

Assessment of Malnutrition & Poor Dietary Status of Children Under 5 Years Among Rohingya Refugees Living in Relocation Camp, Bangladesh

Mst. Farzana Islam Mim¹; Dr. Sheikh Md. Nazmul Hassan²;
Johora Khatun Rima³; Md. Hasan Morshed⁴

¹RN, B.Sc. in Nursing (Dhaka University), M.Sc. in Nutrition (Islamic University),
MPH (Rajshahi University)

²Professor; MBBS, MPH (University of New Castle, USA)

³B.Sc. & M.Sc. In Nutrition (Dhaka University)

⁴B.Sc. & M.Sc. In Nutrition (Dhaka University)

Publication Date: 2026/06/27

Abstract: Since October 2017, citing overcrowding, congestion, and security concerns in Cox's Bazar, the Government of Bangladesh has been relocating Forcibly Displaced Myanmar Nationals (FDMN) to Bhasan Char. This relocation site is situated in Hatiya, an island at the mouth of the Meghna River in the Bay of Bengal. The rapid influx of Rohingya refugees into Cox's Bazar has raised significant public health concerns, particularly regarding the nutritional well-being of children aged 0–5 years. The relocation of FDMN to Bhasan Char presents unique challenges to food security and child health. This cross-sectional survey aimed to generate baseline evidence on the nutritional vulnerabilities and dietary diversity status of under-5 children in the camp. A purposive sampling approach was used to survey primary caregivers of 420 children aged 6–59 months from September 2022 to February 2023. Data was performed using SPSS version 22.0, with statistical significance set at $p < 0.05$. Nutritional status was evaluated using WHO anthropometric indices (WAZ, HAZ, WHZ, and MUAC), and dietary diversity was measured using a standard 24-hour food group recall. Dietary analysis revealed that the majority of children consumed carbohydrate-based diets and did not achieve minimum dietary diversity. Alarming high rates of chronic and acute malnutrition were observed, including stunting (38.2%), wasting (15.2%), and underweight (46.6%). The relocated under-5 population suffers from a high prevalence of malnutrition compounded by poorly diversified diets. Policymakers must design targeted interventions to distribute micronutrient-fortified foods and improve overall camp nutrition programs.

Keywords: Nutritional Vulnerabilities, Dietary Diversity, Under-5 Children, FDMN, Bhasan Char, Rohingya, Bangladesh.

How to Cite: Mst. Farzana Islam Mim; Dr. Sheikh Md. Nazmul Hassan; Johora Khatun Rima; Md. Hasan Morshed (2026) Assessment of Malnutrition & Poor Dietary Status of Children Under 5 Years Among Rohingya Refugees Living in Relocation Camp, Bangladesh. *International Journal of Innovative Science and Research Technology*, 11(6), 1525-1532. <https://doi.org/10.38124/ijisrt/26jun1026>

I. INTRODUCTION

FDMN children are an increasingly vulnerable population in Bangladesh, facing a high risk of health and nutritional disparities. Since 2014, the global refugee population began to surge, reaching an estimated 14.4 million individuals under the mandate of the United Nations High Commissioner for Refugees (UNHCR), marking the highest figure recorded since 1995. In Bangladesh, Rohingya refugee camps currently accommodate approximately 836,000 refugees, of whom 33,956 are under-five children, a group particularly vulnerable to poor health outcomes. Children under five are more likely to fall into high-risk groups for mortality during the first five years of life. The extent of

malnutrition among Rohingya under-five children has become a major public health issue in Bangladesh. This study aimed to investigate the nutritional status and its determinants among Rohingya under-five children. Handwashing practices, vitamin A consumption, and worm infestation were statistically significant factors associated with disease outcomes. In this study population, there was a high prevalence of malnutrition among Rohingya children, especially wasting and underweight, compared to other areas. Prevention of malnutrition plays an important role in achieving a healthy society among Rohingya refugees (Hasib et al., 2020).

On August 25, 2017, the Rohingya were forced to flee Myanmar after attacks and the destruction of their villages by the Myanmar military. This triggered a series of humanitarian crises, leading to an unprecedented flow of refugees across the border to neighboring Bangladesh. Within weeks, half a million Rohingya refugees entered Bangladesh seeking safety and shelter (Taufiq, 2019). The reported prevalence of chronic undernutrition, global acute malnutrition, and severe acute malnutrition among Rohingya children aged 6–59 months in the Kutupalong refugee camp of Cox's Bazar was 43%, 24%, and 7.5%, respectively. Notably, only 9.8% of them consumed a minimally diversified diet (Leidman et al., 2018).

Following a wave of severe violence, persecution, and systemic atrocities in Myanmar's Rakhine State, hundreds of thousands of Rohingya fled to Cox's Bazar, Bangladesh. Data from the UNHCR (2019) indicates that approximately 738,805 Rohingya individuals crossed the border following the events of 25 August 2017, with infants and young children aged 0 to 4 making up 18.5% of this population. Historically recognized as one of the world's most severely persecuted Muslim minorities, the Rohingya have documented roots in Myanmar dating back to at least 1799 (Mahmood et al., 2017; Landry & Tupetz, 2018). Despite this long-standing presence, the enactment of the 1982 Citizenship Act systematically stripped them of full and associated citizenship rights. This legal exclusion led to severe restrictions on freedom of movement and denied them access to essential services, including healthcare, formal education, and lawful employment. Even prior to this mass displacement, malnutrition rates among Rohingya children had already breached the World Health Organization's emergency thresholds. This underlying nutritional vulnerability worsened drastically due to the physical toll of their escape journey and the harsh living environments inside the refugee camps (UNICEF, 2019). Such severe nutritional deficits significantly elevate the risk of infectious diseases, ultimately placing a heavy economic and health burden on the displaced community (Jesmin et al., 2011).

Among the refugees, 720,000 are children (UNICEF, 2017). A total of 14,740 orphaned Rohingya children have been identified since September 20, 2017, in the settlements of Ukhiya and Teknaf (UN Women, 2017). An estimated 250,000 children under eight require life-saving interventions through community-based activities such as vaccination campaigns, while 240,000 under-five children need malnutrition prevention and treatment support through nutritious supplementary food. Additionally, 16,965 children with severe acute malnutrition (SAM) require inpatient and outpatient treatment. (UNICEF, 2017; Islam & Nuzhath, 2018).

A study evaluating 114 Rohingya children aged six months to five years in Bangladesh found alarmingly high rates of malnutrition. Children were measured for weight and height, and their guardians were interviewed. Approximately 86% of the Rohingya children were underweight, 64.9% stunted, 82.1% thin, and 1.8% at risk of overweight. Severe acute malnutrition (MUAC <11.5 cm) was observed in 68.5%

of children. As refugees have limited access to healthcare services, they are at greater risk of health and nutritional problems. This study sheds light on the situation of refugee under-five children through a nutrition lens (Islam et al., 2018).

Evidence from Bangladesh and Myanmar confirms that weight-for-height Z-score (WHZ) and mid-upper arm circumference (MUAC) often yield conflicting rates of acute malnutrition. To address this discrepancy, national treatment guidelines should be updated to admit children based on low WHZ alongside low MUAC criteria. Furthermore, widespread anemia and inadequate dietary variety underscore the urgency of distributing more diverse family food rations, scaling up fortified supplementary food programs, and promoting ongoing breastfeeding (Leidman et al., 2018).

➤ *Research Questions*

The research was designed to achieve specific objectives, guided by the following research questions:

- What are the current prevalence of nutritional vulnerabilities (stunting, wasting, underweight) and the status of dietary diversity among under-5 children residing in the Bhasan Char relocation camp?
- What socioeconomic, demographic, or household factors are associated with inadequate dietary diversity among under-5 children in this context?

➤ *Research Objectives*

The primary aim of this study:

- To determine under-five growth deficits (stunting, wasting, underweight, and thinness) via anthropometric indicators.
- To identify vulnerabilities by measuring food consumption patterns.
- To evaluate dietary diversity and establish the high risk of malnutrition in the Bhasan Char camp setting, demonstrating that poor nutrition and low dietary diversity are prevalent regardless of socioeconomic variations, suggesting a systemic issue in food access.

➤ *Significance of the Study*

The primary significance of this study is that it provides critical baseline evidence on the dietary habits and severe malnutrition risks facing one of the world's most isolated and vulnerable refugee populations. Bhasan Char is a remote island camp located hundreds of kilometers away from the primary refugee hubs in Cox's Bazar. This study offers the first structured data on child nutrition and eating habits in this isolated environment. The findings serve as a call to action for host governments and the international humanitarian community to rethink relief logistics, demonstrating that merely feeding children is insufficient—the quality and diversity of food are essential for their survival. The study exposes hidden malnutrition, identifies monotonous diets, and empowers early recognition tactics.

II. METHODOLOGY & DESIGN

➤ Research Design and Setting

This study was conducted using a descriptive cross-sectional strategy to quantify the anthropometric status of under-5 children, identify vulnerabilities, and evaluate dietary diversity. The study was conducted at Bhasan Char, a remote island camp in Hatiya, Bangladesh. From September 2022 through February 2023, a six-month data collection process was conducted.

➤ Target Population and Sampling Method

Participants included Bhasan Char's FDMN residents, specifically tracking primary caregivers and children under the age of five. A total of 420 children were included. A purposive sampling technique was applied to select individual children.

➤ Inclusion Criteria

- Children must belong to the FDMN (Rohingya) community and be actively living in the Bhasan Char relocation camp during the survey period.
- Children must be between 0 and 59 months of age and be accompanied by a primary caregiver (mother, father, or legal guardian).
- The legal guardian must provide voluntary verbal or written informed consent.

➤ Exclusion Criteria

- Children who are critically ill or have physical deformities or congenital disabilities that prevent accurate anthropometric measurements.
- Absence of a primary caregiver.
- Families who refuse to participate or decline consent.

➤ Creation of the Data Collection Tool

The tool of this research design was guided by three-part approach:

- Existing literature.
- Core variables.
- Expert advisory

➤ Survey Instrument Design:

- General Information & Consent
- Socio-Demographic Profile
- Child's Health & Anthropometric Measurement (WHO, 2018)
- Dietary Diversity (WHO/UNICEF 24-Hour Recall)
- Food Security & Relief Aid Access

To ensure content validity, the draft questionnaire was reviewed by public health experts and the camp coordinator of Bhasan Char. Before formal execution, the survey underwent pilot testing with a minor sample group to verify comprehension and consistency, resulting in targeted revisions.

➤ Data Gathering Process

Before the main study, a pilot study was conducted to validate the questionnaire and understand participant characteristics. This also helped determine the approach for selecting the final study sample and refining the questionnaire. A structured questionnaire was used to gather information through face-to-face interviews with respondents. Anthropometric measurements—height/length, weight, and mid-upper arm circumference (MUAC)—were evaluated against WHO Child Growth Standards. Children stood with feet flat and slightly apart until the measurement was recorded. The scale was calibrated to zero before each weighing session. Body weight was recorded to the nearest 100 g (0.1 kg), repeated, and the average of two measurements was recorded. A modified tape measure was used to measure height. MUAC was measured on the less active hand at the midpoint between the shoulder and elbow. Caregiver interviews used a structured 24-hour dietary recall questionnaire to assess daily food group intake.

➤ Data Analysis

Collected questionnaires were checked for completeness and consistency. Data were manually coded and entered into a computer database. Statistical analysis was performed using SPSS version 22.0. Descriptive statistics (frequency and percentage) summarized categorical variables. Inferential statistical tests were applied where appropriate to determine associations between variables. A p-value <0.05 was considered statistically significant.

➤ Ethical Statement

The authors state that this is an original article and has not been submitted to any other journal for publication. The data are original, and the volume of data was not split to create multiple publications. No manipulation was done by the researchers that would compromise the ethics of the study.

III. RESULTS

➤ Socio-Demographic Profile

Table 1 shows the age distribution of under-5 children: 22.4% aged 0–11 months, 27.3% aged 12–23 months, 16.8% aged 24–35 months, 20.3% aged 36–47 months, and 13.2% aged 48–59 months.

Table 1 Age Distribution of Under-5 Children (n=420)

Age (months)	Frequency	Percentage (%)
0–11	94	22.4
12–23	115	27.3
24–35	70	16.8
36–47	85	20.3

48–59	56	13.2
Total	420	100

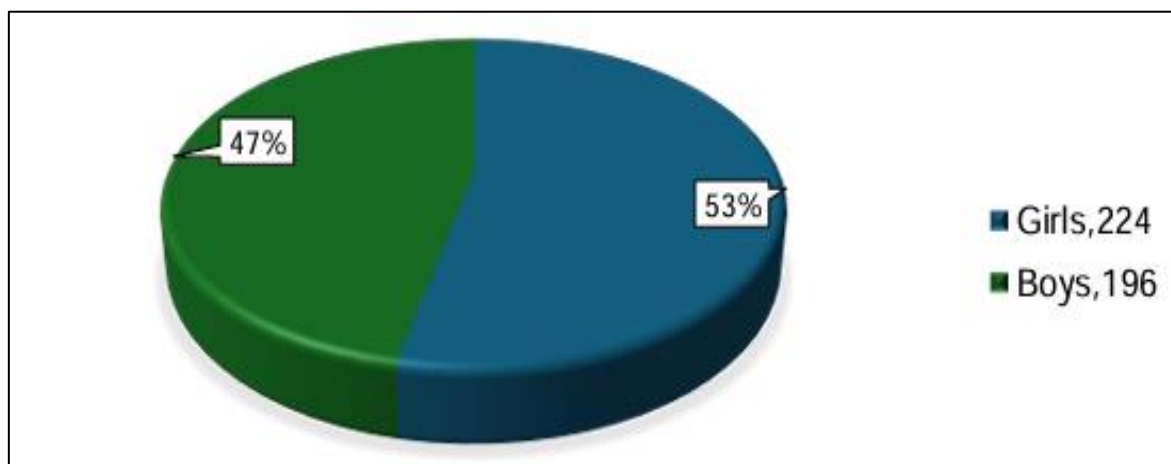


Fig 1 Gender Distribution of Respondents (n=420)

Figure 1 illustrates the gender distribution: girls comprised 224 (53%) and boys 196 (47%).

Table 2 shows the prevalence of stunting: 23.1% of children were severely stunted and 15.0% moderately stunted.

Table 2 Prevalence of Stunting Among Children (n=420)

Indicator (Z-score)	Frequency	Percentage (%)
Severely stunted (< -3SD)	97	23.1
Moderately stunted (-3SD to -2SD)	63	15.0
Normal height (>-2SD to 2SD)	250	59.6
Above normal (>+2SD)	10	2.3
Total	420	100

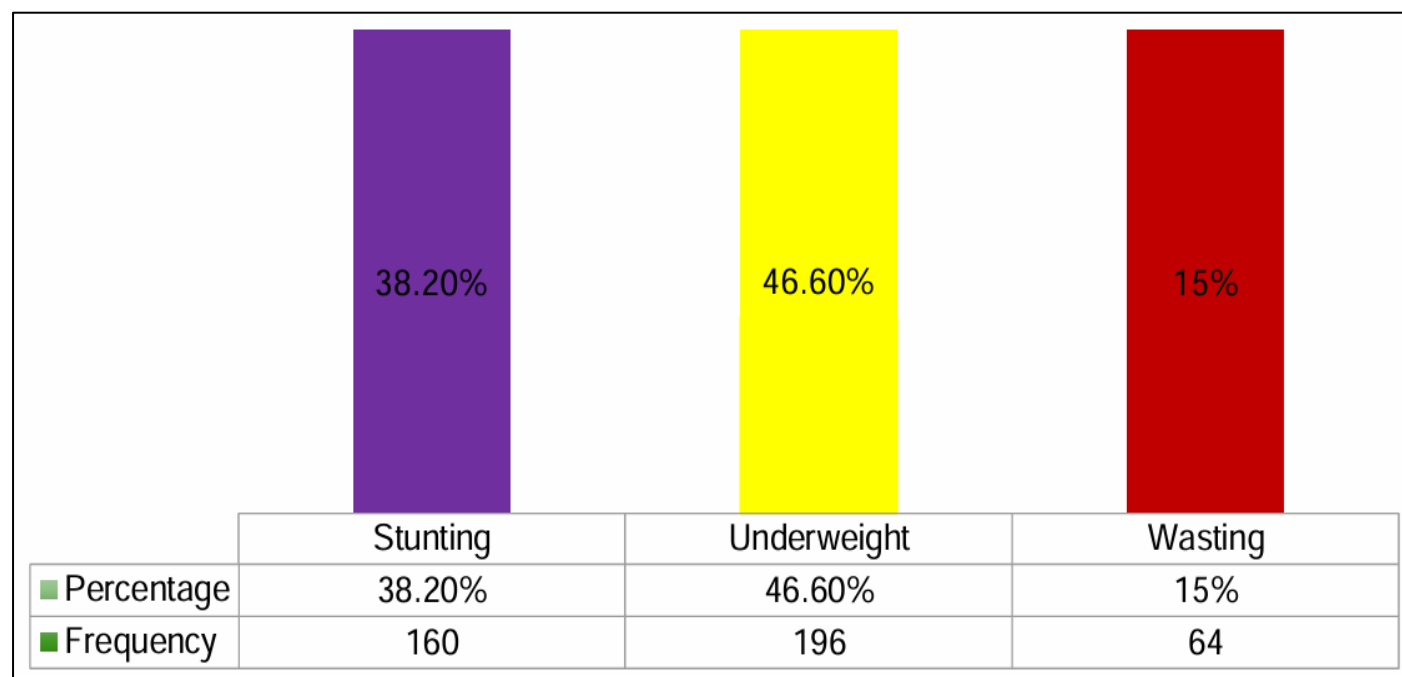


Fig 2 Prevalence of Stunting, Underweight, and Wasting Among Under-5 Children

Figure 2 shows the overall prevalence of malnutrition: stunting (38.2%), underweight (46.6%), and wasting (15.2%).

Table 3 shows the prevalence of wasting: 14.8% of children were severely wasted and 7.2% moderately wasted.

Table 3 Prevalence of Wasting Among Children (n=420)

Indicator (Z-score)	Frequency	Percentage (%)
Severely wasted (< -3SD)	62	14.8
Moderately wasted (-3SD to <-2SD)	30	7.2
Mildly wasted (>-2SD to <-1SD)	13	3.0
Normal (>-1SD to +1SD)	315	75.0
Total	420	100

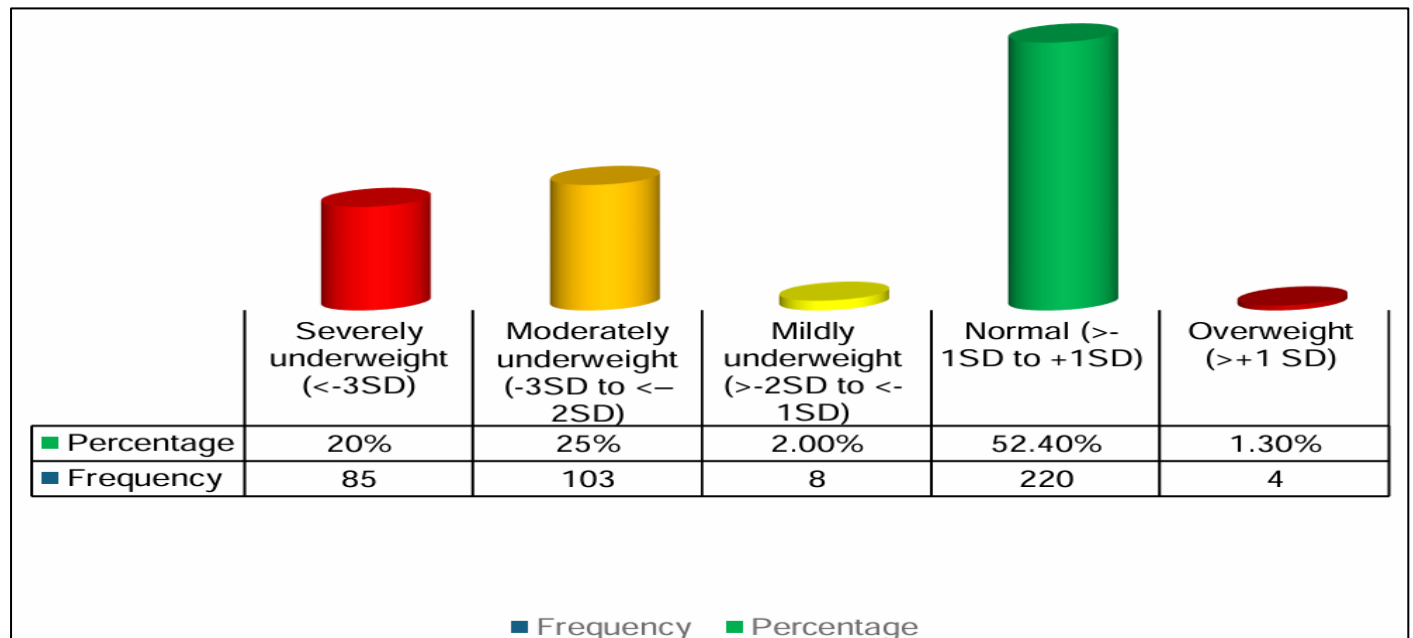


Fig 3 Prevalence of Underweight Among Children

Figure 3 shows the prevalence of underweight: severe underweight (20%) and moderate underweight (25%).

Table. 4 illustrate that 30% children were at risk of malnutrition, 22.2% of them were at.

Table 4 Frequency and Percentage of Wasting (Z-Score)

Indicator (Z-score)	Frequency	Percentage (%)
Severely wasted (<-3SD)	62	14.8
Moderately wasted (-3SD to <-2SD)	30	7.2
Mildly wasted (>-2SD to <-1SD)	13	3.0
Normal (>-1SD to +1SD)	315	75.0
Total	420	100

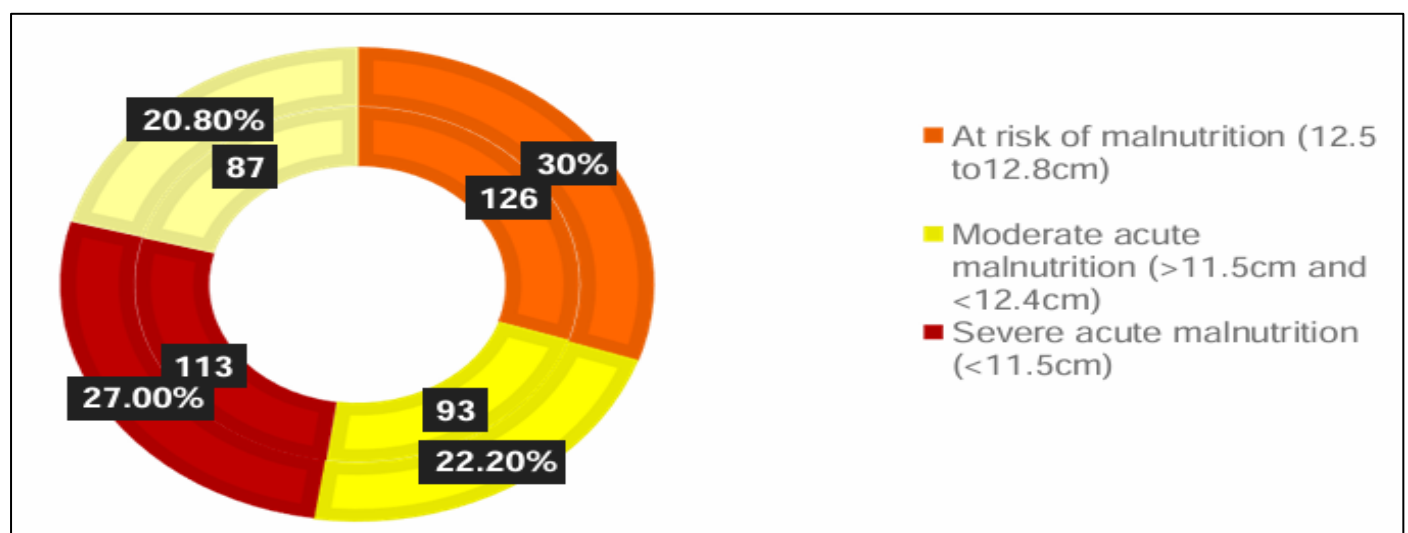


Fig 4 Nutritional Status Based on MUAC Among Under-5 Children

Figure 4 illustrates MUAC-based nutritional status: 30% of children were at risk of malnutrition, 22.2% moderately malnourished, and 27% severely malnourished.

IV. DISCUSSION

Nutritional status depends on multiple factors, including caregiver nutritional knowledge, hygiene practices, and sanitation behavior. This study investigated malnutrition of Rohingya children under the age of five. UNHCR & WFP have established objectives to prevent malnutrition among refugee populations.

A survey of under-five children among Forcibly Displaced Myanmar Nationals (FDMN) in Bhasan Char revealed that 38.2% suffer from stunting, 46.6% are underweight, and 15.2% experience wasting. These figures indicate a higher prevalence of undernutrition, particularly wasting and underweight, compared to the 2017–2018 national averages for Bangladesh, which were 31% for stunting, 22% for underweight, and 8% for wasting, according to the NIPORT & ICF report, 2020.

A 2023 study by Das et al. revealed that one-third of surveyed children under five suffered from stunting, with 8.5% classified as severe and 23.1% as moderate. Additionally, 27% were underweight (4.4% severe, 23.0% moderate), and 12% experienced wasting (1.2% severe, 10.9% moderate). In comparison, the current sample of Rohingya children displayed elevated rates of both moderate and severe acute malnutrition. Notably, the prevalence of global acute malnutrition indicated by a weight-for-height z-score under 2 surpassed the international emergency benchmark of 10%. (Das, S., et al. 2023)

Similar to the elevated stunting rates observed among young FDMN children in Bhasan Char, a 2014 study in Jordan's Za'atari camp revealed that Syrian refugee children inside the camp were significantly more stunted than those integrated into the surrounding host communities (Bilukha et al., 2014).

A demographic analysis of the 269 pediatric participants (6–59 months; mean age 31.9 months; 45.0% female) indicated that 55.0% were registered refugees, while 95.9% of the unregistered cohort had arrived in Bangladesh following the August 25, 2017 crisis. Household participation was near-universal, with only one refusal. Nutritional metrics indicated critical levels of both acute and chronic undernutrition. WHZ screening placed GAM at 24.3% and SAM at 7.5%, whereas MUAC screening estimated these rates much lower at 5.9% and 0.7%, respectively. Additionally, nearly half the cohort experienced chronic malnutrition (43.4%). (Eva Leidman et al. 2018)

A total of 470 participants were enrolled by a purposive sampling method from patients attending the hospital. Weight-for-height Z-score was calculated based on the 2006 World Health Organization growth standards guideline. Moderate acute malnutrition and severe acute malnutrition have defined as weight-for-height Z-score between -2 SD to

-3 SD and <-3 SD respectively. Result: Out of all, 282 (60.0%) belonged to the age group of <2 years, the mean age was 2.16 years (SD, 1.40) and 251 (53.4%) was male. The prevalence of moderate acute malnutrition and severe acute malnutrition were 25.1% and 18.5% respectively. The prevalence of acute malnutrition was significantly different compared to the sociodemographic factor particularly in age and sex (p -value <0.05). (Rashid Md Haroon et al. 2020)

Hasib et al. (2020) reported that approximately 41% of Rohingya children, 43% of children in surrounding areas, and 46% of children in Dumki were stunted (HAZ). Wasting (WHZ) was observed in 13%, 11%, and 4%, respectively, and underweight (WAZ) in 18%, 15%, and 10%, respectively. Food groups, disease, and worm infestation were statistically significant across the three study areas ($p < .05$).

Despite efforts to address malnutrition, the problem persists, especially in protracted refugee camps. Refugee children from Myanmar living in Thai camps had undernutrition rates of 33.7% underweight, 36.4% stunted, and 8.7% wasted. In a cross-sectional survey of refugee children in Syria, undernutrition and overnutrition coexisted: 17.9% were overweight, 9.7% stunted, and 49.6% anemic. Forcibly displaced populations often have poor income, housing, and sanitation conditions. Their food practices also change; they consume whatever is available, sometimes lacking three meals a day.

In a previous study by Islam et al. (2018), 85.96% of Rohingya children under five were underweight, 65% stunted, and 82% wasted. This high prevalence indicates severe food insecurity and potentially poor immunization and deworming status. Congested living standards and unprotected sanitation exacerbate the situation. Literature suggests Rohingya families hesitate to seek medical care due to fear of detention and high costs. Language and communication barriers further hinder access. Psychological trauma, mental shock, and uncertainty about the future continuously affect their well-being.

V. LIMITATIONS

This study is not without limitations. Anthropometric measurement approaches may not perfectly reflect actual nutritional conditions. The sample size and use of purposive sampling limit the generalizability of the findings to the broader Rohingya population in Bangladesh. Additionally, recall bias may have affected self-reported data. This study was limited to Cluster-9 FDMN under-five children in Bhasan Char.

VI. IMPLICATIONS FOR POLICY AND PRACTICE

The findings of this cross-sectional survey highlight critical nutritional vulnerabilities that require an immediate policy shift from emergency food aid to sustained, diverse food security frameworks in Bhasan Char. Policymakers should transition from generic food rations to diversified electronic voucher systems that allow families to access fresh,

micronutrient-dense foods. Humanitarian agencies must scale up localized vertical agriculture to overcome the camp's geographical isolation. Practically, integrating routine MUAC screenings into existing camp clinics will ensure early detection of acute malnutrition in under-five children, ultimately reducing mortality rates.

VII. CONCLUSION

This cross-sectional survey highlights a critical conclusion: stunting (38.2%), wasting (15.2%), and underweight (46.6%) were observed across the cohort, indicating a high prevalence of nutritional vulnerabilities and inadequate dietary diversity among under-five children in the Bhasan Char relocation camp. The findings reveal that despite ongoing humanitarian assistance, a significant proportion of children fail to meet the minimum acceptable diet, heavily relying on poorly diversified diets and lacking essential micronutrients from animal-source foods, fruits, and vegetables.

The nutritional deficits are strongly linked to limited household income, restricted market access, low maternal literacy, and large family size. These results indicate that current food distribution models alone are insufficient to ensure optimal child growth and development in this displaced population.

To mitigate these vulnerabilities, immediate policy shifts are required. Humanitarian agencies must transition from basic food aid to targeted nutrition interventions, such as promoting fresh food markets, implementing cash-based transfers, and scaling up community-based infant and young child feeding (IYCF) counseling. Addressing these gaps is vital to preventing long-term stunting and developmental delays among these forcibly displaced children.

ACKNOWLEDGEMENTS

Sincerely thank to FDMN community living in relocation camp, Bhasan Char for their participation and to Prof. Dr. Sheikh Md. Nazmul Hassan for data collection and continuous support.

➤ *Conflict of Interest*

The authors declare no conflict of interest regarding the publication of this article.

➤ *Authors' Contribution*

This study framework designed & overseen by Prof. Dr. Sheikh Md. Nazmul Hassan & also performed the final manuscript revision. Data collection, analytical task & initial draft conducted by Mst. Farzana Islam Mim. Johora Khatun Rima and Md. Hasan Morshed assisted in data collection and statistical analysis.

➤ *Funding Sources*

- No financial support.

➤ *Data Availability*

The manuscript includes all data generated during this study. The raw data remain the corresponding author & are accessible by request.

REFERENCES

- [1]. Tarannum S (2023). Problems in Bangladesh Health Sector World-Class Facilities Get in Touch Today, no. June: 1-17.
- [2]. United Nations High Commission for Refugees. (2015). UNHCR Global Trends: Forced Displacement in 2014.
- [3]. Hasib, Md., Hassan, Md., Hasan, M., & Khan, M. S. I. (2020). Effect of nutritional status on Rohingya under-five children in Bangladesh. *International Journal of Public Health Science (IJPHS)*, 9, 101-106. <https://doi.org/10.11591/ijphs.v9i4.20546>
- [4]. Taufiq, H. A. (2019). China, India, and Myanmar: Playing Rohingya roulette? In *South Asia in Global Power Rivalry: Inside-out Appraisals from Bangladesh* (pp. 81-99). Singapore: Springer Singapore.
- [5]. BBC News. (2018). Bangladesh to return 300 Rohingya a day. Retrieved from <http://www.bbc.com/news/world-asia-42699602>
- [6]. Leidman, E., Humphreys, A., Greene Cramer, B., Toroitich-Van Mil, L., Wilkinson, C., Narayan, A., & Bilukha, O. (2018). Acute Malnutrition and Anemia Among Rohingya Children in Kutupalong Camp, Bangladesh. *JAMA*, 319(14), 1505–1506. <https://doi.org/10.1001/jama.2018.2405>
- [7]. UNHCR. (2019). Situation refugee response in Bangladesh. Retrieved from https://data2.unhcr.org/en/situations/myanmar_refugees
- [8]. Mahmood, S., Wroe, E., Fuller, A., & Leaning, J. (2017). The Rohingya people of Myanmar: Health, human rights, and identity. *The Lancet*, 389(10081), 1841-1850.
- [9]. World Health Organization. (2018). The WHO child growth standards: Length/height-for-age, weight-for-age, weight-for-height and body mass index-for-age. Retrieved from http://www.who.int/childgrowth/standards/technical_report/en/
- [10]. Landry, M., & Tupetz, A. (2018). Disability and the Rohingya displacement crisis: A humanitarian priority. *Archives of Physical Medicine and Rehabilitation*, 99(10), 2122-2124.
- [11]. UNICEF. (2019). Malnutrition rates among Rohingya refugee children in Bangladesh appear to be at least double earlier estimates. Retrieved from https://www.unicef.org/media/media_101448.html
- [12]. Jesmin, A., Yamamoto, S., Malik, A., & Haque, M. (2011). Prevalence and determinants of chronic malnutrition among preschool children: A cross-sectional study in Dhaka city, Bangladesh. *Journal of Health, Population and Nutrition*, 29(5).
- [13]. World Health Organization. (2017). *Bangladesh/Myanmar: Rakhine Conflict 2017.

Public health situation analysis and interventions*. Geneva: WHO.

- [14]. Islam, M. M., & Nuzhath, T. (2018). Health risks of Rohingya refugee population in Bangladesh: A call for global attention. *Journal of Global Health*, 8(2), 020309.
- [15]. UN Women. (2017). Rohingya refugee crisis: UN Women response. Retrieved from <https://www.unwomen.org>
- [16]. UNICEF. (2017). Rohingya crisis: Children in need. Retrieved from <https://www.unicef.org>
- [17]. Helen Keller International (HKI) & James P. Grant School of Public Health (JPGSPH). (2016). State of food security and nutrition in Bangladesh: 2014. Dhaka, Bangladesh: HKI and JPGSPH.
- [18]. Islam, K., Kundu, C., Rahman, M., Alam, N., Mohsin, S., Mohsin, F., & Md, F. (2018). Nutritional status of under-5 children of forcibly migrated people living in Ukhia, Cox's Bazar. Unpublished manuscript / Available upon request.
- [19]. Abdullah, A., Rifat, M., Hasan, M., Manir, M., Khan, M., & Azad, F. (2018). Infant and young child feeding (IYCF) practices, household food security and nutritional status of under-five children in Cox's Bazar, Bangladesh. *Current Research in Nutrition and Food Science Journal*, 6, 789-797. <https://doi.org/10.12944/CRNFSJ.6.3.21>
- [20]. National Institute of Population Research and Training (NIPORT), & ICF. (2020). *Bangladesh Demographic and Health Survey 2017-18*. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT and ICF.
- [21]. Rashid, Md. H., Choudhury, M. U. A., Loha, A., & Shaika, M. A. (2020). Nutritional status of Rohingya under-5 children in Jamtoly Rohingya camp. *Journal of Health and Environmental Research*, 6(3), 86-90.
- [22]. Bilukha, O., Jayasekaran, D., Burton, A., Faender, G., King'ori, J., Amiri, M., et al. (2014). Nutritional status of women and child refugees from Syria—Jordan, April–May 2014. *MMWR. Morbidity and Mortality Weekly Report*, 63(29), 638-639.
- [23]. The Independent News. (2019). IOM report on Rohingya malnutrition. The Independent, Dhaka.
- [24]. VOA News. (2019). UN report on Rohingya child malnutrition. Voice of America. Retrieved from <https://www.voanews.com>.
- [25]. Das, S., Fahim, S. M., Rasul, M. G., Afrin, S., Alam, M. A., Uz Zaman, M., Chowdhury, M., Arifeen, S. E., & Ahmed, T. (2023). Nutritional and dietary diversity status of under-5 children and adolescent girls among forcibly displaced Myanmar nationals living in Bhasan Char relocation camp, Bangladesh: a cross-sectional survey. *BMJ open*, 13(3), e068875. <https://doi.org/10.1136/bmjopen-2022-068875>