate services, different cultural beliefs, and practices play vital roles behind this.

4.3.4 Violence against women

Violence against women, especially by intimate partners and sexual violence, is a major public health problem and a violation of women's human rights. Violence can adversely affect a woman's physical, mental, sexual, and reproductive health. Women are more likely to undergo these experiences if they lack education, exposure to domestic violence against their mothers, child abuse, and having attitudes of accepting violence, male privilege, and women's subordinate status. These have serious short- and long-term health consequences. There are fatal outcomes like homicides or suicides, injuries, unwanted pregnancies, gynecological problems, STDs, including HIV and depression, anxiety disorders, post-traumatic stress, etc. (WHO) Article 25 of the Universal Declaration of Human Rights state that:

a) *Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in the circumstances beyond his control.*
b) *Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.*

This part covers a range of rights necessary to establish one's health and well-being. As per this, females have the equal rights to have adequate food, water, sanitation, clothing, housing, medical attention, as well as security which covers situations beyond one's control to maintain their optimum health. But still, widespread violation of all these rights is experienced by women all over the world.

4.4 Rohingya refugee women and health

As stated by the United Nations Declaration on the Rights of Indigenous People published on the general assembly on article 24, no 1, *"Indigenous peoples have the right to their traditional medicine and maintain their health practices, including the conservation of their vital medicinal plants, animals, and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services".* However, little attention is paid

to gender-based violence victims and their urgent need for security and access to basic amenities.

Since the fast deluge of Rohingya refugees into Bangladesh started in 2017, general wellbeing authorities have been worried that a horde of medical problems among the displaced people would emerge. As anticipated, mental health has deteriorated, food-and water-borne illnesses are spreading, infraction sicknesses are occurring, malnutrition is prevalent, and reproductive wellbeing for women and young ladies must be tended to.

The principal point of general health and help organizations has been treating actual injury, irresistible sicknesses like diarrhea, hepatitis, vector-borne illnesses like malaria, dengue, and vaccinating against polio, diphtheria, cholera, measles, and rubella. (Hossain, M. M., Sultana, A., & Das, A. (2018). There is deficient flexibility of essential reproduction alongside maternal, youngster, and infant wellbeing administrations. From 1991-1992 a mass departure of more than 250,000 Rohingya exiles fled oppression in the Union of Myanmar. It showed up in Bangladesh, living in impermanent camps and subject to outside help from the United Nations (UN), the Government of Bangladesh (GOB), and various non-legislative associations (NGOs). (Masud, A., Ahmed, M. S., Sultana, M. R., Alam, S. I., Kabir, R., Arafat, S. Y., & Papadopoulos, K. (2017).

Around the world, the all-out populace of exiles is about 9.9 million. The overall well-being status of exiles in different nations is accounted for to be low, with unhealthiest being a significant medical issue because of the absence of admittance to adequate food and supplement admissions. Other medical conditions among refugees incorporate dysfunctional behaviours, intestinal parasites, hepatitis B, tuberculosis, explicitly communicated infections, HIV/AIDS, malaria, and anaemia. Children and little youngsters are regularly the soonest and most successive casualties of brutality, infection, and lack of healthy food, which go with populace relocation and refugee surges. Concerning instances of sexual misuse of kids, there have been reports and examples of outcast minors (females) being harassed, mishandled, or assaulted by nearby residents. A study found that out of 508 children under five years old, 65% were anemic and, accordingly, frequently malnourished. A review led to a commonplace community found among women in the age bunch 15-49, iron (by 50%), and B12 nutrient inadequacy (by 46%).

Masud, A., Ahmed, M. S., Sultana, M. R., Alam, S. I., Kabir, R., Arafat, S. Y., & Papadopoulos, K. (2017).

As per the MSF overview, 2.6% of women and young girls have passed on due to sexual viciousness in any event. All through their excursion to Bangladesh, they are an injury because of assault and sexual maltreatment. The victim doesn't know about emergency contraception (inside 120 hours) and prophylaxis against HIV contamination (inside 72 hours, etc. and there is restricted admittance to those medical care offices. (Hossain, M. M., Sultana, A., & Das, A. 2018). Myanmar is a High HIV predominance neighbouring nation of Bangladesh. A little community Teknaf is in the Chittagong Division arranged at the southern tip of Bangladesh. It isolates Bangladesh and Myanmar from the eastern side. A considerable number of refugees are now living in poverty on the Bangladeshi side (Gazi R, Mercer A, Wansom T, Kabir H, Saha NC, Azim T,2008). More than Hundreds of Rohingya have been the survivors of torture, dictatorially authority, assault, sexual harassment, inappropriate behaviour, and different types of actual physical and mental damage. Rohingya have been completely deprived of the opportunity for development and admittance to food, clean drinking water, disinfection, clinical consideration, work facilities, and education. (Masud, A., Ahmed, M. S., Sultana, M. R., Alam, S. I., Kabir, R., Arafat, S. Y., & Papadopoulos, K. (2017).

There is no homegrown law in Bangladesh to manage exile undertakings or to ensure outcast rights. New outcasts experience issues getting to medical care; their medical problems may compound with time. Social separation and detachment appeared to add to unexpected passing among individuals from confined networks. In refugee camps, clinical administrations are generally disabled as there is no assessment and except for community health centers, no pregnant women and new-born child is observing either since family planning administrations for refugee are not accessible, there are unwanted births and expansion in baby mortality, women also face dangers of gender discrimination, sexual brutality, early marriage, and unsuccessful labour and birth confusions ((Masud, A., Ahmed, M. S., Sultana, M. R., Alam, S. I., Kabir, R., Arafat, S. Y., & Papadopoulos, K. (2017). Besides, there isn't sufficient clinical administration of rape survivors and family planning just as juvenile agreeable wellbeing administrations. Specialist co-ops experienced difficulties recognizing private and safe administrations for women for an enormous number of displaced people. (Learson, C., 2018)

4.5 Women health situation among Rohingya in Bangladesh

A significant number of minorities' health imbalances in Bangladesh for the low standard of health infrastructure together with the absence of equal entrance in many organizations' facilities such as housing, healthy food, disinfection, etc. These issues will be explored in this paper to find out the way of improving the health outcomes of the indigenous women.

All things being equal, this paper considers these health issues for the welfare of minorities regarding the value of general liberty. It is an essential principle of general human rights law that if all rights are interconnected and affect the satisfaction of one right, it will affect the satisfaction of the other. Because of this cooperation, human rights provide a structure for discussing the health effects of government approaches on projects and the potential wellbeing of projects on minority people. (The Australian Human Rights Commission, 2021)

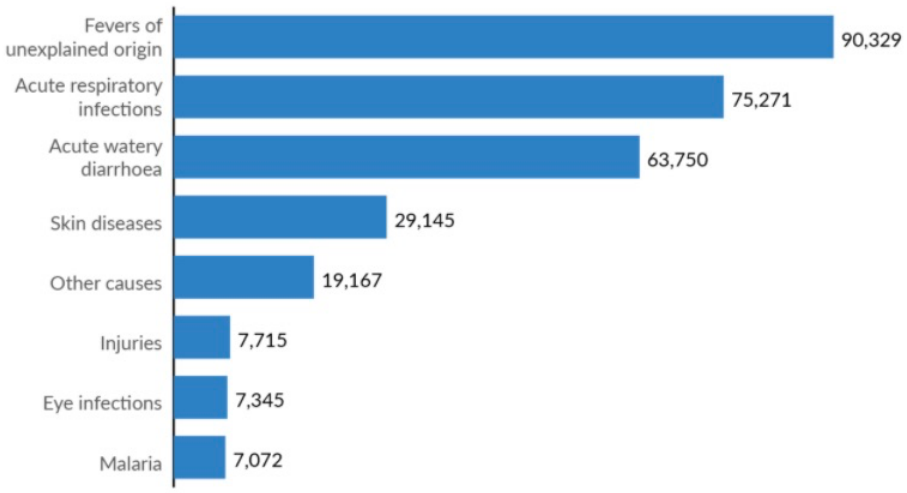
4.5.1 Food and waterborne diseases

Poor foundations and disinfection in refugee camps pose a widespread threat to Rohingya refugee food-water-borne infections. As indicated by the minimum criteria in the humanitarian response, the prescribed number of inhabitants per toilet is 20 for the reduction of waterborne diseases. Unfortunately, there is one toilet for every 37 people in the IDP camps of Rohingya refugees in Bangladesh. (Mahmood, S. S., Wroe, E., Fuller, A., & Leaning, J. (2017). Apart from this, clean water is one of the most demanding things of the Rohingya displaced people. Numerous people collect water from the streams for drinking water. Nevertheless, these waterways are used for washing, bathing, and open poo, especially in informal Rohingya camps. (Mahmood, S. S., Wroe, E., Fuller, A., & Leaning, J. (2017); Chan, E., Chiu, C. P., & Chan, G. (2018). Contaminating these waterways and toilets with harmful germs during the monsoon season becomes more dangerous in Myanmar and Bangladesh's Rohingya camps.

Inadequate structures in the camps will not protect them from flooding activities without large quantities of food and waterborne pathogens. (Ahmed, B., Orcutt, M., Sammonds, P., Burns, R., Issa, R., Abubakar, I., & Devakumar, D. (2018). Besides these, the lack of sanitation and hygienic conditions in Rohingya camps increases the risk of diarrhea transmission. For example, Escherichia coli was tested in that region, and water tests in the camps showed that 92% of the water was contaminated with Escherichia coli and 47% extremely polluted. Cholera,

hepatitis A, hepatitis E, and typhoid are other waterborne diseases that outbreak in the refugee camp and are a matter of great concern. These infections are largely responsible for the devastation that occurred in the refugee camps. Acute Watery diarrhoea (AWD) represented 7 in 9% cognitive state in camps in 2015, and 22% seek help from the consultation. (Chan, E., Chiu, C. P., & Chan, G. (2018). According to UNHCR, 63,750 Rohingya refugee AWDs visited the medical center of a listed camp between August 25 and December 2, 2017. It has been reported that 15 people passed due to AWD. (UNHCR (2018). The risk of food and waterborne illness is particularly acute among minority populaces, including women and children. In IDP camps, 40% of Rohingya children under five have been infected with diarrhea. The incidence of diarrhea among young people living in informal camps is more pronounced due to limited access to good toilets, where a number of 37 individuals used a single toilet. (Mahmood, S. S., Wroe, E., Fuller, A., & Leaning, J. (2017). Lastly, the frequent pregnancy rate complicates women's ability to fight pollution. For example, the mortality rate of hpatitis E is as low as 1% for everyone, but in the case of pregnant women, it can certainly be as high as 20-25% if it is happening in the third trimester. (Chan, E., Chiu, C. P., & Chan, G. (2018).

Figure- Food and waterborne diseases.



Source - UNHCR (2018). Rohingya Refugee Emergency at a Glance

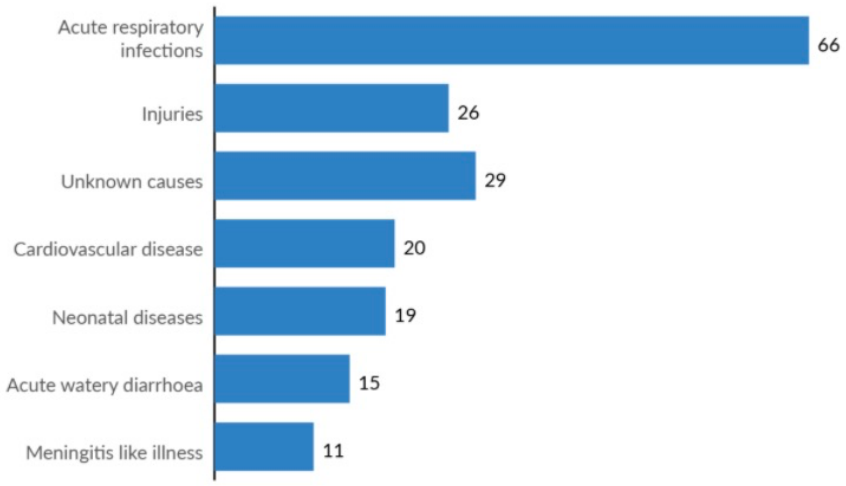
For this topic, I took help from an online article and Journal, specially "The Rohingya people of Myanmar: health, human rights, and identity by Mahmood, S. S., Wroe, E., Fuller, A., & Leaning, J. (2017) and Medical and health risks associated with communicable diseases of

Rohingya refugees in Bangladesh 2017 by Chan, E. Y., Chiu, C. P., & Chan, G. K. (2018) respectively. There is also a article name "Humanitarian disaster for Rohingya refugees: impending natural hazards and worsening public health crises" by Ahmed, B., Orcutt, M., Sammonds, P., Burns, R., Issa, R., Abubakar, I., & Devakumar, D. (2018) which is a part of project "The Rohingya Exodus: Issues and Implications for Stability, Security and Peace in South Asia" and most important report by "UNHCR (2018). Rohingya Refugee Emergency at a Glance."

4.5.2 Infectious diseases

Due to inadequate sterilization, low water quality, proximity, and significant levels of drug trafficking and sexual brutality, the outbreak of the irresistible disease in Rohingya exile camps are alarming for general health care. A high percentage of respiratory contaminations and diarrhea have quite recently been reported. Children are more affected unexpectedly by infectious diseases than grown-ups due to inadequate healthy and nutritious food. However, people from all ages are fighting against respiratory infections and diarrhea. (Mahmood, S. S., Wroe, E., Fuller, A., & Leaning, J. (2017). Furthermore, diphtheria is another major concern among the Rohingya population because of the poor sanitation and water conditions. 35 deaths were recorded in February 2018 because of diphtheria. (Ahmed, B., Orcutt, M., Sammonds, P., Burns, R., Issa, R., Abubakar, I., & Devakumar, D. (2018). Due to the lack of social distance and the exploration of the Rohingya people, it has become difficult to stop the spread of diphtheria. To prevent the new spread of diphtheria, the Bangladesh and health authority government executed a diphtheria vaccination campaign in December 2017. (Jalloh, M. F., Bennett, S. D., Alam, D., Kouta, P., Lourenço, D., Alamgir, M., Feldstein, L. R., Ehlman, D. C., Abad, N., Kapil, N., Vandenent, M., Conklin, L., & Wolff, B. (2019). Another concern for general wellbeing within the management is the increase in explicitly infectious contaminants. Among the expatriates, 83 known HIV patients were in critical condition though there were more patients who were not diagnosed. (Hossain, M. M., Sultana, A., Mazumder, H., & Munzur-E-Murshid (2018). Lastly, Hepatitis E virus is a problem in developing countries, especially found in the first trimester of pregnancy when the mortality rate increases from 10% to 25%. (Chan, E., Chiu, C. P., & Chan, G. (2018). Other serious illnesses include acute respiratory infections (ARI), fever, cholera, dehydration, E-coli and chickenpox. (Health Sector Cox's Bazar, 2019.)

Figure-Name of Infectious diseases in the Refugee Camp



Source - UNHCR (2018). Rohingya Refugee Emergency at a Glance

Table- Camp name with FGD

Community	Rohingya population	Number of focus group discussions	Number of key information interviews
Balukhali	35,599	3	5
Hakimpara	59,158	3	5
Kutupalong	53,648	3	5
Total	144,405	9	15

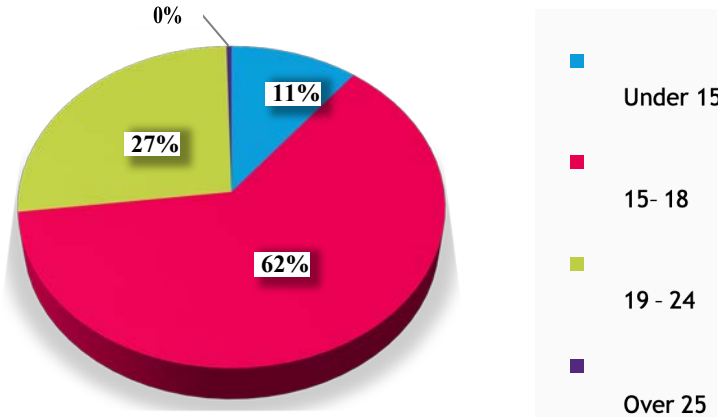
Source- Rapid behavioral assessment of barriers and opportunities to improve vaccination coverage among displaced Rohingyas in Bangladesh (2019)

For the purpose of this research, I have read the qualitative research "Rapid behavioral assessment of barriers and opportunities to improve vaccination coverage among displaced Rohingyas in Bangladesh "by Jalloh, M. F., Bennett, S. D., Alam, D., Kouta, P., Lourenço, D., Alamgir, M., Feldstein, L. R., Ehlman, D. C., Abad, N., Kapil, N., Vandenent, M., Conklin, L., & Wolff, B. (2019) where they survey of focus group discussions (FGDs) and key informant interviews (KIIs) in 3 camps in Ukhia sub-district, Bangladesh: Balukhali, Hakimpara, and Kutupalong. "Rohingya Crisis in Cox's Bazar District, Bangladesh: Health Sector Bulletin,2019" report also helps to understand the overview of the situation. There are also the previous articles "The Rohingya people of Myanmar: health, human rights, and identity" and "Humanitarian disaster for Rohingya refugees: impending natural hazards and worsening public health crises".

4.5.3 Reproductive health

Rohingya minority women feel more helpless and insecure because of the refugee crisis. 67% of Rohingya women from the population in the exile are sexually abused or facing harassment. (Hutchinson. S., 2018). Out of the approximate 70,000(20%) from the 335,670 female refugees in total were found pregnant or would be new mothers. Apart from these, gender inequality along with the overestimation of men is another factor responsible for the high rate of brutality against refugee women. Here we can see the reflection of feminist theory that women are dominant by men. Child marriage became high in the Rohingya camps without any legitimate strategy and restrictions age of the minimum marriageable. Most of the parents fixed their daughter's marriage to protect them from the sexual violence in the camps. After the marriage, they are forced to expand their family as they believe that women should not limit the number of kids. Generally, the knowledge regarding sexual information and contraception is given by the older generation within this geographical location. Though this can be effective, reproductive health can be affected by their knowledge. Therefore, contraceptive techniques are not popular among them because of their religious and social beliefs. Rather, family planning is considered unethical, and contraception is considered life-threatening, and they believe that it will make them infertile. (Ainul, S., Ehsan, I., Haque E. F., Amin, S., Rob, U., Melnikas, A., J., Falcone. J, 2018).

Figure - Age of girls getting married



Source- Rohingya refugee response gender: Recognizing and responding to gender inequalities, (2018)

Although there is a reproductive welfare administration within the camps, a relatively small number of individuals seek conceptual consideration due to a lack of confidence in the clinical faculty and practice. There are also barriers for transportation. Also, in general, women are prohibited from moving freely within their communities. The free movement issue of women is also mentioned the feminist theory. Limited interest in hospital setups and advice from healthcare providers need to be improved to combat unprotected pregnancies and sexually transmitted infections. (Ainul, S., Ehsan, I., Haque E. F., Amin, S., Rob, U., Melnikas, A., J., Falcone. J, 2018).

The social and clinical information of minority midwives and their contributions to the prosperity and positive health of minority people are generally unknown and are divided by the public welfare structure now and then. Thus, minority midwife assistance should be supported by the state health strategies. (UN). A large part of the Rohingya outcast delivers children with the help of midwives. UNFPA has been responsible for guaranteeing maternity care recognition programs in refugee camps for the increase in brutality among displaced people. Midwives are ineligible for the best possible admission to medical services and resources. A significant number of birth specialists in this region are unable to offer the best sexual welfare advice due to their cultural difference and language barriers. There are about 19 offices inside the outcast camps which help women to get conceptual treatment services. In any case, the administration needs support and assistance for the problem of reproductive wellbeing. (Wadia, R. (2018).

Indigenous peoples have urged the United Nations system, provincial welfare agencies and governments to integrate a social approach to health approaches and programs and to the Reproductive Health Administration to focus on Indigenous women. In addition, the work of traditional birthing specialists should be re-examined and expanded to assist local minority women during the reproductive wellness cycle and act as social entrepreneurs within the wellness structure and qualities of indigenous networks and world perspectives. UN

In this subchapter, I have collected all the data from "Marriage and sexual and reproductive health of Rohingya adolescents and youth in Bangladesh: a qualitative study." By Ainul, S., Ehsan, I., Haque, E., Amin, S., Rob, U., Melnikas, A. J., & Falcone, J. (2018). They survey data from Balukhali- Kutupalong, Palongkhali Union of Ukhia upazila. They focus on five camps out of 20 camps and cover east, west, south, north and centre sides. The camp was named by 4, 8E, 10, 15, and 20.

Figure- Camp name and population

Camp	Total household	Total population
Camp 4	6905	29009
Camp 8E	7915	33541
Camp 10	7943	31540
Camp 15	10002	45130
Camp 20	1999	8173

Source- Marriage and sexual and reproductive health of Rohingya adolescents and youth in Bangladesh: a qualitative study.

Figure- Rohingya refugee Camp locations in Ukhia

Source- Marriage and sexual and reproductive health of Rohingya adolescents and youth in Bangladesh: a qualitative study.

Another data and Observations were made from JOINT AGENCY RESEARCH REPORT AUGUST 2018 titled as ROHINGYA REFUGEE RESPONSE GENDER ANALYSIS Recognizing and responding to gender inequalities. They focus on four camps – Balukhali, Kutupalong, Unchiprang and Nayapara – to make this document. This survey was followed by Oxfam in partnership with the help of Action Against Hunger and Save the Children. There are also contributions from CARE, UNHCR, ISCG and UN Women.

4.5.4 Malnutrition

Inadequate nutrition is one of the serious problems which affect indigenous people worldwide. Despite the extreme poor conditions, indigenous women along with other minority people suffer from inadequate food sources. The natural environment and the loss of land and territories are some reasons behind this food crisis, making them unhealthier and needy.

A common health problem among the minority people, i.e., Rohingya refugee children and women, is malnutrition. Malnutrition is the inadequacy of a healthy diet, and the abundance of individual characteristics of a person's energy inputs, and additional supplements prescribed by the WHO. According to Action against Hunger, more than one fifth of Rohingya children in the camp are suffering from malnutrition, and more than 12% are facing extreme problems, creating conditions of starvation and lack of healthy living in refugee camps in Bangladesh. New-borns under the age of one and a half are among the most at-risk groups and their malnutrition health rate is close to 50%. (Patinkin. J, 2018). This happens because of their inability to breastfeed as they have limited access to nutritious foods, resulting in poor health conditions. In short, Rohingya women fail to properly breastfeed their newborn children because they are otn fully healthy and suffer from malnutrition. Rohingya refugees mostly rely on humanitarian assistance. Although attempts to reduce the hunger of war are in progress, there is still an alarming pace of unhealthiness. UNICEF's initiatives in Bangladesh are Action Against Hunger, and they provide food and water for further growth in the Ukhia town. (Patinkin. J, 2018).

Malnutrition is well above the crisis level. Among the children who have fled to Bangladesh, 60% of them have suffered from a chronic lack of healthy food. Numerous factors are responsible for malnutrition among Rohingya refugee women, such as shortage of food, diseases, poor sanitation infrastructure, and polluted water. There is a particular problem - the

lack of enough food, as only 6% of outcasts report having great food preservation sources. The situation of frailty is additionally disturbed by the subhuman situation in the camps. Lack of healthy eating habits among women and youth is close to the crisis level. Anemia among kids 6-23 months (> 50 percent) and hunger due to illness increases the risk of current recovery of children in refugee camps. In any case, effectively removed from destroyed networks in Myanmar; their longevity) and barriers (for low Height for age) in children between 0-59 months (> 40 %) remain important issues. (UNHCR, 2019). Limited food options in the camps increase the risk for malnutrition and illness, especially among children (0-6 months) and exclusively breastfed mothers. (UNHCR, 2019). Measures need to be taken to provide them plenty of water (2 million per day) and nutritional food supplements to avoid the risk of malnutrition. (White, k., 2017)

For this subchapter I investigated the report of "JRP for Rohingya Humanitarian Crisis, January-December" UNHCR, February 2019, which was produced on behalf of Strategic Executive Group and partner. This report shared the level of crisis and pressing humanitarian needs. Other sources are Rohingya in Bangladesh: an unfolding public health emergency by White, K. (2017) which focused on the area of Ukhia clinic and camp and Patinkin, J. (2018). Rohingya Refugees Face Malnutrition. Voice of America.

4.5.5 Mental health

Rohingya refugees, especially women, suffer from mental health for a variety of reasons. According to the National Aboriginal Health Strategy (1989), Indigenous people expressed that their health condition is connected to '*control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity*

The poor mental health situation of the refugees was raised as an important issue during the joint assessment mission in 2016 by the Government of Bangladesh, World Food Program and UNHCR. The report stated that *"many refugees became quite emotional regarding their vulnerable situation and lack of hope."* (Tay, A. K., Islam, R., Riley, A., Welton-Mitchell, C., Duchesne, B., Waters, V., & Ventevogel, P. (2018). Nonetheless, it is difficult to compare the different settings and periods of Rohingya groups because the changed contexts affect the level of symptoms and the ability of refugees to cope. Both qualitative and quantitative investigations

of Rohingya refugees provide evidence of one of the risk factors responsible for the psychological crisis, including the prevalence of being a woman. The other factors contributing to women's mental health are exposed to potentially traumatic events (PTEs), experienced/received threats of human right violations, loss of identity, sexual violence, congestion, substance misuse, separation of mothers from their children, separation from community members, lack of food or security, unemployment, poverty, lack of access to services and freedom of movement (particularly in Myanmar), lack of activities, recreation and support in camps (particularly in Bangladesh), etc. These make Rohingya women powerless against mental illness and often cause them memory loss, focus issues, obsessive-compulsive disorder, nervousness, stress, guilt, sadness, fear, nightmares, excitement, sadness, homesickness, shock etc. Physical exposure includes somatic complaints, pain, dyspepsia, stomach problems, weakness, sexual dysfunction, etc. Thoughts about suicidal tendencies are prevalent among Rohingya women due to feelings of frustration considering their current and future situation and loss of identity. Because of the strong condemnation of suicide in Islam, they often hide their suicidal ideas. Myanmar field workers have revealed that Rohingya women keep their thoughts secret for fear of being judged. When their thoughts were shared with friends and family, they were told that they would go to hell, which eventually intensified their suffering and shame. In 2008, a survey of Rohingya women among underage children in registered Rohingya refugee camps in Bangladesh confirmed that 61.7% of them were considered suicides. (Tay, A. K., Islam, R., Riley, A., Welton-Mitchell, C., Duchesne, B., Waters, V., & Ventevogel, P. (2018).

Women suffering from severe psychiatric or manic disorders often experience auditory and visual hallucinations. People with intellectual disabilities are often stigmatized. Spirit possession (locally called jinn) is a common folk diagnosis where individuals behave erratically, experiencing psychic confusion and visual hallucinations. Since it is believed that contaminated spirits are attracted by dirt and menstrual blood is considered dirty, women are particularly at risk for menstruation, delivery, and post-delivery jinn attacks. Religion plays an important role and acts as an aid to Rohingya refugees. They seek the help of traditional healers and religious leaders who conduct a ritual to eradicate the jinn. It is important to understand their traditional therapeutic support-seeking behavior to ensure the provision of culturally approved psychotherapy and psychological support. Major agencies involved in the psychological response to Rohingya refugees in Bangladesh include the Government of

Bangladesh, UN agencies, national and international NGOs, and Red Cross Societies. Adequate access to primary health care has become problematic, mental health care continues to face problems, and there is a significant gap in service delivery. (Tay, A. K., Islam, R., Riley, A., Welton-Mitchell, C., Duchesne, B., Waters, V., & Ventevogel, P. (2018). This section is solely relying on the research of "Culture, Context and Mental Health of Rohingya Refugees: A review for staff in mental health and psychosocial support programmes for Rohingya refugees. Geneva: United Nations High Commissioner for Refugees (UNHCR)" by Tay, A. K., Islam, R., Riley, A., Welton-Mitchell, C., Duchesne, B., Waters, V., & Ventevogel, P. (2018). Their research is managed by several sources of information in the Asia-Pacific and other regions about mental health. The research is covered with online information, literature, unpublished reports from non-profit organizations and United Nations agencies published until 2018.

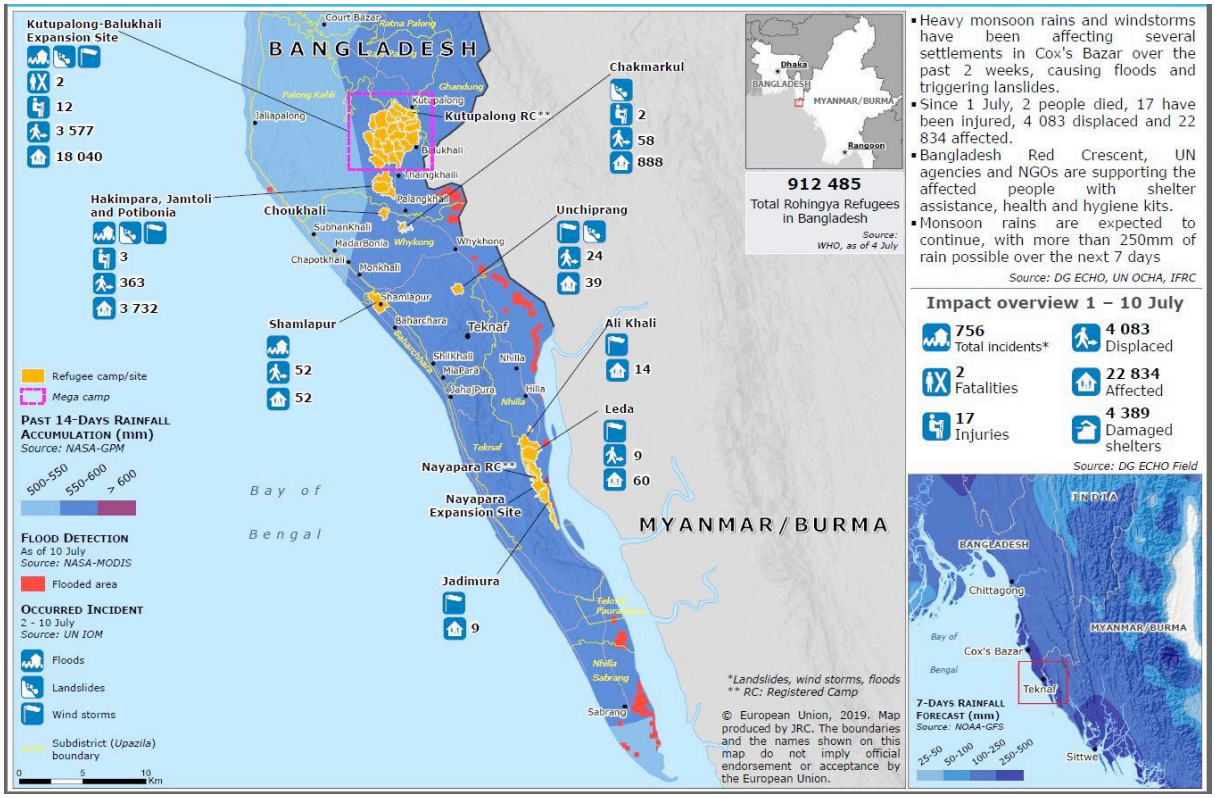
4.5.6 WASH (water, sanitization, and hygiene)

Minority people are not getting access to the essential medical care and wellbeing infrastructure, for example, safe drinking water, sewerage condition, garbage collection administrations, safe place to refresh and walk, and finally a suitable housing. Lack of land in the refugee camp area hinders waste disposal. Toilets have shallow holes and are found near water sources that are used for drinking. 12% of emergency toilets were full or non-functional. 15% of the toilets are found within 10 meters of water source. (UNHCR, 2018). Additionally, toilets often remain dirty due to the lack of water. Many latrines are without any lock and lights don't perform inside the camp. (Sang, D. (2018). Actually, refugee women are suffering from the WASH facilities for a long year because of the migration issue which mention in migration and feminist theory.

As a result, the danger leads individuals, especially women and young people, to rely on open latrines, which endangers their wellbeing and safety. Some women increase the risk of disease by using canvas / cloth pieces to create temporary washing spaces and latrines to avoid open washing and toilets in open spaces. They also harm their health by starving them and their children due to the unavoidable risk of using unhygienic latrines. They preferred to practice open defecation and dispose of waste manually but could no longer practice it due to the scarcity of burial ground. (Sang, D. (2018). Some reports indicate that the accessibility of water and cleanser inside or outside toilets, and regular hand wash is deficient. Since cleansers are

expensive, personal purchases are extra far-reaching. Handwashing is a quick and critical priority of clean-up control. There is no essential space for housing for the garbage. Garbage is dumped in inadequate places now and then and also on riverbanks. These rivers are used as sources of drinking water, which significantly induces health risks.

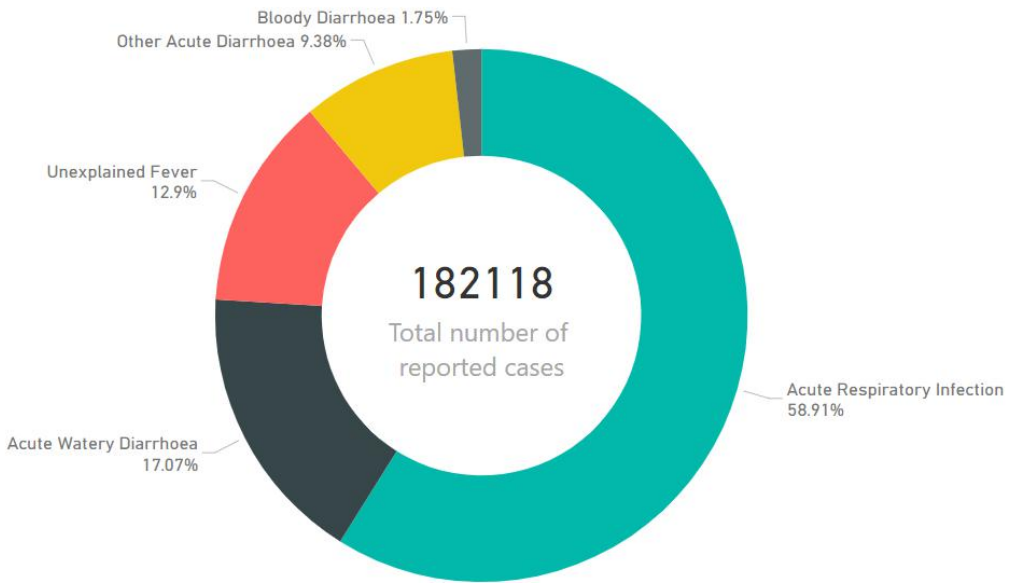
Figure - Rohingya refugee crisis



Source-Reliefweb, 2019.

In addition, monsoon, heavy rainfall, and flooding hampers the refugees' general health situation and prosperity. (Kirtane, S, 2018). Due to lack of practice about WASH among Rohingyas living in camps are responsible for countless medical conditions. (Health Sector Cox's Bazar, 2019). Cholera and diarrhea are rampant in Bangladesh, and they could show serious signs of malnutrition among the Rohingya population. Diarrhea is the second leading cause of death in children under five years of age. (Health Sector Cox's Bazar, 2019). Approximately 224,145 people suffered from acute watery diarrhea (AWD) which was reported in 2018. (Health Sector Cox's Bazar, 2019).

Figure- WASH related diseases.



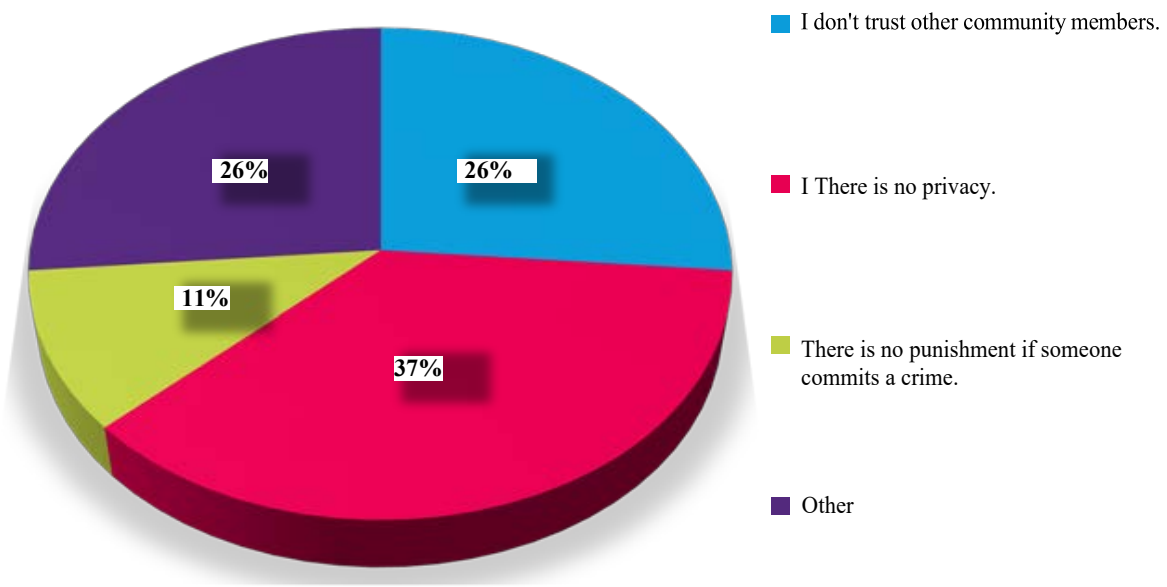
Source - Rohingya Crisis in Cox's Bazar District, Bangladesh: Health Sector Bulletin,2019

These issues are discussed in the article named "One Year On: Time to put women and girls at the heart of the Rohingya response" by Sang, D. (2018), which was carried out by Oxfam's primary report. For my research purpose, I have studied this report, which was done by altogether 104 focus group discussions (FGDs) with women and men from host and refugee minority communities; 134 interviews with male and female formal and informal community leaders and representatives from refugee and host communities; and a survey of 482 households in refugee and host communities. There are also other sources like "Rohingya Crisis in Cox's Bazar District, Bangladesh: Health Sector Bulletin,2019" that helped me to write this paper.

4.5.7 Sex explicit dangers

In Rohingya camps in Bangladesh, women and young girls represent more than 52 percent of the population, and single parents run one in six families. Some elements lead women not to use the washing service at an event when they are accessible, mainly due to lack of protection and embarrassment. (ISCG (2019). 'Embarrassment,' like some other encouraging localities, has played a significant role among Rohingya women as they are also underestimated within their minority network. Women stop using the latrines and washing spaces because of the scarcity of extra private and secure rooms. (REACH and UNICEF,2018).

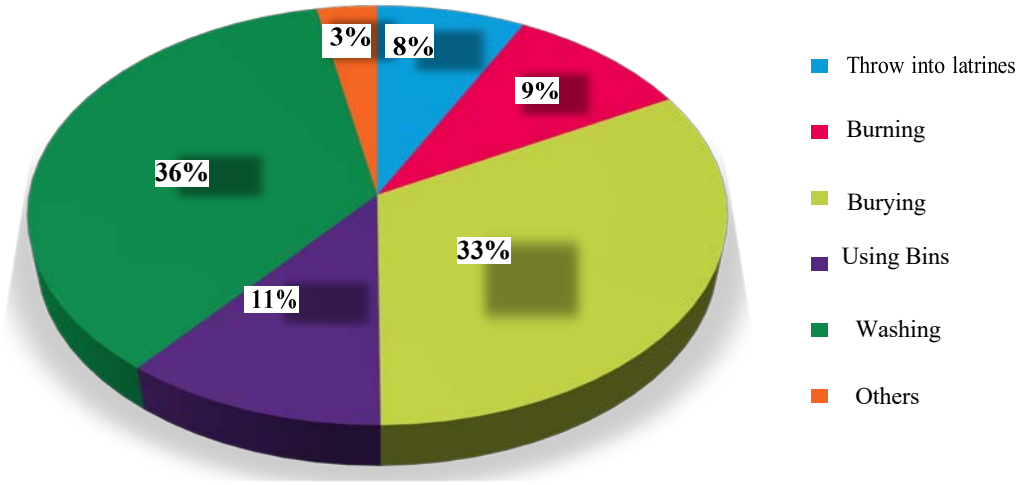
Figure- Reasons for feeling unsafe (female)



Source- Rohingya refugee response gender: Recognizing and responding to gender inequalities, (2018)

The faulty foundation for the toilet and bathroom creates a long queue, including men, which make it harder for women to use it. Lots of women from these lines prefer to wash and urinate in their inadequate place in the camp shelter. (REACH and UNICEF,2018). Since social and cultural values, Rohingya women do a significant job following the structure of the veil. When women go outside to use latrines, their society expects them to dress appropriately, which is a problematic responsibility and can be avoided by only staying inside their shelter. (REACH and UNICEF,2018). Moreover, a specific group of people needs proper information about menstrual hygiene, as this period is often associated with discomfort and social stigma. Rohingya women usually use reusable cloth and sanitary pads during their periods. (Sang, D. (2018). Regardless of the arrangement of menstrual clean-up items or the component of their Pride Kits, they cannot be able to use these privately and hygienically due to their shame and awkwardness, especially when it comes to dumping or washing in the same place used by men. For this reason, a shortage of water supply and separate toilets increases the risk of illness in women and children. (International Organization for Migration, (2019).

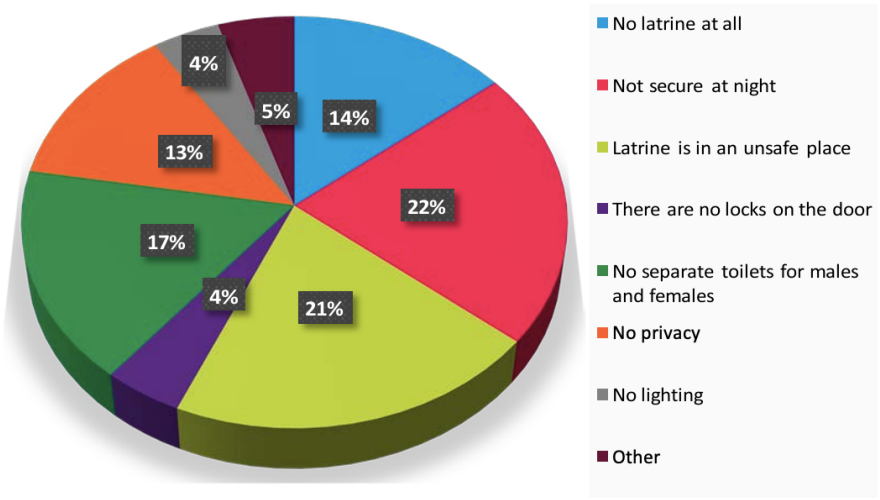
Figure- Disposal of menstrual hygiene materials



Source- Rohingya refugee response gender: Recognizing and responding to gender inequalities, (2018)

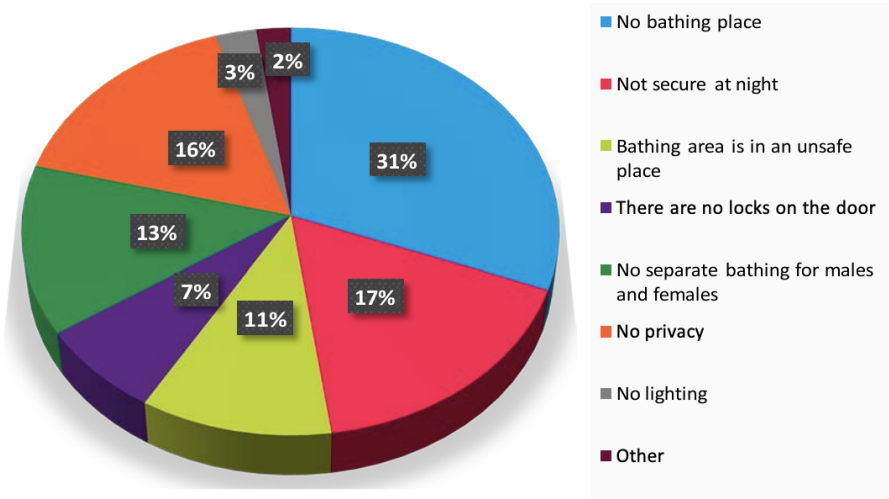
Many women used to wash or shit in the open spaces because of the shortage of toilets and bathing places. When women are provided with latrine facilities, they often miss the perfect locks, making them risky. Water shortage is another reason for their sorrows. The women used to travel in a specific way to collect water. Generally, they collect water from the selective place at odd times in the night because of the long line, which hampers their safety and protection. (International Organization for Migration (2019). Although some solar-powered lighting posts have been set up, there is still a lack of streetlights. Snatchings and robberies often occur in the Rohingya camp. In addition, lighting can make a difference and create a safer place, especially for women who suffer from sexual harassment and abuse inside the camps. (BRAC (2018)

Figure - Reason of latrines are unsafe (female)



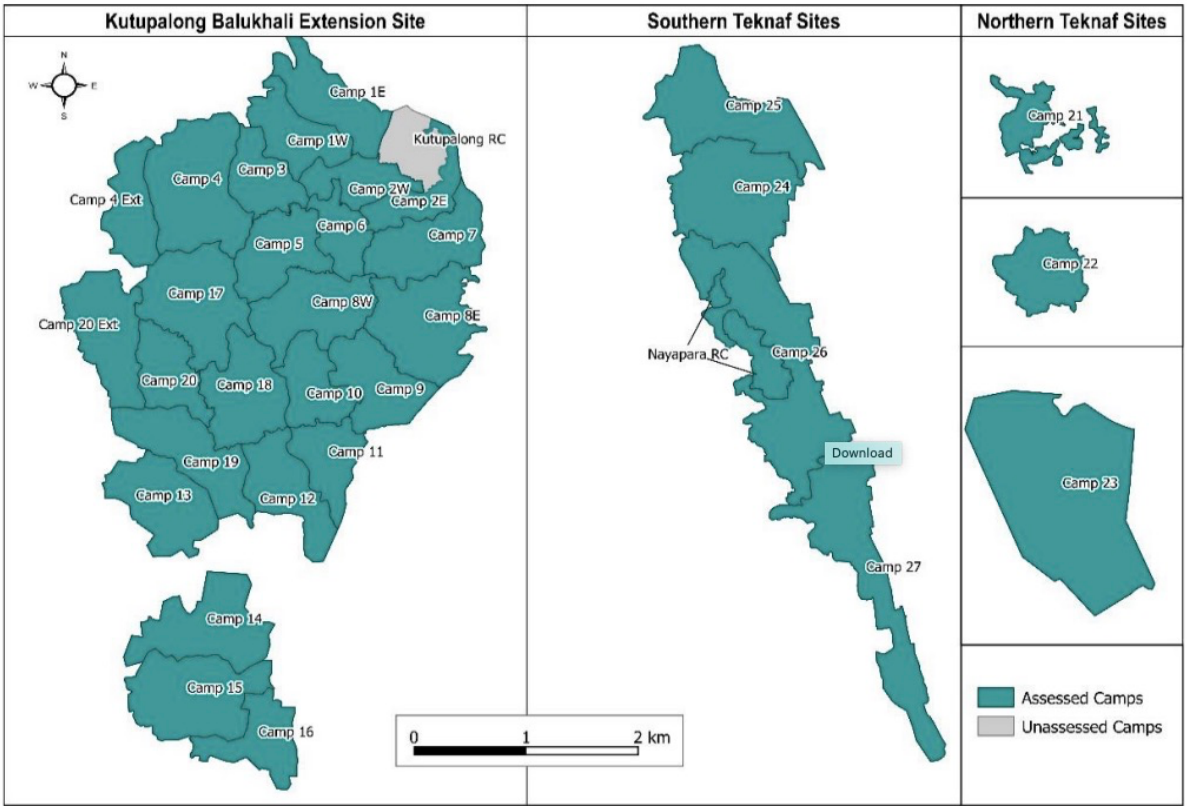
Source- Rohingya refugee response gender: Recognizing and responding to gender inequalities, (2018)

Figure: Reason of bathing places unsafe (female)



Source- Rohingya refugee response gender: Recognizing and responding to gender inequalities, (2018)

Figure-Camp location in Bangladesh



Source- REACH and UNICEF (2018). Water, Sanitation and Hygiene Assessment – Monsoon Follow- up. Cox's Bazar – Rohingya Refugee Response Report.

To collect the data and information, I took the help from the report "REACH and UNICEF (2018). Water, Sanitation and Hygiene Assessment – Monsoon Follow- up. Cox's Bazar – Rohingya Refugee Response Report." This report was a household survey in Kutupalong camp by interviewing 3,563 in total from 14 August and 3 October 2018. Another source of main data and Observations were made from JOINT AGENCY RESEARCH REPORT AUGUST 2018 titled ROHINGYA REFUGEE RESPONSE GENDER ANALYSIS: Recognizing and responding to gender inequalities. They focus on four camps – Balukhali, Kutupalong, Unchiprang, and Nayapara – to make this document. This survey was followed by Oxfam in partnership with the help of Action Against Hunger and Save the Children. There are also contributions from CARE, UNHCR, ISCG, and UN Women.

5 Discussion

In this chapter, I will discuss the analysis of Rohingya women's health situation in Bangladesh and give some recommendations based on my research finding. In the previous section, my focus is to find out the health situation of Rohingya women in Bangladesh and how they survive in Bangladesh, which covers my first research question. This part will try to answer my last two research questions. One of the questions is about the Rohingya are a minority people, who are refugee in Bangladesh and how does it affect them. And another one is about the affords and aim of the Bangladesh government to improve women's health conditions according to minority rights. As I already discussed in the last chapter about their situation, I will do some findings from the previous chapter, which meant their feelings when they are staying in the refugee camp in Bangladesh. There are also some recommendations related to the Rohingya health facilities in Bangladesh and the Bangladesh Government's response. Suppose the Bangladesh government will implement all those recommendations with the help of national and international NGOs. In that case, that will surely help to protect the fundamental human rights of Rohingya minority women. This chapter's last part will help me get the answer to the last question about medical care facilities in Bangladesh. Though I am, I didn't go through deeply and discuss the solution more briefly but tried to give an overall situation of aim and response of Bangladesh Government. My main purpose is to focus on minority issues from an indigenous perspective if they were getting enough facility in Bangladesh as minority refugee people.

5.1 Findings and recommendation

This part is about the previous chapter's findings and some proposals that could be beneficial and solutions for both the Rohingya women and the host country. Suppose the proposal will be implemented and take the proper steps to ensure the health services available and accessible, which will protect the fundamental human rights of refugee women. A model could be implemented, which precisely shows these linkages, providing a rights-based appraisal pointer to investigate factors influencing a populace's physical and psychological wellness. I will follow the structure and resource from previous chapter.

5.1.1 Food and waterborne diseases

Finding

People inside the refugee camp use the same water sources for drinking, washing, bathing, and open poo. Another issue is the flooding will expand the danger of waterborne infections. Moreover, insufficient toilets for the huge population are one of the main reasons for waterborne disease. Rohingya refugees at risk are cholera, hepatitis A, hepatitis E, and typhoid.

Recommendation

The foundation should be inspected for primary versatility comparable to medical care, instruction, administrations, and help services. Proper training should be provided among the local area volunteers and acknowledge risk information among the evacuees. To make sure the proper sanitation and hygienic condition of the refugee camp. Its need to make more toilets inside the camp to stop food and waterborne disease.

5.1.2 Infectious diseases

Finding

Lack of sufficient disinfection, low water quality, and living closely are the main reasons for the infectious disease outbreak in Rohingya exile camps. Diphtheria is a major concern among the Rohingya population because of poor sanitation and water conditions. Children are more affected than grown-up people. Drug trafficking and sexual harassment are more common in the refugee camp in Cox's Bazar, Bangladesh.

Recommendation

The General Health Authority takes steps to increase insulation and alleviate the burden of vaccination prevention of Rohingyas for new diphtheria afforestation. Improving the living condition of the refugee camp and maintaining proper social distance can prevent the outbreak of infectious diseases. Expand efforts to improve adolescent sexual and reproductive well-being. The global-local area is gradually realizing that working with and focusing on adolescents is an effective process for improving public speaking for people in the present and

the future. (Ainul, S., Ehsan, I., Haque E. F., Amin, S., Rob, U., Melnikas, A., J., Falcone. J, 2018). Rohingya adolescents and young people have changed their views about contraceptive use after the movement in Bangladesh to expand contacts with specialists. All these steps should be taken to provide more potential counseling to Rohingya adolescents on the accessibility of Sexual Reproductive Health administration in their areas. Health education devices should be accessible at a lower education level among Rohingya and provide techniques related to alternative strategies for HIV and contraception should be used. Promote the interest and administration of women and girls, men, and boys in all areas of programming and establish resources within the boundaries of organizations that specialize in sexuality (especially women's privileged associations). Introduce independent sex-based programming in the wild, not just in response to sexual-based brutality, the promotion of female empowerment, and the response to potential issues for women and men, women, and adolescents. (Sang, D. (2018).

5.1.3 Reproductive health

Finding

Child marriage became high in the Rohingya camps without any legitimate strategy and restrictions age of the minimum marriageable. This research is to find out if the Rohingya are generally preferred for early marriages. Conventional Islamic beliefs, such as the desire to protect the sexual purity of young women, are factors that persuade parents to give marriages to young girls. Children have high demand, and large families prefer Rohingya, and religion plays a significant part in the trend of larger family size. The most influential and natural response to the desired family size is "God's will" and "as much as God gives." Research has shown that economic interest also plays a role in prioritizing larger family sizes - it is believed that more children will bring prosperity. Accurate information and utilization of contraception are restricted and limited among the Rohingya. Injection and oral pills are the two most well-known contractive methods among them. Husbands and in-laws are the main decision-makers about taking the children. Religious beliefs play the justification non-utilization of contraception which is seen as 'haram' and 'sin' and considered precluded by Islam. Rohingya women are afraid to take family planning products and use them because of misinterpretations and rumors. Specifically, fear of preventive consequences, including infertility and even death, frightening factors prevent many women from using their technology. Hearing conversations

from neighbors, friends and locally elderly women spreads deception. Horrible and misguided judgments regarding institutional delivery are spread excessively among the Rohingya. (Ainul, S., Ehsan, I., Haque E. F., Amin, S., Rob, U., Melnikas, A., J., Falcone. J, 2018).

Recommendation

Focus on sexual and reproductive health issues among elderly Rohingya women and engage them as experts for positive change. Local elders' experiences regularly manage young women and girls and advise them to choose conceptual health issues. The advice shared by female seniors may be more respected than any clinical specialist. It is harmful if elderly women lead to inadequate, confusing, or misleading information and stories. Respected seniors' women should be able to give accurate information about SRH through careful preparation and resources. Rohingya is a dominant male group, and women should comply with their spouses concerning childbearing and fertility choices. The best way to work with males and make them understand the importance of contraceptives. Another effective way that local pioneers, such as Majhees, should come together is to provide accurate information and work with husbands to encourage them that the use of contraceptives may benefit both their wives and their children. Connect with young people instead of believing that young people will connect. It is difficult for young people to access health facilities due to norms, modesty, and transportation issues. Versatile effort camps can be a practical and powerful choice for connecting with teenagers. This effort will be promising if the Rohingya volunteer works with Bangladeshi experts together. The Safe space model in the refugee camp can create social cooperation, system administration, and portability among adolescents and young Rohingya young women inside the camp. If these spaces act as an organizing center for outreach practice, young women and their families would likely improve along with government support. (Ainul, S., Ehsan, I., Haque E. F., Amin, S., Rob, U., Melnikas, A., J., Falcone. J, 2018).

5.1.4 Malnutrition

Finding

There is a matter about malnutrition among youngsters as long as five years old, with specific troubles for breastfeeding kids under a half-year-old enough, additionally anxiety about nutritional deficiencies among women and girls, as men and boys are getting priority for taking food. There is the issue of malnutrition among long-five-years-old children. There are specific problems with breastfeeding for children under one and a half years. In addition, there are concerns about malnutrition among women and girls, as men and boys are given priority in food intake. There is malnutrition among long-five-years-old. There are specific problems with breastfeeding for children under one and a half years. There are also concerns about malnutrition among women and girls, as men and boys prioritize food intake. There are other issues concerning the nutritional deficiencies of newborn children. (Joint Agency Research Report, August 2018)

Recommendation

Provide multi-year financing for independent sexual orientation programming that plans to address a portion of the main drivers of sex inequality and gender-based viciousness. (Sang, D. (2018). The Government of Bangladesh with the help of NGO's should create a broader and stronger response for Rohingya women, youth, men, and boys who can support them to understand their privileges in times of extinction and the longer term, consolidating by providing long-term emergencies. Observe sexual orientation and other destructive traditional customary practices related to gender issues to stop malnutrition and treat nutrition. Develop custom-made sexual orientation, extensive information, training, and correspondence materials on nutrition to adapt to unique situations. In nutritional knowledge and effective change practice, make people understand that get acquainted with the benefits of caring for children and young people to attend nutrition meetings, contact parents / male parents including implementation for children under five and Nutritional requirements. Assist mothers with proper guidance, straightforward breastfeeding practice, and psychosocial upbringing. Promote men's participation in developing responsibilities to reduce women's workload and encourage

equal sharing of parenting responsibilities. Ensure that both men and women are equipped with information on the health and nutrition of women and youth to establish a strong climate for positive nourishment. (Joint Agency Research Report, August 2018)

5.1.5 Mental health

Finding

Women's mental health are related to traumatic events which include threats of human right violations, loss of identity, sexual violence, congestion, substance misuse, separation of mothers from their children, separation from community members, lack of food or security, unemployment, poverty, lack of access to services and freedom of movement.

Rohingya women feel powerless against mental illness and cause them memory loss, focus issues, obsessive-compulsive disorder, nervousness, stress, guilt, sadness, fear, nightmares, excitement, sadness, home sickness, shock etc. Due to feelings of frustration considering their current and future situation and loss of identity Rohingya women often think about suicide. Religion plays an important role and acts as an aid to Rohingya women. It is common belief that women are particularly at risk for menstruation, delivery, and post-delivery jinn attacks.

Recommendation

Improve the protection of women and young women through sexual orientation equity mainstream absolute obligations throughout the response. Recruit more female staff, especially for administration, and help focus primarily on women and young women. To work with women in local area design plans and make sure this gender issue is sensitive. Focus on support to help women in the time of deliveries and provide transports from their allocations. Work with Majhis and local area pioneers to create opportunities for women to enter existing interpersonal spaces, including schools and mosques. They should also try to find alternative safe spaces inside the camps for women. Humanitarian actors can work with local women's groups to encourage them to deal with female strengthening and create space for exiled women and don't forget that these women are overcomers from sexual abuse, trauma, and injury. Ensure that sympathetic activities in the Rohingya response are linked to the recently settled

women's humanitarian platform in Bangladesh. (Sang, D. (2018). Strengthen casual female pioneers in Rohingya people and men and establish formal female pioneers in the local host area. Promote women's contributions in a decision-making situation. Support women-only self-improvement gatherings to provide overall support and basic capabilities. (Joint Agency Research Report, August 2018)

5.1.6 WASH (water, sanitization, and hygiene)

Finding

There is a lack of wash structure to fulfill society's needs, especially enough toilets and washing space for women in the camp. Women's menstrual hygiene requirements are neglected mainly, which is a basic need. Toilets are found near water sources that further stain the tube wells. Due to lack of water, toilets remain dirty which create unhygienically. Women are at higher risk of disease by using canvas/cloth pieces to create temporary washing spaces and latrines to avoid open washing and toilets in the open. Cleaning items like handwash is a luxury in the refugee camp.

Recommendation

Enough toilet spaces with water sources should be organized in the camp area. An initial requirement should be consulted with women and young girls in the hygiene opportunity organization, making sure their views will be valued. A menstrual hygiene space should be implemented by authority into each female washroom. Women should have separate and private spaces for bathing. The structure of the camp area must be inspected continuously by the administration to guarantee that it complies with the minimum standards for health and safety by adding lights and locks at the entrance.

5.1.7 Sex explicit dangers

Finding

There is no separate space for women's toilets and washing space. Due to lack of protection and embarrassment, commonplace is not accessible for women. Women prefer to use their inadequate place because of the faulty foundation in the camp.

Recommendation

The Government of Bangladesh allocates land for the development of women inside the camps for foundation, including latrine, washing space, and water points. Make sure women feel safe inside the camp. Create a separate space for women for washing and toilets so that they can feel comfortable.

5.2 Medical care facility in Bangladesh

Altogether, they work 170 fundamental health units: 33 primary health communities and 10 secondary organizations. Cox's Bazar has around 910 medical clinic beds, 290 in Government-run offices and others in private facilities or in impermanent emergency clinics that have been set up as a component of the humanitarian organizations (Inter Sector Coordination Group, 2018). Since the beginning of the emergency in August 2017 until 21 June 2018, health organizations have given over 2 million health counsels to the displaced people and host populaces. (Inter Sector Coordination Group, 2018). Inside the evacuee settlements, there is a topographical division for coordinating medical care benefits among IOM and UNHCR, each covering various zones with their accomplices. Because of medical problems that have emerged from the compassionate crisis, a Strategic Advisory Group for Health was set up by WHO and the Ministry of Health and Family Welfare (MOHFW) of Bangladesh, including the United Nations and significant NGOs (Tay, A. K., Islam, R., Riley, A., Welton-Mitchell, C., Duchesne, B., Waters, V., & Ventevogel, P. (2018). Many projects on indigenous people's wellbeing keep on being supported by worldwide organisations like PAHO, the World Bank and the Inter-American Development Bank. In 1993, the World Health Organization and PAHO received the Health of the Indigenous Peoples Initiative, which advanced 5 key standards: 1) The requirement for a comprehensive way to deal with wellbeing, 2) The privilege to self-assurance

of indigenous peoples, 3) The privilege to efficient cooperation, 4) Respect for and revitalisation of native societies 5) Reciprocity of relations. Hughes, J. (2004)

5.2.1 Coordination of health services

Numerous associations are presently engaged with giving health services to Rohingya displaced people. Significant service contributor along with the Bangladesh government (the Ministry of Health and Ministry of Women and Children); Relief International, international NGOs (ACF, Danish Refugee Council, Handicap International, UN agencies (IOM, UNFPA, UNHCR, UNICEF); the International Rescue Committee, Medical Teams International, MSF, Save the Children and World Concern); national NGOs BRAC; and other international organizations such as the International Federation of the Red Cross, the Danish Red Cross, and Red Crescent Societies (IFRC). Most of these associations have medical facilities in the refugee settlements. A few associations have likewise given the health facilities of the national framework, for instance in Baharchara (through ACF) and Ukhiya Upazila Health Complex (through MSF). (Tay, A. K., Islam, R., Riley, A., Welton-Mitchell, C., Duchesne, B., Waters, V., & Ventevogel, P. (2018). Most nations have signed different global deals, assertions, and laws, including the Declaration of Human Rights (1948), and the Resolutions of the Americas Summit (1994), yet the ILO Convention 169 on indigenous and Tribal Peoples (1989) is by a wide margin the broadest as far as arrangements for government managed security and health. Other authoritative archives incorporate the Agreement for the Construction of a Development Fund for Indigenous People of Latin America and the Caribbean (1992), the International Decade of the World's Indigenous People groups (1995-2004) embraced by the UN General Assembly, and the Agreement between the Indigenous Parliament of America and the Pan-American Health Organization (1995). (Hughes, J. (2004)

5.3 Summarize of the study

In this master's thesis, I tried to feature chronic health results of the Rohingya displaced women living in outcast camps in Bangladesh. It recognizes fundamental human rights issues of delayed relocation, abandoned living status, absence of social milieu, restricted access to administrations, and the diligent shortage of assets as key contributing components of poor physical and mental wellbeing results. Additionally, the research establishes that these

components are reliant and cooperate with hidden strategy and rights issues, which further increment their weakness to the entrance and apply health services.

The most widely recognized medical issue distinguished in refugee camp settings is those spinning around hygiene, respiratory problems, and irresistible sicknesses, which are frequently ascribed to the climate conditions. Notwithstanding the actual restrictions inside camps, there are different psychological health outcomes of abuse, war, and historical trauma joined with everyday natural stressors related to lengthy dislocation, statelessness, and life in evacuee camps. There is currently developing literature that explicitly recognizes daily climate stressors' expanded function in psychological health consequences. Besides, the worldwide refugee emergency presents a reasonable connection between the refugee issue and human rights, as likewise featured in the research findings. Nonetheless, the sophisticated interchange of fundamental and quick basic rights of outcasts and health results has restricted arrangement on Bangladesh's account. It should tend to through a detailed methodology. There is an absence of a properly necessary human rights substructure to illuminate general health mediations. This survey presents a model that recognizes social structure to comprehend and investigate common human rights factors influencing the physical and psychological well-being of a populace. Subsequently, it decidedly enriches the current information hole in this developing region of research. It features the need to apply fundamental rights to deal with outline activities at the program and strategy level to guarantee improved Rohingya populace's improved health results. Such policy approaches will focus on finding a long periodical solution for coordinating the Rohingya refugees while designating their prompt rights issue.

It was found from this study that sexual and reproductive well-being is a critical issue among the Rohingya influx in Bangladesh. The past examination additionally found that refugee and forcedly dislodged women are incredibly helpless against negative sexual and contraceptive wellbeing results, generally because of the absence of information on sexual and reproductive medical problems, for example, monthly cycle, menopause, sexually contaminated illnesses, and cervical screening. Having a lack of knowledge on health administration in a host nation and giving lower preference to one's well-being in contrast with concerns, such as shelter, food, and other fundamental requirements, also assume a function in such consideration. In compassionate settings, women experience pregnancy-related complexities and unfriendly birth results often when contrasted and pre-struggle circumstances. Subsequently, associations

working in Rohingya settlements should find an essential way to make reproductive health aid accessible, available, and reasonable, to guarantee the standard of care and increment sexual and contraceptive wellbeing information and consciousness among exile women. Utilizing advanced innovations, such as cell phones, portable applications, and online media, can help deal with these issues, notwithstanding, some extra matters considered cautiously before utilizing innovation in Rohingya settlements. These incorporate the accessibility of advanced technology among the focus group, their schooling strength, and health-related convictions and standards. (Joarder T, Sutradhar I, Hasan M, et al. (August 15, 2020)

6 Conclusion

Indigenous peoples experience highly undeniable degrees of maternal and neonatal mortality, morbidity, HIV / AIDS, and other irreversible infections such as intestinal illness and tuberculosis. Among them, minority women face this medical condition terribly as they are affected by natural disasters together with armed conflict. Let alone the regularly denied access to education, land, property, and other financial resources. Fortunately, they take a necessary part in managing the well-being and prosperity of their families and networks. (Health, United Nations for Indigenous Peoples. (2021)

More common issues, such as other general medical problems such as drug abuse, alcohol use, increased grief and self-destruction, stress, and concerted efforts, are expected to move forward in the well-being of indigenous women groups. (Health, United Nations for Indigenous Peoples. (2021). Similarly, minorities all throughout the world are victim of conflicts and internal clash. The circumstance of refugee and inside dislodged people from minority background, specifically women and kids, is of special concern. People having a place with ethnicity, and religious and linguistic minorities are regularly discriminated. They may need admittance to, in addition to other things, housing, land and property, and identity. (UN, 2010).

Thus, the tremendous emotional sufferings and continuous systemic oppression Rohingya refugee women faced enormous difficulties, and humanitarian help can go without much of a stretch vibe in the face of various requirements. Nonetheless, the current emergency also gives new assets and new opportunities to create administrations and supports that are socially relevant and contextually appropriate. Regarding the previous background to traumatic accidents and misfortunes should be matched with consideration for progressing stressors and issues related to stresses about the near future. It is essential to plan health policy to activate refugees' individual and group strengths and expand their versatility. This plan requires efforts from the host country to work with Rohingya refugees with the help of international organizations to protect their minority rights. A sound comprehension of how Rohingya individuals forget their sufferings and work towards solutions is a basic need. (Tay, A. K., Islam, R., Riley, A., Welton-Mitchell, C., Duchesne, B., Waters, V., & Ventevogel, P. (2018).

Finally, Indigenous people can claim minority rights under global law, there are United Nations orders and components devoted explicitly to ensuring their privileges. by following its work, the United Nations has applied the guideline of self-ID as to indigenous people groups and minorities. In viable terms, various associations and shared traits exist between aboriginal people and national, ethnic, linguistic and religious minorities. Both indigenous peoples and minorities regularly wish to hold and advance their identity. Circumstances can be found on the ground where a native gathering could wind up in a minority-like circumstance and, similarly, a few minorities have solid and long-standing connections to their properties, what's more, domains as do indigenous people. Minorities, nonetheless, don't essentially have the long familial, customary, and spiritual connection and furthermore, associations with their properties and regions that are generally related with self-recognizable proof as indigenous people. (United Nations, (2010)

I hope that this paper will start more conversation on the manners by which the global local area, experts and the government of the Region can work with indigenous people to give available, quality, and socially sensitive wellbeing administrations to indigenous people. This will require a deeper comprehension of how the interchange between sex, identity, culture, financial status, age, and region of home effects the strength of indigenous people.

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Appendix

Figure - Overall health Condition of Rohingya refugees in Bangladesh (June 2018)

Type of disease/symptom/health event	Name of disease/symptom/health event	Affected population	Total cases	Prevalence	Reference
Infectious Diseases	Unexplained fever	Adult, children	2,27,928	N/A	WHO, 2018a
	Acute respiratory infection	Adult, children	2,23,651	N/A	WHO, 2018a
	Diarrhea (watery and bloody)	Adult, children	1,92,560	N/A	WHO, 2018a
	Malaria	Adult, children	53	N/A	WHO, 2018a
	Measles/Rubella	Adult, children	1,410	N/A	EWARS, 2018
	Acute jaundice syndrome (Hepatitis A, B, C; Leptospira)	Adult, children	12,842	N/A	EWARS, 2018
	Measles (outbreak) (Dec 2017-Apr 2018)	Children (81% U5)	1,231		EWARS, 2018
	Diphtheria (outbreak)	Adult, children	7,772 (42 death)	N/A	EWARS, 2018
	Tuberculosis	Adult, children	4,000 (estimated)	N/A	WHO SEAR, 2018
	HIV/AIDS	Adult, children	5,000 (estimated)	N/A	WHO SEAR, 2018
Non-communicable Diseases	Hypertension	Adult	N/A	51.5%	Balsari et al., 2018
	Diabetes	Adult	N/A	14.2%	Balsari et al., 2018
	Injuries/Wounds	Adult, children	36,930	N/A	EWARS, 2018
Nutritional Deficiency	Stunting/chronic undernutrition	Children (U5)	N/A	43.4%	Leidman et al., 2018
	Global acute malnutrition (GAM)	Children (U5)	N/A	24.3%	Leidman et al., 2018
	Anemia	Children (U5)	N/A	47.9%	Leidman et al., 2018
		Women (RA)	N/A	57.2% (estimated)	WHO SEAR, 2018
	Severe acute malnutrition (SAM)	Children	7,796	4.1%	WHO, 2018a
	Moderate acute malnutrition (MAM)	Children	7,854	4.2%	WHO, 2018a
Child Health*	Acute respiratory infection	Children (U5)	N/A	32.0%	EWARS, 2018
	Unexplained fever	Children (U5)	N/A	27.0%	EWARS, 2018
	Acute watery diarrhea	Children (U5)	N/A	23.0%	EWARS, 2018
	Skin diseases	Children (U5)	N/A	6.0%	EWARS, 2018
Sexual and Reproductive Health	Pregnancy (Feb 2018)	Women (RA)	53,266	N/A	WHO, 2018c
	Expected delivery (Feb-May 2018)	Women (RA)	16,513	N/A	WHO, 2018c
	Obstetrical complications (Feb-May 2018)	Women (RA)	2,477 (estimated)	N/A	WHO, 2018c
Gender-Based Violence (GBV) Related	GBV (Aug 2017-Dec 2017)	Girls, women	>14,036	N/A	UNFPA, 2018
	Forced sexual favors	Girls, women	N/A	12.8%	Riley et al., 2017
	Forced and unwanted sex	Girls, women	N/A	8.1%	Riley et al., 2017
Mental Health	Post-traumatic stress disorder (PTSD)	Adult	N/A	36.0%	Riley et al., 2017
	Depressive symptoms	Adult	N/A	89.0%	Riley et al., 2017
	Suicidal thoughts	Adult	N/A	13.0%	Riley et al., 2017
	Feel afraid	Adult	N/A	14.0%	Riley et al., 2017

Source- A Record Review on the Health Status of Rohingya Refugees in Bangladesh