



# **MSF BRIEF ON THE SITUATION OF ROHINGYAS FLEEING MYANMAR TO BANGLADESH**

*February 2017*



**Bangladesh**

**Dhaka**

**Kutupalong**

**Maungdaw**

**Northern  
Rakhine  
State**

**Myanmar**

**Yangon**

Médecins Sans Frontières (MSF) is an international, independent, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, natural disasters and exclusion from healthcare. MSF offers assistance to people based on need, irrespective of race, religion, gender or political affiliation.

# BRIEF CONTEXTUAL BACKGROUND

Myanmar's estimated one million Rohingyas, a Muslim ethnic minority residing primarily in Rakhine State, have been subjected to decades of persecution and discrimination, in law and in practice. This has resulted in a protracted displacement crisis in the region, with two mass movements of Rohingyas to Bangladesh in 1978 and 1991-92 and a continued influx since then.

In June and October 2012, widespread violence by security forces and mob groups targeting Rohingyas, fuelled by growing tensions between the Muslim and Buddhist communities in Rakhine State, led to the displacement of at least 143,000 people, the majority Muslims, and Rohingyas in particular. More than four years later, some 120,000 people – mainly Rohingyas – continue to live in squalid camps for internally displaced people (IDP) in Central Rakhine State.<sup>1</sup> Rohingyas living outside displacement camps, mainly in Northern Rakhine State, face severe restrictions on their freedom of movement and their access to livelihoods, healthcare, food and education.

On 9 October 2016, a series of armed attacks on the Myanmar Border Guard Police (BGP) in Northern Rakhine State led to nine deaths among security forces and triggered a complete lockdown of the area, while joint BGP/military operations were conducted. Restrictions on access to Rakhine State imposed by the Myanmar authorities led to a de facto suspension of humanitarian assistance, including lifesaving activities such as the provision of food aid, therapeutic feeding programmes and medical care. Humanitarian programmes, including some of MSF's clinics, were only allowed to resume on 19 December 2016, and only in limited areas. The complete closure of MSF's primary healthcare

**MSF** has been working in Bangladesh's Cox's Bazaar region since 1992 and in Myanmar's Rakhine State since 1994.

In **Cox's Bazaar region**, MSF currently runs a 50-bed clinic in Kutupalong, providing around 9,000 consultations per month for primary healthcare, reproductive health and mental health to both Bangladeshi and Rohingya populations in the region.

In **Northern Rakhine State**, MSF normally conducts more than 5,000 primary healthcare and reproductive health consultations per month in nine locations, and refers patients requiring secondary healthcare to Maungdaw hospital. *These activities were entirely suspended between 9 October and 19 December 2016, after which they were allowed to resume only partially: It was not until January, that MSF was able to fully resume its programmes.*

In **Central Rakhine State**, MSF conducts an average of 3,000 primary healthcare and reproductive health consultations per month in five IDP camps and nine Rakhine villages, and supports emergency medical referrals to Sittwe general hospital.

clinics for more than two months left thousands of patients with very limited or no access to healthcare: MSF was able to provide just over 2,000 medical consultations<sup>2</sup> during the last quarter of 2016, compared to the roughly 15,000 consultations MSF would normally have conducted based on its monthly

1 OCHA Humanitarian Needs Overview 2017

2 In October 2016, MSF conducted 995 consultations (before the events on 9 October), none in November and 1,038 in December (after the partial resumption of activities on 19 December).

average. Hospital referrals, including emergency referrals for complicated deliveries, were also put on hold by the authorities.<sup>3</sup> This has most likely led to a number of avoidable deaths, in particular maternal deaths, amongst the population MSF usually serves. As an example, MSF's community health workers recorded eight maternal deaths in October and four in November,<sup>4</sup> as compared to an average of 1.1 per month since the beginning of the year.

The BGP/military operations have been accompanied by widespread and serious human rights abuses, such as arbitrary arrests, extrajudicial and other unlawful killings, rapes, looting and arson, according to reports. This violence has caused displacements both within Northern Rakhine State and towards Bangladesh, where recent estimates put the number of newly arrived refugees at 66,000<sup>5</sup> as of 5 January 2017 – a number which continues to grow.

Members of the host community in Bangladesh describe this influx as the largest since 1991-92. While, in the past, refugees' complaints were predominantly about their lack of rights in Myanmar, today the refugees are clearly the collective victims of widespread violence.

*"In 1991-92, people complained about citizenship issues, the lack of access to education and jobs, or being underpaid as daily labourers. This time it's different. It's about killings and house burnings. It's much more violent than back then."*<sup>6</sup>

MSF staff member, Kutupalong

## ROHINGYA REFUGEES IN BANGLADESH FALL INTO THREE CATEGORIES:

**Registered refugees**, recognised as such by the government, and receiving humanitarian aid from UNHCR and partners: 32,894<sup>7</sup> living in two official camps in Nayapara and Kutupalong.

**Unregistered Rohingyas**, who have been arriving continuously since 1992; they have no legal status in Bangladesh and are thus not afforded any form of protection or support by the government: estimated to be 400,000-500,000<sup>8</sup>, living in makeshift settlements in Kutupalong, Shamlapour and Leda, as well as among host communities in Chittagong division.

**"New arrivals"** who fled the recent violence in Myanmar and arrived mostly over the past two months: estimated to be 66,000<sup>9</sup>, living in the same locations as the unregistered refugees and similarly deprived of legal status. Their immediate humanitarian and medical needs mean that currently they are the most vulnerable of the three groups.

<sup>7</sup> UNHCR, Factsheet, 2016

<sup>8</sup> Ibid.

<sup>9</sup> IOM, Op.cit. 5 January 2017

<sup>3</sup> 101 referrals were completed over the three month period of October, November and December 2016, as compared to a usual monthly average of more than 150.

<sup>4</sup> The actual number is likely to be higher, as the area where MSF was able to conduct this surveillance was more restricted after October 2016.

<sup>5</sup> Minutes of International Organization for Migration (IOM) meeting in Cox's Bazaar, 5 January 2017.

<sup>6</sup> Senior MSF national staff in Kutupalong, interviewed on 24 December 2016.

# NEW ARRIVALS IN KUTUPALONG MAKESHIFT SETTLEMENT

Prior to the recent influx, there were 6,786 makeshift shelters in Kutupalong Makeshift Settlement (KMS), hosting approximately 35,000 unregistered refugees in extremely poor conditions. A total of 13,214 new arrivals (representing 2,674 households) had taken refuge in the camp as of 29 December 2016, putting a heavy strain on an already excessively vulnerable population.

Despite the increase in the population, the number of shelters remains limited due to the authorities' efforts to stop the expansion of KMS, worsening the already overcrowded living conditions. Since early November, at least 139 temporary shelters built on public land have been demolished by the local Forest Department.<sup>10</sup>

In addition to KMS, new arrivals have been settling in other areas such as Shamlapur, Leda and Phalungkhali.

MSF and other humanitarian organisations' direct observations on the ground, as well as interviews with new arrivals, unregistered refugees, registered refugees and host community members, revealed that:

- New arrivals, fleeing acts of violence or the threat of violence, generally reach Bangladesh after a long and perilous trip lasting eight days on average.<sup>11</sup>
- New arrivals leave Myanmar with virtually no personal belongings and 95% have no source of income in Bangladesh.<sup>12</sup>
- New arrivals rely heavily on support from already overstretched relatives to cover their most basic needs. While the existing refugees and host

communities are extremely supportive of new arrivals, the heavy burden this represents on these impoverished populations means that this solidarity is unlikely to be sustainable in the long run.

- Shelter and food are the new arrivals' most urgent concerns; in some instances, more than 17 people are sharing a room, while food availability is generally reported to be insufficient.<sup>13</sup> Many new arrivals have urgent medical needs: of the surveyed population, 16% reported injuries, half of which were due to shooting and physical assault; 4% reported being raped; 20% were suffering from various diseases; 25% had psychological trauma; and 33% of children under five were found to be malnourished.

Despite a significant increase in the KMS population and the new arrivals' extreme vulnerability, the political unwillingness to provide a clear legal framework has led to a slow scale-up of assistance. Private community members are providing spontaneous support to new arrivals (blankets, food, cash), albeit through uncoordinated, one-off private donations. Several international and national humanitarian organisations are also providing ad hoc donations (blankets, non-food items, food, cash). Despite the collaborative approach of the authorities on a local level, humanitarian organisations' ability to provide well-assessed and well-funded operations to respond to the needs of the Rohingya population on a larger scale are being hampered by bureaucratic obstacles and the official policy of not granting authorisations to work.

<sup>10</sup> Information received from MSF outreach workers. According to their assessment, the Forest Department has conducted three operations – the latest on 5 January – since early November 2016, and demolished more than 139 new shelters located in the south part of KMS. Some incidents of violence between security forces and refugees occurred during the demolitions.

<sup>11</sup> Multi-cluster/sectoral initial rapid assessment of new arrivals (MIRA): based on a sample of 584 families, representing 17% of new arrivals, in three camps and host communities as of 4 December 2016.

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.

# MEDICAL NEEDS AMONG NEW ARRIVALS IN MSF'S KUTUPALONG CLINIC

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MSF's clinic in Kutupalong saw an increase in patients from late November 2016, corresponding with a large influx of new arrivals following intensified military operations in Myanmar; this impact was even more marked in December. In the second week of December, MSF medical staff provided **487** consultations to new arrivals, compared to a weekly average of 157 consultations before December.

Unable to access any medical care in Myanmar, and after a long, perilous journey on foot to Bangladesh, many of the new arrivals have serious medical needs, such as severely infected wounds, acute diseases and advanced obstetric complications.

*"Maybe the [newly arrived] refugees are suffering from the same diseases as the host community. But throughout this whole time, they are always in distress trying to cross the border, looking for food, shelter etc. So maybe the morbidity is the same in terms of medical complications, but the suffering is more. Conditions are more critical, more severe."*<sup>14</sup>

MSF doctor, Kutupalong

Obstetric complications due to lack of access to medical care in Myanmar and delayed admission are a significant issue.

*"Patients from Myanmar come to us; they have received no antenatal care or any medical support during their pregnancy in Myanmar. When they come they have sometimes been in labour already for 3-4 days, spending days on the road. They arrive in the very late stage of labour, often with complicated pregnancy problems. One patient gave birth while crossing the border and directly came*

*to our birth unit in December – her sister-in-law carried her in her arms, and brought her to us. She had delivered five hours before she arrived at our clinic. But the umbilical cord had wrapped around the baby's neck and arm, and the placenta remained inside the mother's body. For both the mother and the baby this was a life-threatening situation."*<sup>15</sup>

MSF midwife supervisor, Kutupalong

MSF medical data reveals the following patterns among new arrivals: a sharp increase in patients with **violence-related injuries** (including gunshot wounds), **sexual violence** (including rape) and **mental health issues**; an increase in **suspected measles cases** (163 suspected cases received in December 2016, 51 admitted for clinical treatment) and a general increase in the number of outpatient consultations, inpatient admissions and emergency referrals. Delayed admission is also an issue: the average duration between the incident date and admission to MSF's clinic for patients with gunshot wounds is 14 days, while sexual violence survivors did not reach our clinic until 5-20 days after the event. The delay in medical access can be **life-threatening** due to complications such as **infection or sepsis** for patients with violence-related injuries, especially gunshot wounds.

## Violence-related injuries

Since early November 2016, MSF's Kutupalong clinic has received an unusually high number of people with violence-related injuries, including gunshot wounds, blunt trauma, bruises and broken bones. Many of these patients tell similar stories: they report that their villages were raided by the Myanmar Army, their houses were torched, male villagers were killed, and they lost contact with family members.

<sup>14</sup> Focus group discussion with medical staff on 24 December 2016, Kutupalong.

<sup>15</sup> MSF midwife supervisor, interviewed on 4 January 2017, Kutupalong.

<sup>16</sup> Sixteen-year-old patient, admitted with infected gunshot wound and sepsis, interviewed on 23 December 2016.

*"I was sleeping at my home when the [Myanmar] military raided our village. There were more or less 50 soldiers, fully equipped with helmets, vests and weapons. They surrounded the village and started to torch houses. When they were setting our house on fire, we went out and started to run. The military was all around; I was shot and fell down. I am here in Bangladesh for the first time. I have no relatives here, no one. I have also not been able to contact my family – I don't know if they are alive or dead."*<sup>16</sup>

Sixteen-year-old patient with infected gunshot wound and sepsis

In total, MSF saw 52 people with violence-related injuries in November and **61 in December**, compared with an average of 29 per month for the rest of the year. Of these, **17 had gunshot wounds**;<sup>17</sup> all had recently arrived from Myanmar. These are exceptional circumstances for the MSF clinic which does not usually treat these types of injuries.

*"During my time here, I didn't see any gunshot wounds before this started, not one. Interestingly, most entry points are in the back, which fits the story patients tell of being shot while running away."*<sup>18</sup>

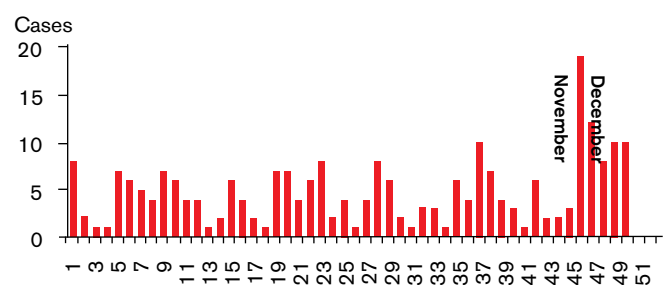
MSF doctor, Kutupalong

Confirming the MSF medical team's observations, two brothers with bullet injuries with entry points on their back right thighs reported that they were shot as they ran from a military attack.

*"There was no medical help. Since early October, there is no available clinic. They are all closed, banned. They don't work anymore, so we didn't try to go there after the incident. Our wounds got worse, infected and smelled so bad. I had severe pain, I couldn't even move. Someone, we don't know who, carried us to the border and handed us over to some fishermen to cross the border by boat. We only had our clothes, no money... nothing."*<sup>19</sup>

Twenty-nine-year-old patient with bullet injury with entry point on back

**Violence-related injury cases:** Rohingya refugees 2016



Given the virtual unavailability of medical services in Northern Rakhine State, and considering the severe travel restrictions and risks incurred crossing the border, it can only be assumed that many people are not getting the urgent medical care they need.

### Sexual violence

From the end of November 2016, MSF also saw a sharp increase in sexual violence patients treated at its clinic in Kutupalong. In December, MSF treated 18 survivors of rape, compared to an average of 8.5 per month since the beginning of the year.<sup>20</sup> Sixteen of these cases were new arrivals, all of whom said they had been raped by the Myanmar military. An alarming number of the survivors of sexual violence – six in total – were under 18 years old, while one was as young as 13.

<sup>17</sup> Based on Kutupalong Project monthly medical report (MMR) December; 12 patients with gunshot wounds were admitted in November and five in December 2016.

<sup>18</sup> MSF international staff doctor, working in Kutupalong since April 2016, interviewed on 22 December 2016.

<sup>19</sup> 29-year-old MSF patient, interviewed on 23 December 2016, admitted with his 16 year old brother. Both were shot in the back right thigh while fleeing from a military attack on their village.

<sup>20</sup> Based on Kutupalong project monthly medical report for December 2016: 16 new arrival refugees, one patient from KMS and one from the host population.



*“They [Myanmar soldiers] attacked my village. The men ran into the forest to hide. The women all hid in houses, we gathered together. Five of us were hiding in one house, five soldiers came, one stood guard, they tortured us, they started touching our breasts and all over our bodies. They touched our stomachs to see if we were young and had had children. Those of us that are young, they raped. They raped three of us, while one soldier stood guard at the house. The soldiers raped 50 or 60 of the women in my village.”<sup>21</sup>*

Seventeen-year-old patient treated for sexual violence

Due to long travel times from Myanmar to Bangladesh, all the sexual violence survivors treated by MSF reached the clinic between five and 20 days after the event, past the window for preventive measures such as post-exposure prophylaxis to prevent the transmission of HIV or emergency contraception to prevent pregnancies. However, patients were able to benefit from other essential measures, such as vaccinations against hepatitis B and tetanus, prophylactic treatment against sexually transmitted infections and mental health counselling.

## **Mental health**

Referrals to the mental health service at MSF’s clinic increased significantly following the influx of new arrivals to the area in November 2016. In December, 537 patients received individual counselling, of whom 183 were new patients. This compares to a previous monthly average of 365 consultations. It was the highest figure for the whole of 2016, and 66.5% higher than the previous month. Among patients attending their first individual counselling session, the majority (76%) were new arrivals from Myanmar. MSF’s mental health team in Kutupalong report that the increase in patients can be interpreted as a consequence of the traumatic events witnessed or experienced by new arrivals before crossing the border.

*“New arrivals, they have witnessed violence in their villages, lost their houses and it’s really common to find persons with missing family members. They are hopeless, fearful, with low mood and sometimes flashbacks.”*

Mental Health Activities Manager, Kutupalong

## **Malnutrition**

While malnutrition in KMS is not a new phenomenon, the recent influx of refugees has increased the scale of the needs and the number of cases treated.

In December 2016, an MSF outreach team visited 6,882 households in KMS and carried out a mid-upper arm circumference (MUAC)<sup>22</sup> assessment among 5,313 children aged 6 to 60 months. Of these, **73 children** were identified as having severe acute malnutrition (SAM), all of them new arrivals. In MSF’s clinic in Kutupalong, MUAC screenings indicate an overall monthly SAM rate of 3%; while this figure remains stable, the total number of children screened in MSF’s inpatient and outpatient departments went up from 1,955 in November to 2,537 in December, confirming both the longer-term needs in KMS and the increased volume of patients brought about by the current crisis.

<sup>21</sup> Seventeen-year-old MSF patient, interviewed on 27 November 2016.

<sup>22</sup> A measurement used to assess a child’s nutritional status.

<sup>23</sup> The Myanmar Ministry of Health and Sports 2015-16 DHS survey indicates that rates of global acute malnutrition (GAM) and severe acute malnutrition (SAM) in Rakhine State are 13.9% and 3.7% respectively. Furthermore, 2015 SMART data suggests that, according to nutrition sector partners in Rakhine State, acute malnutrition rates are particularly high in Maungdaw township, where the GAM prevalence rate is 19.0% - significantly above the World Health Organization (WHO) emergency threshold of 15%.

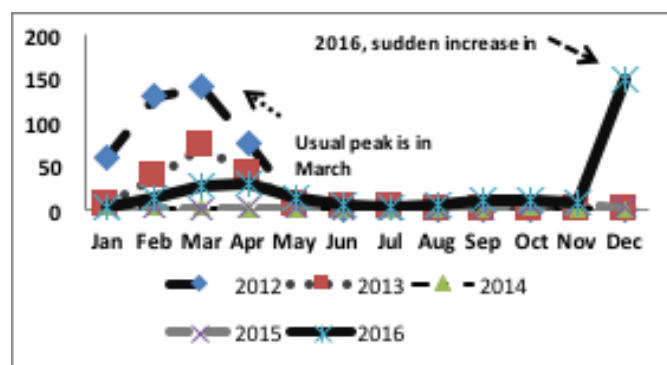


Malnutrition rates in Maungdaw township, in Northern Rakhine State, where the majority of refugees come from, were already above emergency thresholds<sup>23</sup> before the current crisis. The main causes identified are chronic food insecurity and limited access to health services. The suspension of crucial therapeutic nutritional programmes in Northern Rakhine State, as well as the reduced availability of food during the lockdown period, is likely to have exacerbated the problem. Indeed, nearly all 3,466 children under treatment for SAM in Buthidaung and Maungdaw townships before the October events were unable to access lifesaving treatment for over 2.5 months – or even longer for the children in Maungdaw North, where programs have still not resumed as of mid-February 2017. Approximately another 3,203 children with moderate acute malnutrition (MAM) are at increased risk of becoming severely malnourished, while new cases of acute malnutrition are not being detected or treated.

*“Yesterday I came to the clinic because my baby had a fever. The doctor gave him some treatment and told me he had to be admitted as he is also malnourished. The military has stolen food from my house. I went days without eating. I couldn't feed my baby properly.”<sup>24</sup>*

Mother of a seven-month-old baby receiving treatment for malnutrition

MEASLES CASES, MSF KUTUPALONG CLINIC



## Measles

In December, MSF received 163 suspected measles cases at its clinic in Kutupalong (147 under five years, 16 over five years). Of these, 51 were admitted for clinical treatment.

Since 2012, MSF has observed a particular epidemiological pattern with measles, with cases documented in January, reaching a peak in March and then gradually decreasing over the next two months. But in 2016, there was a sharp rise in suspected measles cases in December, which was a clear deviation from the normal epidemiological pattern. This could be a possible impact of an influx of unvaccinated children from Myanmar to KMS.

Following the increase in measles cases, MSF conducted a mass measles vaccination, alongside the Ministry of Health, for a target age group of nine months to five years, with a reported coverage rate of more than 90% in KMS. However, since the total population continues to increase with new arrivals, figures for the initial targeted population may be skewed. MSF also opened up a 20-bed measles tent and hired extra staff to cover the needs.

<sup>24</sup> Recently arrived 25-year-old mother of a seven-month-old male patient, interviewed on 29 December 2016.

# PROTECTION OF REFUGEES CROSSING THE BORDER AND AFTER ARRIVAL IN BANGLADESH

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In order to prevent more Rohingya refugees from crossing into Bangladesh, the Bangladeshi government has detained refugees and tightened its borders. This has included pushing Rohingyas back from the border into Myanmar, which is in breach of the principle of non-refoulement.

*"I do not know where my mother and brother are. They were on the second boat behind us. The man on the boat heard that the navy [Border Guard] was coming, so he made them all get out on an island. My brother was shot already, he was running to hide – [and the Myanmar] military shot him. I do not know where he is now."*<sup>25</sup>

Seventeen-year-old patient, Kutupalong

Although the Bangladeshi national media regularly publishes quotes from Border Guards Bangladesh (BGB) commanders reporting on pushback operations,<sup>26</sup> the continuous influx of new arrivals suggests that the official policy may not be fully implemented. Even if such deterrence measures do not stop refugees from entering the country, they may prevent them from seeking healthcare in government facilities out of fear of arrest or deportation.

## **Lack of recognition and vulnerability**

Of the 400,000-500,000 Rohingya refugees within Bangladesh, only the 33,000 or so who live in the UNHCR-supported refugee camps at Kutupalong and Nayapara are recognised by the government as refugees. The vast majority of Rohingyas are unregistered and live in a state of chronic vulnerability.

Under Bangladeshi law, unregistered refugees are not allowed to work. In addition due to their lack of status they do not receive sufficient food support. As a consequence, their situation is extremely precarious. This is compounded by the strain brought about by large numbers of new arrivals who depend on the existing community for food and shelter.

MSF believes that Rohingyas who choose to leave their homeland, due to a well-founded fear of persecution, should be afforded refuge, and that, wherever they live, they should have their humanity recognised and should be given the opportunity to live in dignity.

<sup>25</sup> Seventeen-year-old MSF patient, interviewed on 27 November 2016.

<sup>26</sup> For example: "We raided three different points of the river around 7.30 am and pushed back at least 75 Rohingyas boarded in five boats," said Teknaf 2 BGB Commander Lt Col Abujar Al Zahid. [www.dhakatribune.com/bangladesh/2016/12/09/bgb-sends-back-75-rohingyas/](http://www.dhakatribune.com/bangladesh/2016/12/09/bgb-sends-back-75-rohingyas/)

## Humanitarian access in Myanmar

Despite repeated government statements to the contrary over the past two months,<sup>27</sup> access negotiations between humanitarian organisations and the Myanmar government are complicated by delays in response to requests, an absence of authorisations to work in certain areas, ambiguous and contradictory information, a multiplicity of administrative obstacles, and opaque procedures with little accountability. The lack of accountability is especially challenging, and sustained negotiations by humanitarian organisations to regain access since October 2016 show a disconcerting lack of clarity about where the decision-making power lies. “Misunderstandings” between national, state and local levels are constantly put forward to explain the blockages, resulting in endless back-and-forth communications with no tangible outcome.

Humanitarian access to the townships of Northern Rakhine State was reinstated on 19 December 2016, but in a very limited manner. Access remains largely blocked in the most affected areas, primarily in Maungdaw North, whilst international staff are unable to travel outside Maungdaw and Buthidaung towns.

While MSF was able to gradually resume activities – with national staff presence only – in Maungdaw South between 19 December and 2 January, major concerns exist about people’s ability to access MSF’s services, especially those who have suffered violence at the hands of the security forces. Numerous checkpoints have been set up or reinstated, which deter and often prevent people travelling to MSF’s primary healthcare clinics or accessing emergency and secondary healthcare.

Of even more concern is the fact that between 9 October and the second week of January, no humanitarian access was allowed into Maungdaw North, with a short-lived exception between 19 and 28 December, when humanitarian access to the 17 villages was granted. The area was declared off-limits again on 28 December following the killing of three Muslim men. Currently no independent assessment of Maungdaw North has yet been completed, as access to these areas remains exceptionally difficult and limited, both in terms of scope of activities and geographical coverage.

In addition to these serious access issues, MSF teams are currently observing worrying developments in Northern Rakhine State that have the potential to further impact the deteriorating humanitarian situation:

<sup>27</sup> The most recent example is the press release of 18 December 2016 which stated that humanitarian organisations were “providing humanitarian assistance to all affected people in Maungdaw” when 1) the authorisation to resume activities had only been given that day (a Sunday), just ahead of the ASEAN foreign ministers’ retreat, and 2) the authorisation only covered limited areas, leaving the majority of Maungdaw North inaccessible: [www.myanmargeneva.org/pressrelease\\_PMGeV/Press%20Release%2018%20Dec%202016.pdf](http://www.myanmargeneva.org/pressrelease_PMGeV/Press%20Release%2018%20Dec%202016.pdf)

Since early December 2016, the Border Guard Police have served verbal orders to demolish at least 1,984 “illegal”<sup>28</sup> buildings (mostly houses, but also shops, mosques and schools) owned by Muslims in Maungdaw, Buthidaung and Rathedaung townships. During December and January a total of 1,078 structures - 80% of which were individual houses - were dismantled, allegedly by villagers forced to do so at gunpoint while the BGP looked on and took photographs. The central government states that this was done despite orders given to Rakhine officials “to hold their plan in this very sensitive situation,”<sup>29</sup> with the latter claiming it was simply “a misunderstanding at the grassroots level”.<sup>30</sup> It took sustained advocacy from humanitarian actors for the demolitions to be finally suspended: no further demolitions have been reported since 10 January. Meanwhile, the local authorities have rejected suggestions from humanitarian organisations to provide temporary shelter to the affected families, arguing that they are not homeless as they can stay with relatives and neighbours. This demolition drive heightens the risk of new displacement, both within Northern Rakhine State and across the border to Bangladesh, and can only reinforce the persistent accusations of persecution of the Rohingya minority.

The annual Northern Rakhine State household survey, which is usually conducted by the immigration authorities, appears to have begun early this year, with security forces reportedly

checking the so-called family lists during their “clearance operations” and removing any absentees from the list. There are concerns that the tens of thousands of Rohingyas who have been displaced by the recent outbreak of violence are being permanently struck from the official list of residents, leaving them unable to return home legally if the security situation improves.

Lastly, authorities appear to have chosen these troubled times to reactivate the citizenship verification exercise in Northern Rakhine State, despite the population’s extreme reluctance to engage with this process. Although Rohingyas fear it is a further step towards the ultimate denial of any form of citizenship, they are increasingly pressurised into applying for an Identity Card for National Verification (ICNV). Failing to apply results in Rohingyas no longer being able to register births or apply for border passes, travel authorisations, fishing permits etc. This could further restrict freedom of movement and have a severe impact both on humanitarian staff’s ability to conduct activities and on the population’s ability to access humanitarian services. As an example, three patients referred by MSF were refused access to Maungdaw hospital for secondary healthcare as they did not possess an ICNV; one MSF staff was also turned away at a checkpoint for the same reason.

28 I.e. erected without building permits; note that such permits are virtually never granted to Rohingyas through official channels.

29 According to Zaw Htay, a spokesperson for the office of President Htin Kyaw as relayed by IRIN, UN warns Myanmar that demolishing Rohingya homes will ‘heighten tensions’, 2 January 2017, [www.irinnews.org/news/2017/01/02/exclusive-un-warns-myanmar-demolishing-rohingya-homes-will-%E2%80%98heighten-tensions%E2%80%99](http://www.irinnews.org/news/2017/01/02/exclusive-un-warns-myanmar-demolishing-rohingya-homes-will-%E2%80%98heighten-tensions%E2%80%99)

30 According to Tin Maung Shwe, deputy director for Rakhine State at the General Administration Department. See link to article above.

# KEY RECOMMENDATIONS

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## To the government of Bangladesh:

- Avoid deterrence policies and keep borders open to allow Rohingya refugees fleeing Myanmar to cross safely into Bangladesh, and uphold the principle of non-refoulement.
- Ensure that the delivery of humanitarian assistance is unhindered and remove obstacles, in law or in practice, that prevent humanitarian organisations from carrying out their work.
- Give people in need of international protection the opportunity to access asylum procedures, and ensure that reception policies are respectful of people's health, dignity and human rights.
- Facilitate the issuing of visas and travel authorisations for humanitarian agencies staff in all areas of the country requiring humanitarian and medical assistance.
- Repeal discriminatory laws and end policies of discrimination, displacement, segregation and confinement. Such measures have a devastating effect on access to healthcare and livelihoods for hundreds of thousands of Muslims in Rakhine State. This includes any policy that impacts negatively on people's health.
- Fulfil its responsibility to provide adequate healthcare, especially for the most vulnerable.

## To the government of Myanmar:

- Allow humanitarian organisations to respond to the urgent needs of the population in Maungdaw North by immediately facilitating access for assessment by international and national staff to the most affected areas.
- Allow unhindered and unconditional access for humanitarian agencies and international organisations, including international staff, to all areas of the northern Rakhine townships to continue to provide healthcare and other essential services.

## To UN agencies:

- Ensure that sustained pressure is put on the governments of Myanmar and Bangladesh to facilitate an immediate response to improve living conditions and access to services for thousands of Rohingya who have been displaced within Myanmar or recently fled violence and abuse across the border to Bangladesh.
- Ensure that sustained pressure is put on the government of Bangladesh to repeal deterrence policies.
- Press the government of Bangladesh and other receiving countries to allow for the registration of refugees, in line with international law.

### **To donors and Myanmar's trade partners:**

- Ensure that funding is made available to UN agencies and humanitarian organisations providing assistance in Myanmar and Bangladesh, and publicly promote the need for unhindered access for humanitarian organisations and the delivery of humanitarian assistance to all populations in need.
- Share responsibility with and provide assistance to the government of Bangladesh and any other receiving country for protecting Rohingya refugees fleeing Myanmar.
- Prioritise the situation in Rakhine State in bilateral agenda for engagement with Myanmar.
- Hold the government of Myanmar accountable for its actions or lack thereof in response to the ongoing crisis.
- Ensure concerted and committed advocacy on behalf of displaced and non-displaced communities facing discriminatory policies and obstructed access to basic services, including healthcare.
- Engage with all parties in addressing the immediate needs of the population, and cease prescribing development assistance as a key response to the violence, displacement and segregation in Rakhine State.
- Ensure that any future development projects in Rakhine State take into account their impact on all communities.

### **To the representatives of Austria, Belgium, Canada, Denmark, Finland, France, Greece, Ireland, the Netherlands, Poland, Spain, Sweden, Turkey and the United States, following the joint statement<sup>31</sup> and expression of concern about the humanitarian situation in the north of Rakhine State:**

- Press through diplomatic channels the government of Myanmar to address the situation in Rakhine State.
- Press through diplomatic channels the government of Bangladesh to respect the principle of non-refoulement and to allow for the registration of refugees in line with international law.
- Urge the Myanmar government to allow unhindered access to affected areas to conduct independent comprehensive assessments of the current humanitarian needs and to provide essential assistance including in Maungdaw North.
- Publicly put pressure on the Myanmar authorities to end discrimination and violence against Rohingyas and other vulnerable minorities, making clear that such actions will harm Myanmar's bilateral relationships and international standing.

<sup>31</sup> Joint Statement on Humanitarian Access to northern part of Rakhine State, December 2016: [mm.usembassy.gov/joint-statement-humanitarian-access-northern-part-rakhine-state/](http://mm.usembassy.gov/joint-statement-humanitarian-access-northern-part-rakhine-state/)



**To ASEAN member states:**

- Hold the government of Myanmar responsible for the root causes of refugee outflows and engage in direct advocacy to address the ongoing systematic persecution of Rohingyas in Myanmar.
- Urge the Myanmar government to allow unhindered access to affected areas to conduct independent comprehensive assessments of the current humanitarian needs and to provide essential assistance, including in Maungdaw North.
- Continue to highlight the issues faced by Rohingyas in Myanmar and insist on including them on the agenda of upcoming ASEAN summits.
- Ensure that Rohingyas fleeing Myanmar and Bangladesh can access their borders safely and apply for asylum in a fair, equitable and efficient way.
- Ensure that Rohingyas on their territory are treated with dignity and respect and given access to humanitarian and medical assistance.



