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Right to Health and Nutrition of Refugee Children: A Legal and Human Rights Perspective with Special Reference to Rohingya Children in South Asia

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Abstract

The global refugee crisis has placed millions of children in conditions of extreme vulnerability, with their fundamental rights to health and nutrition frequently compromised. This article examines the international legal framework governing the right to health and nutrition of refugee children, with particular focus on the Convention on the Rights of the Child (CRC), the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the guidelines established by the United Nations High Commissioner for Refugees (UNHCR). Taking the Rohingya refugee crisis in South Asia as a case study, the article critically analyses the implementation gaps that persist between the normative standards enshrined in international human rights instruments and the lived realities of refugee children in Bangladesh and India. The study reveals that despite a robust international legal architecture, structural deficiencies in domestic legal frameworks, the absence of refugee-specific legislation in host states, and chronic underfunding of humanitarian operations contribute to widespread malnutrition and health deprivation among Rohingya refugee children. The article concludes with recommendations for strengthening legal accountability and bridging the implementation gap.

Keywords: Refugee children, right to health, right to nutrition, Convention on the Rights of the Child, Rohingya, UNHCR, malnutrition, South Asia, international humanitarian law, statelessness

1. Introduction

The twenty-first century has witnessed an unprecedented escalation of forced displacement worldwide. According to the United Nations High Commissioner for Refugees, by the end of 2020, approximately 82.4 million people had been forcibly displaced, of whom 26.4 million were refugees and nearly 42 per cent were children below the age of eighteen (UNHCR, 2021). Among displaced populations, children represent the most vulnerable demographic, disproportionately affected by malnutrition, disease, and the denial of basic health services. The intersection of international refugee law, human rights law, and humanitarian standards creates a complex normative framework intended to safeguard the health and nutritional rights of these children. However, the translation of these legal commitments into tangible protections remains deeply inadequate.

The Rohingya crisis, which intensified dramatically following the military operations in Myanmar's Rakhine State in August 2017, provides a particularly illustrative case study. Over 700,000 Rohingya, including approximately 370,000 children, fled to Cox's Bazar district in Bangladesh within a matter of months (UNICEF, 2018). The scale and rapidity of this

displacement created an acute humanitarian emergency characterised by severe malnutrition, disease outbreaks, and a near-total absence of legal protections. Neither Bangladesh nor India, the two primary South Asian host states, is a signatory to the 1951 Refugee Convention or the 1967 Protocol, creating a critical legal vacuum in refugee protection.

This article undertakes a doctrinal analysis of the international legal framework governing refugee children's right to health and nutrition, evaluates its application in the context of the Rohingya crisis, and identifies the structural and institutional barriers to effective implementation. The article argues that while international instruments provide a comprehensive normative foundation, the absence of binding enforcement mechanisms and the reluctance of host states to incorporate these standards into domestic law perpetuate a significant implementation gap.

2. International Legal Framework Governing the Right to Health and Nutrition of Refugee Children

2.1 The Convention on the Rights of the Child (CRC)

The Convention on the Rights of the Child, adopted by the United Nations General Assembly in 1989 and entering into force in 1990, constitutes the most comprehensive international instrument dedicated to the rights of children. With near-universal ratification, the CRC establishes binding obligations on States Parties to ensure the survival, development, protection, and participation of every child within their jurisdiction, irrespective of the child's nationality, immigration status, or statelessness (Tobin, 2019).

Article 24 of the CRC is of central importance, recognising the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties are specifically obligated to take appropriate measures to combat disease and malnutrition, including within the framework of primary health care, through the provision of adequate nutritious foods and clean drinking water (CRC, 1989, Art. 24(2)(c)). Article 27 further supplements this by recognising the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral, and social development, placing primary responsibility on parents but requiring States to assist through material support and nutrition programmes.

Article 22 of the CRC addresses the specific situation of refugee children, requiring States Parties to take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee receives appropriate protection and humanitarian assistance in the enjoyment of the rights set forth in the Convention. Critically, this provision mandates that refugee children be treated as children first and foremost, and that immigration considerations must not override their fundamental rights (Pobjoy, 2017). The Committee on the Rights of the Child, in its General Comment No. 6 (2005) on the treatment of unaccompanied and separated children outside their country of origin, reinforced that the obligations under the Convention extend to all children within a State's jurisdiction, without discrimination.

General Comment No. 15 (2013) of the Committee on the Rights of the Child provides authoritative interpretation of Article 24, elaborating the determinants of children's health to include adequate nutrition, safe drinking water, sanitation, and environmental health. The

Committee emphasised that States must address the underlying social determinants of health and that particular attention must be paid to children in vulnerable situations, including refugee and displaced children (CRC Committee, 2013). The General Comment explicitly acknowledges that malnutrition constitutes a violation of the right to health when it results from State failure to adopt adequate policies and allocate sufficient resources.

2.2 The International Covenant on Economic, Social and Cultural Rights (ICESCR)

The ICESCR, adopted in 1966 and in force since 1976, establishes the right of everyone to an adequate standard of living, including adequate food (Article 11), and the right to the enjoyment of the highest attainable standard of physical and mental health (Article 12). The Committee on Economic, Social and Cultural Rights, in General Comment No. 12 (1999) on the right to adequate food, clarified that the right to food is realised when every person has physical and economic access at all times to adequate food or means for its procurement. General Comment No. 14 (2000) on the right to health identified vulnerable and marginalised groups, including refugees and asylum seekers, as requiring special protection.

While the ICESCR applies to all individuals within a State's territory or jurisdiction, the principle of progressive realisation (Article 2(1)) allows States a degree of flexibility based on available resources. However, the Committee has consistently maintained that certain core obligations are immediate and non-derogable, including the obligation to ensure access to the minimum essential food which is nutritionally adequate and safe, and to essential primary health care (CESCR, 1999; CESCR, 2000). For refugee children, this means that host states cannot invoke resource limitations to justify complete deprivation of food or health services.

2.3 The 1951 Refugee Convention and 1967 Protocol

The 1951 Convention Relating to the Status of Refugees and its 1967 Protocol establish the foundational legal framework for refugee protection. While the Convention does not contain explicit provisions on children, it guarantees refugees the right to public relief and assistance on par with nationals (Article 23) and access to medical services equivalent to that available to nationals (Article 24). However, the significance of these provisions is substantially limited in the South Asian context, as neither Bangladesh nor India has ratified either instrument (Abrar, 2009). This creates a paradoxical situation wherein the states hosting among the largest Rohingya refugee populations bear no formal treaty obligations under the primary international refugee protection framework.

2.4 The Global Compact on Refugees (2018)

The Global Compact on Refugees, affirmed by the United Nations General Assembly in December 2018, represents the most recent multilateral effort to strengthen international cooperation on refugee protection. While not legally binding, the Compact identifies health and nutrition as priority areas, calling for the inclusion of refugees in national health systems and the strengthening of food security interventions (UNGA, 2018). The Compact specifically recognises the needs of refugee children and calls for enhanced support for host countries and communities. UNHCR has subsequently developed guidance on operationalising the Compact's health and nutrition commitments, including evidence-based nutrition response plans aligned with the Sustainable Development Goals (UNHCR, 2020).

3. The Rohingya Refugee Crisis: Health and Nutritional Realities

3.1 Background and Scale of the Crisis

The Rohingya, a predominantly Muslim ethnic minority in Myanmar's Rakhine State, have faced decades of systematic persecution and denial of citizenship under Myanmar's 1982 Citizenship Law, which excluded them from the list of recognised national races and effectively rendered the entire community stateless (Cheung, 2012). The military operations of August 2017 precipitated the most rapid forced displacement in the region's recent history. By early 2018, approximately 900,000 Rohingya refugees were sheltered in densely overcrowded camps in Cox's Bazar district, Bangladesh, constituting one of the world's largest refugee settlements (ISCG, 2018).

The conditions in the camps were characterised by severe overcrowding, inadequate water and sanitation infrastructure, and limited access to health care. The Government of Bangladesh, while demonstrating initial generosity in opening its borders, did not formally recognise the Rohingya as refugees, instead designating them as "Forcibly Displaced Myanmar Nationals" (FDMNs). This terminological distinction had significant legal and practical consequences, as it placed the Rohingya outside the formal protections afforded under Bangladesh's limited domestic legal provisions and subjected them to restrictions on freedom of movement, employment, and access to national services (Bhatia et al., 2018).

3.2 Malnutrition Among Rohingya Refugee Children

The nutritional situation of Rohingya refugee children in Cox's Bazar has been consistently alarming since the onset of the crisis. A preliminary nutrition assessment conducted at Kutupalong refugee camp in November 2017 revealed a 7.5 per cent prevalence of severe acute malnutrition among children under five, a rate double that recorded in the same population in May 2017 (UNICEF, 2017). Subsequent surveys demonstrated that while emergency interventions achieved some improvements, the situation remained critical. A cross-sectional study by Leidman et al. (2020), analysing data from October 2017 to May 2018, found that stunting rates declined from 44 per cent to 38 per cent in the main camp, though this remained perilously close to the World Health Organisation's critical emergency threshold of 40 per cent. Acute malnutrition rates declined from 19 per cent to 12 per cent, but the prevalence remained well above the WHO threshold of 10 per cent for a serious public health emergency.

The drivers of malnutrition among Rohingya refugee children are multifactorial. The camp environment limits dietary diversity, with refugees largely dependent on food rations provided by the World Food Programme. Inadequate infant and young child feeding practices, exacerbated by the disruption of breastfeeding during flight and displacement, contributed to elevated rates of wasting and stunting among the youngest children (Hossain et al., 2020). The outbreak of COVID-19 in 2020 further compounded the crisis, as UNICEF reported that lockdown measures forced the scaling down of nutrition facility operations, reducing access to treatment for severe and moderate acute malnutrition at a time when the need was most acute (UNICEF, 2020).

3.3 Health Service Gaps and Disease Burden

Beyond malnutrition, Rohingya refugee children in Cox's Bazar faced a heavy burden of communicable diseases, including acute respiratory infections, diarrhoeal diseases, and measles. The overcrowded camp conditions, combined with inadequate sanitation and limited access to clean water, created an environment highly conducive to disease transmission. A diphtheria outbreak in late 2017, which disproportionately affected children, highlighted the consequences of prolonged denial of routine immunisation services in Myanmar (Polonsky et al., 2019). While the joint humanitarian response, coordinated by the Inter Sector Coordination Group (ISCG), established over 150 health facilities in the camps by 2019, these facilities remained understaffed and under-resourced relative to the population's needs.

4. Legal Analysis: The Implementation Gap

4.1 Absence of Domestic Refugee Legislation in South Asia

The most fundamental structural barrier to the realisation of refugee children's health and nutritional rights in South Asia is the absence of dedicated domestic refugee legislation. Bangladesh, despite hosting over one million Rohingya refugees, has neither ratified the 1951 Refugee Convention nor enacted any domestic legislation recognising or protecting refugees as a legal category. The Foreigners Act of 1946 remains the primary domestic legal instrument applicable to non-nationals, treating refugees indistinguishably from other foreign nationals and providing no framework for the recognition of international protection obligations (Islam, 2019). While the Bangladesh Supreme Court has acknowledged in obiter that certain principles of the 1951 Convention, including non-refoulement, have attained the status of customary international law binding on all states, this judicial recognition has not been translated into comprehensive legislative protection.

India similarly lacks a formal domestic law governing asylum and refugee rights. India is not a party to the 1951 Refugee Convention or the 1967 Protocol, and its treatment of refugees is governed by executive discretion rather than legislative mandate. The Foreigners Act of 1946 and the Citizenship (Amendment) Act of 2019 further complicate the legal landscape, with the latter explicitly excluding Muslim refugees, including the Rohingya, from its ambit (Bhattacharjee, 2019). Indian courts have upheld the principle of non-refoulement as implicit in the right to life under Article 21 of the Constitution, yet the practical enforcement of this principle has been inconsistent, with documented instances of Rohingya deportations.

4.2 Statelessness and Its Compounding Effect

The statelessness of the Rohingya compounds the legal protection deficit in a manner that is particularly damaging for children. Stateless children occupy a uniquely precarious legal position: denied citizenship by their country of origin and unrecognised as refugees by their host states, they fall into a protection gap that international human rights instruments were designed to prevent but have proven inadequate to close (Institute on Statelessness and Inclusion, 2020). Article 7 of the CRC guarantees every child the right to acquire a nationality, and Article 8 protects the right to preserve identity, including nationality. Yet for Rohingya children born in refugee camps in Bangladesh, neither Myanmar's citizenship law nor

Bangladesh's nationality framework provides a pathway to citizenship, perpetuating a cycle of statelessness across generations.

The consequences for health and nutrition are direct and severe. Stateless children are frequently excluded from national health insurance schemes, public distribution systems, and social welfare programmes that are conditioned upon citizenship or formal legal status. In Bangladesh, Rohingya children's access to health and nutrition services is mediated almost entirely through humanitarian agencies rather than the national health system, creating a parallel and chronically underfunded service delivery structure (Wali et al., 2018).

4.3 Institutional and Funding Challenges

The humanitarian response to the Rohingya crisis has been consistently underfunded. The Joint Response Plan for the Rohingya Humanitarian Crisis has repeatedly failed to meet its funding targets, with the 2020 plan receiving only 56 per cent of the requested USD 1.05 billion (ISCG, 2021). The nutrition sector has been particularly affected, with funding shortfalls directly translating into reduced ration quantities, limited therapeutic feeding programmes, and gaps in micronutrient supplementation. The World Food Programme, which provides monthly food vouchers to the refugee population, has faced ongoing pressure to reduce per capita allocations due to donor fatigue and competing global emergencies.

From a legal accountability perspective, the fragmentation of responsibility among multiple institutional actors, the host government, UNHCR, WFP, UNICEF, and a constellation of international and national NGOs, creates challenges for determining legal responsibility when nutritional and health standards are not met. The question of whether humanitarian agencies bear legal obligations analogous to those of states under international human rights law remains unresolved in international legal scholarship, though there is growing academic support for the proposition that international organisations exercising effective control over refugee camp populations bear corresponding human rights obligations (Verdirame & Harrell-Bond, 2005).

5. Comparative Perspectives: Lessons from Other Jurisdictions

The South Asian experience contrasts instructively with other jurisdictions that have developed more robust legal frameworks for refugee protection. Turkey, the world's largest refugee-hosting country, extended Temporary Protection status to Syrian refugees and progressively integrated them into its national health system, providing free access to primary and secondary health care, including paediatric nutrition services (Doocy et al., 2015). While significant gaps remain, the Turkish model demonstrates that domestic legal recognition of refugee status can substantially improve access to health and nutrition services.

In Africa, the Organisation of African Unity Convention Governing the Specific Aspects of Refugee Problems in Africa (1969) adopts a broader refugee definition and has been complemented by domestic legislation in several states. Kenya's Refugee Act of 2006, for instance, provides a legal framework for refugee recognition and service provision, though implementation challenges persist. Uganda's Refugee Act of 2006 is frequently cited as a progressive model, granting refugees the right to work, freedom of movement, and access to public services including health care on par with nationals (Hovil, 2018).

These comparative examples underscore that the legal recognition of refugee status and the development of domestic legislative frameworks are critical preconditions for the effective realisation of refugee children's health and nutritional rights. The absence of such frameworks in Bangladesh and India represents not merely a legal lacuna but a structural barrier to the fulfilment of international human rights obligations.

6. Recommendations

First, Bangladesh and India should consider enacting comprehensive domestic refugee legislation that incorporates the core protections of the 1951 Refugee Convention, the CRC, and the ICESCR. Such legislation should explicitly guarantee refugee children's right to health and nutrition, providing a statutory basis for their inclusion in national health systems and public nutrition programmes. Ratification of the 1951 Convention and 1967 Protocol would provide the strongest legal foundation, but even in the absence of ratification, domestic legislation can achieve substantial protective gains.

Second, the international community should strengthen accountability mechanisms for ensuring that humanitarian agencies meet minimum nutritional and health standards in refugee settings. The Sphere Standards and UNHCR's Standardised Expanded Nutrition Survey (SENS) guidelines provide useful benchmarks, but compliance monitoring and enforcement remain weak. An independent monitoring mechanism, potentially under the auspices of the Committee on the Rights of the Child, should be established to regularly assess and report on the nutritional status of refugee children.

Third, donor states must commit to sustained and predictable funding for refugee nutrition and health programmes. The chronic underfunding of the Joint Response Plan for the Rohingya crisis has directly contributed to malnutrition among refugee children. Burden-sharing, as envisaged by the Global Compact on Refugees, must be operationalised with binding funding commitments rather than voluntary pledges.

Fourth, host states should grant Rohingya refugee children birth registration and documentation that, at minimum, acknowledges their legal personhood and facilitates their access to services. While the resolution of statelessness ultimately requires Myanmar's reform of its 1982 Citizenship Law, interim measures at the host state level can mitigate the most severe consequences of undocumented status.

7. Conclusion

The right to health and nutrition of refugee children is firmly established in international law, anchored in the CRC, the ICESCR, and reinforced by UNHCR guidelines and the Global Compact on Refugees. The normative framework is neither ambiguous nor inadequate; what is lacking is the political will to implement it. The Rohingya refugee crisis in South Asia illustrates with stark clarity how the convergence of statelessness, the absence of domestic refugee legislation, institutional fragmentation, and chronic underfunding can systematically deny children their most fundamental rights.

The international legal order's failure to protect Rohingya refugee children from malnutrition and health deprivation represents not merely a humanitarian failure but a legal

one. The obligations articulated in the CRC and ICESCR are binding, and States that host refugee populations without providing access to adequate nutrition and health care are in breach of their international commitments. Closing the implementation gap requires a multi-faceted response: domestic legal reform, strengthened international accountability, sustained funding, and a fundamental reorientation that treats refugee children not as subjects of charity but as holders of rights. Only through such an approach can the promise of international human rights law be made meaningful for the millions of refugee children who currently exist in its shadow.

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