

Protecting Human Rights: Situation of Rohingya Refugees in Bangladesh during Covid-19

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Introduction

The outbreak of COVID-19 has created a huge global health crisis that has had a deep impact on the way we see our world and our everyday lives. Especially when most governments across the world enforce lockdowns or other restrictions to suppress the spread of COVID-19, there will be a potential economic crisis worldwide. The case of Bangladesh is no different. There will be a negative impact on

Bangladesh's economy due to COVID-19 without doubt, however, the extent of that negative impact will depend on the duration of the crisis.

What is unique about Bangladesh's situation, however, is that it is the site of the world's largest refugee camp, with a population density one and a half times higher than New York City (Map of Cox's Bazar: Rohingya population density by Camps in Ukhia (here)). This article posits that Rohingya refugees, a stateless Muslim minority from Myanmar, living in Cox's Bazar, are among the most at risk groups globally in this pandemic. Because these individuals are stateless, they risk falling through the cracks at a time when individuals worldwide are incredibly dependent on their governments for providing health services and social safety nets.

This article explores the following questions: as a matter of international law, what are the internationally protected rights of the Rohingya refugees in Bangladesh with respect to their health and who has the responsibility to respect, protect and fulfill these rights? At a time when a developing country such as Bangladesh is under tremendous strain to take care of its citizens, the oft-ignored responsibility of States with regard to international cooperation under human rights treaties takes on renewed relevance.

The Situation in Bangladesh

Although the economic growth rate in Bangladesh has been very high for the last decade, and poverty rates have been drastically reduced (The World Bank: Bangladesh: Reducing Poverty and Sharing Prosperity (here)), Bangladesh still continues to struggle in many ways to provide adequate services to its citizens, in part because it remains one of the most densely populated countries in the world. Even before the COVID-19 crisis, Bangladesh's health system was struggling to combat the increasing burden of existing diseases, the low quality of health care coverage and an inadequate national budget for health. According to the World Health Organization, only about 2.4 to 2.8% of the Gross Domestic Product (GDP) is spent on health services. And the expenditure of the Government on health care is less than 1% of GDP – the rest coming from Out of Pocket Expenditure. Although the country has a growing private health sector primarily providing tertiary level health care services, Bangladesh still does not have a comprehensive health policy to strengthen the system as a whole. Bangladesh was therefore unprepared when the pandemic arose.

On March 7, Bangladesh announced its first confirmed cases of COVID-19, and since then the number of infections in the country has grown significantly. Like many countries, the government is facing difficulties in ensuring basic public healthcare and controlling negative economic impacts. As soon as the first cases started popping up, Bangladesh opted for a contained shutdown. Restrictions were imposed strictly on transportation and no vehicles were allowed on roads except for emergency needs to quell the spread of the COVID-19 pandemic.

Rohingya Refugees' presence in Bangladesh

Of note during this crisis is the fact that Bangladesh has accommodated the world's largest refugee camp. In accordance with its non-refoulement obligations under treaty (the *International Covenant on Civil and Political Rights* (ICCPR) (here) and the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (here)) and customary international law, Bangladesh has provided a safe haven to Rohingya people crossing into the Southern part of the country from Myanmar for the last several years.

The displaced Rohingya people living in Cox's Bazar are *de jure* stateless, as Myanmar, their country of origin, does not recognize their citizenship, nor have they obtained citizenship in Bangladesh. Article 1 (1) of the *1954 Convention relating to the Status of Stateless Persons* (here) defines a stateless person as "a person who is not considered as a national by any State under the operation of its law". In Myanmar, under the 1982 Citizenship Law (here) the acquisition of nationality is based on race or ethnicity. For citizenship at birth the law requires that both parents must be members of national ethnic groups and citizens. The Rohingya face racial discrimination under the application of the Citizenship Law, the reason being they are not included in the list of 135 races that are considered the national races of Myanmar, therefore, they are denied citizenship.

Not being a party to the *1951 Convention relating to the Status of Refugees* ("1951 Refugee Convention") (here), the Government of Bangladesh does not recognize the Rohingya people as refugees, but rather as "Forcibly Displaced Myanmar Nationals", denying the Rohingya people legal refugee status and the rights associated with it. Therefore, in 2018, the Committee on Economic, Social and Cultural Rights (CESCR), in their Concluding Observations following the Bangladesh periodic report, expressed its deep concern to Bangladesh that "…Rohingya people do not have legal status in the State party, which restricts their movement outside of the camps to access health-care services, education and other basic services" (here, para. 27) (See also Human Rights Watch Report: "Bangladesh is not my country"- 2018 (here)). Notably, UN documents (here) refer to this population as Rohingya refugees (p. 10), in line with the applicable international refugee framework for protection and solutions.

Even before the COVID-19 outbreak, the Rohingya refugees have faced a prolonged humanitarian crisis in the refugee camps. More than a million people live in cramped conditions, with inadequate access to water, telecommunications, and healthcare. As part of Bangladesh's efforts to stem the coronavirus pandemic, the Refugee Relief and Repatriation Commission required that camp operations be minimized to slow the spread of COVID-19. The UN High Commissioner for Refugees wrote in Update #2 15-30 April 2020 (here):

"Government authorities, in consultation with the UN and other humanitarian partners, introduced restrictions on activities in the camps, to reduce the risk of transmission of COVID-19. Only critical services and assistance are presently allowed, including programs in the areas of health, nutrition, food and fuel distribution, hygiene promotion, hygiene kit distribution, water and sanitation activities, construction of health and water and sanitation infrastructure, site management support, logistics, identification and quarantine of new arrivals, and family tracing."

On May 14, 2020, the first COVID-19 positive case within the Rohingya refugee community was confirmed (here). On June 2, 2020, the first Rohingya man died and as of 3rd July, 2020, there are 58 Rohingya refugees in the refugee camps in Cox's Bazar who have tested positive for COVID-19 (here). Those who have tested positive are being treated at an isolation center. Furthermore, there is an increase in confirmed cases in the Cox's Bazar district (here). Therefore, a major outbreak in the overcrowded camps is almost certain to come eventually – and when it does, many experts who work in the humanitarian field (including UNHCHR, IOM, UNICEF, etc.) are deeply concerned that the damage could be severe .

While the World Health Organization, together with the Ministry of Health and Family Welfare of Bangladesh and the Refugee Relief and Repatriation Commissioner's office, have taken significant steps to curb the spread of COVID-19, they are ill-prepared to respond to an outbreak in the camps.

Internationally Protected Human Rights of Rohingya People in the Refugee Camps with respect to Health

A pandemic engages a number of internationally protected human rights. These include the right to life (Article 6 of the ICCPR) and the right to the highest attainable standard of health (article 12 of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) (here).

There is no question that Rohingya refugees within Bangladesh's territory have civil and political rights under the ICCPR vis-à-vis Bangladesh. The ICCPR protects, among others, the right to life (article 6) and prohibits discrimination (articles 2(1), article 26). As illustrated below these rights impose a positive obligation on States to ensure that everyone has access to essential health care necessary to prevent foreseeable risks to life, regardless of migration status.

In its General Comment No. 36 (2018) on article 6 of the ICCPR, the Human Rights Committee, in paragraph 26, explained that "*the duty to protect life also implies that States parties should take appropriate measures to address the general conditions in society that may give rise to direct threats to life or prevent individuals from enjoying their right to life with dignity. These general conditions may include…the prevalence of life threatening diseases*…." (here)

The ICESRC provides the most comprehensive article on the right to health. Article 12 provides:

"*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:
...
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

Article 12 of the ICESCR has universal application, extending to everyone in a State Party's jurisdiction. But, like the ICESCR in general, article 12 has special relevance to the impoverished. As explained in General Comment No. 14 (2000) adopted by the CESCR, the right to health is not to be understood as a right to be healthy. It contains entitlements that include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable standard of health. This notion must be understood as "a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health". (here, paras. 8-9)

More specifically, article 12(2)(c) of the ICESCR imposes an obligation on States to take the steps necessary for "the prevention, treatment and control of epidemic, endemic, occupational and other diseases". It requires the creation of a system of urgent medical care in cases of epidemics and the provision of disaster relief and humanitarian assistance in emergency situations.

Individuals should not be discriminated against in the exercise of their right to health. Paragraphs 18 and 19 of General Comment No. 14 (2000) recall that by virtue of articles 2(2) and 3 of the ICESCR, no discrimination should occur by the State in access to health care on, *inter alia*, the grounds of race, colour, national or social origin, or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. The Committee further recalls General Comment No. 3 (2009) (here) on the Nature of States Parties' Obligations, paragraph 12, which states that even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programs. In General Comment 14 (paragraph 30), the CESCR opined that "other status" includes nationality and that the Covenant rights apply to everyone, including non-nationals.

Article 2(3) of the ICESCR allows developing countries 'with due regard to Human Rights and their national economy' to 'determine to what extent they would guarantee the economic rights recognized in the [ICESCR] to non-nationals'. Article 2(3) of the ICESCR effectively authorizes developing countries to limit the extent to which they guarantee economic rights recognized in the Covenant to non-nationals. However, it is the author's view that the right to health is not such an economic right on which limitations can be imposed on non-nationals. With respect to the right to health, the CESCR has stated in its General Comment No. 14 that the Covenant proscribes "any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status, sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health". Therefore, according to the broad non-discrimination principle articulated in General Comment No. 14, States parties to the Covenant cannot discriminate against non-citizens with respect to the right to health (UN: Preliminary report of the Special Rapporteur on the rights of non-citizens, para. 56, (here)).

Identifying the Duty-Bearer(s) in a Time of Crisis

As is well known, the influx of Rohingya refugees has already put Bangladesh under significant economic and administrative strain and COVID-19 is exacerbating the already tenuous situation. Under such circumstances, the question arises: under international law, who has the responsibility to ensure the right to health for the Rohingya refugees in camps in Bangladesh?

Most international human rights treaties confer obligations on States parties to respect and ensure the rights of individuals within their territory and jurisdiction. This is the case for the ICESCR and the ICCPR. Article 2(1) of the ICESCR reads:

"*Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.*"

Based on the interplay of articles 2(1) and 2(2) on non-discrimination, we can argue that Bangladesh, being a party to the ICESCR, is obliged to take necessary steps, to the maximum of its available resources, to achieve progressively the full realization of the right to health of the Rohingya refugees. Article 25(c) of the Constitution of Bangladesh (the constitution of Bangladesh (here)) captures the same spirit of safeguarding the racially oppressed people of the world as a fundamental principle of state policy. Furthermore, articles 31 and 32 of the Constitution guarantee equal protection of life and liberty to every person within the territory of Bangladesh.

That the ICESCR creates positive obligations on Bangladesh is clear. But one cannot bear this burden alone, and this article posits that the ICESCR does not require it to. In a time of pandemic (or other health emergency), the right to health takes on increased importance. The global health challenge of the pandemic, in the context of stark international inequalities, requires a dramatic shift towards global solidarity and shared responsibility. The ICESCR, consistent with other human rights treaties, recognizes that international assistance and cooperation is an obligation of all States in a position to assist (here).

The ICESCR has built in a mechanism recognizing the difficulties that developing countries can face for expanding their health and other essential services to nationals and non-nationals. By referring to "international assistance and co-operation" in article 2(1), it addresses this very serious issue by distributing the burden for the realization of ESC rights across the States parties and the international community. In its General Comment on Article 3 (paragraph 13), the CESCR notes "the phrase 'to the maximum of its available resources' was intended by the drafters of the Covenant to refer to both the resources existing within a State and those available from the international community through international cooperation and assistance". This has also been emphasized in General Comment No. 14 (2000) on article 12 of the ICESCR which underlines that, "depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible, and provide the necessary aid when required" (here, para. 39). The

CESCR also underlines that the international community has a collective responsibility to address the problem of diseases that are easily transmissible beyond the frontiers of a State.

Indeed, in 2018, the CESCR, in their Concluding Observations following Bangladesh's periodic report, recommended at paragraph 28 that Bangladesh, with the humanitarian assistance of the international community, take immediate measures to ensure the safety of the Rohingya refugees in camps and to safeguard against outbreaks of diseases such as diphtheria and cholera.

In September 2016, the United Nations General Assembly unanimously adopted the *New York Declaration for Refugees and Migrants* (here) in which States "acknowledge a shared responsibility to manage large movements of refugees and migrants in a humane, sensitive, compassionate and people-centred manner. [States] will do so through international cooperation, while recognizing that there are varying capacities and resources to respond to these movements" (paragraph 11). States commit to respect the human rights of refugees and to support the countries that welcome them. The Declaration paved the way to the *Global Compact on Refugees* (GCR) (here), which was affirmed in December 2018 by the United Nations General Assembly. The GRC highlights that "countries that receive and host refugees, make an immense contribution from their own limited resources to the collective good, and indeed to the cause of humanity" (para. 14). The GCR is a new international agreement to forge a stronger, fairer response to large refugee movements and protracted situations. Paragraph 14 continues: "It is imperative that these countries obtain tangible support of the international community as a whole in leading the response". The GCR builds upon the existing international treaties or instruments relating to refugees and to human rights. To operationalize burden-sharing the GCR states are paragraph 32: "Through the arrangements set out above, and other related channels, resources will be made available to countries faced with large-scale refugee situations relative to their capacity, both new and protracted, including through efforts to expand the support base beyond traditional donors." Indeed, the 1951 Refugee Convention, in its Preamble, recalls that "the grant of asylum may place unduly heavy burdens on certain countries" and that a satisfactory solution cannot be achieved without international co-operation.

Although the GCR is not legally binding (paragraph 4 of the GCR), it acknowledges the relevance of international law, including human rights and refugee law. Therefore, the responsibility of States with regard to international assistance and to burden/responsibility-sharing is more than a moral obligation considering the various commitments made by States (Part III.A of the GCR). At a time when all States' resources are strained to respond to this crisis, the world's most marginalized and vulnerable must not be overlooked.

Conclusion

In sum, Bangladesh has serious human rights obligations towards the Rohingya refugees in its territory, regardless of their stateless status. In this time of crisis, Bangladesh must continue to uphold its obligation of non-refoulement and pay special attention to the needs of the Rohingya refugees with respect to their rights to life and health. The particular vulnerability of this population should be

addressed through a uniform policy aimed at protecting them from the consequences of COVID-19. National and international funding must be mobilized to fight COVID-19 and should include resources for refugees and forcibly displaced communities. However, the concern is that the donor countries might restrict funding toward humanitarian crises in light of their own projected economic crises due to the outbreak of COVID-19.

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