BEHIND THE WIRE

IMPACT OF STATE CONTAINMENT AND EXCLUSION STRATEGIES ON THE ROHINGYA

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MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

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IMPACT OF STATE CONTAINMENT AND EXCLUSION STRATEGIES ON THE ROHINGYA

Aug 2024
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Edited by Paul Brockmann
Published by Médecins Sans Frontières/Doctors Without Borders

CONTENTS

HEADLINE

There are approximately 2.8 million Rohingya people in the world today and the overwhelming majority— an estimated 99%—are contained or marginalized by harmful policies that deny them basic human rights and self-determination. An unacceptable 39% of all the Rohingya in the world live in fenced camps in Bangladesh and Myanmar with limited or no access to livelihoods, education, or healthcare, and with no proposed solutions. In Malaysia, where they are not contained in camps, even those registered as refugees have no right to employment or education. The fundamental containment and lack of freedom of the Rohingya profoundly impacts their physical and mental health and threatens their existence as a people.

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EXECUTIVE SUMMARY

Finding reliable and comprehensive information about the situation of Rohingya populations living around the world is extraordinarily difficult because they are forced to hide to survive. A comprehensive understanding of the collective plight of the Rohingya as a people who have been persecuted for generations is needed in public discourse, along with action. Those who seek to support the Rohingya people can indirectly contribute to their marginalization by not analysing the situation globally, rendering the sum total of their plight invisible.

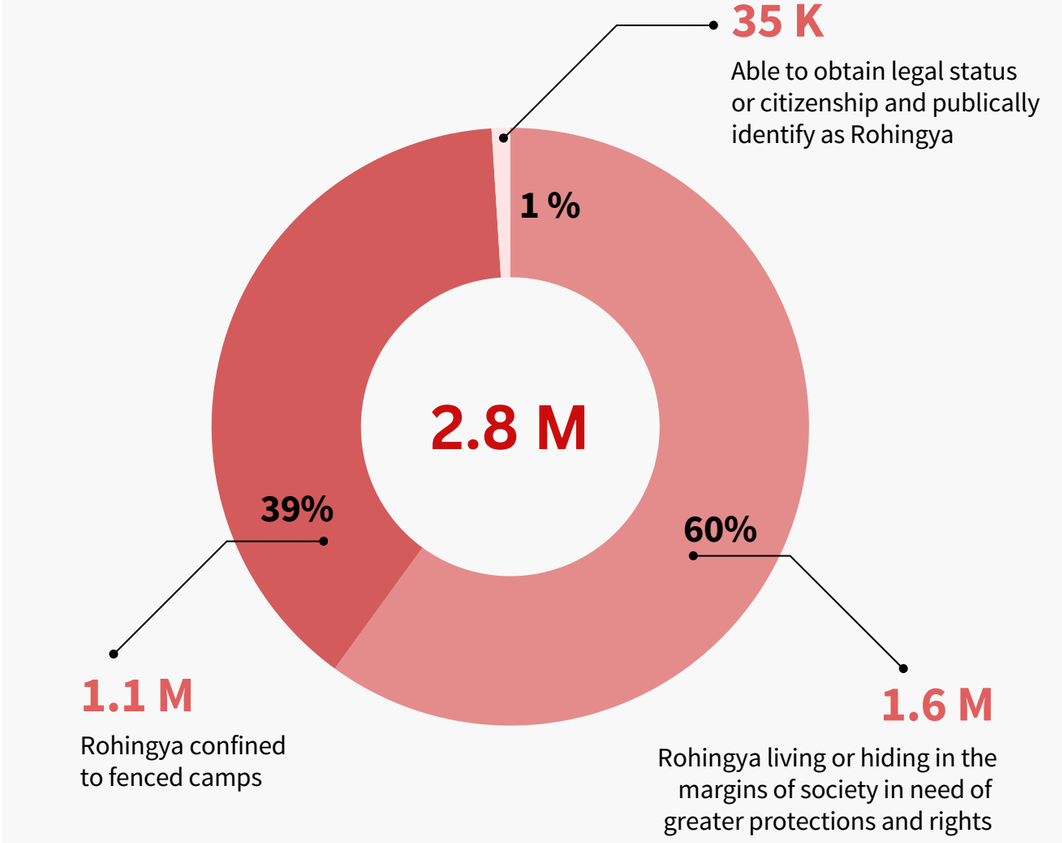
Fundamentally, the Rohingya, as a people, are not free. Nearly everywhere they exist, whether in their home country of Myanmar or in the countries they fled to, Rohingya are met with policies and actions by states that contain them in harmful situations and reinforce the negative consequences of imposed statelessness.

Médecins Sans Frontières (MSF) works with Rohingya communities in Myanmar, Bangladesh, and Malaysia. Over the past three decades, MSF has borne witness to an increasingly fragile and desperate present and an uncertain, bleak future for Rohingya communities.[1]

Rohingya families are divided by local and international boundaries that they are legally prohibited from crossing. Intergenerational statelessness[2]—meaning that their lack of citizenship and rights are passed on from one generation to the next—and the fragmentation of Rohingya society pose a threat to their existence as a people.

Based on exhaustive review of public and private sources and key informant interviews, the most credible and conservative estimate for the global Rohingya population is 2.8 million. With this number as a baseline, we can extrapolate the circumstances for different segments of the Rohingya population.

99% of all Rohingya in the world are contained or marginalized



Shockingly, over 1.1 million (39% of all Rohingya people) live behind wire-fenced camps in Bangladesh and Myanmar, where their coming and going is inhibited or prohibited altogether. When we add the additional Rohingya who are confined to villages in Rakhine state in Myanmar (approximately 450,000), we note that at least 57% live in conditions of extreme containment.[3]

It is likely that at least 16,300 Rohingya are currently held in detention centres or prisons around the world, largely for immigration violations that they have no legal recourse to correct due to their denial of citizenship in Myanmar.[4] In destination countries, the lack of policies that protect refugees further entrench statelessness and vulnerability.[5]

Four countries are home to 75% of the global Rohingya population living outside Myanmar: Bangladesh, Pakistan, Saudi Arabia and Malaysia. A majority of Rohingya children are now born outside Myanmar and have never known their homeland. By the end of this decade, another 700,000 Rohingya children will be born,[6] but only one in five will be born in their native land. Yet the international community, host states, and United Nations[7] still focus on the return of Rohingya to Myanmar as the primary solution to the problem, despite decades of persecution that has driven the majority of them out of the country.

"We are losing our culture living in hiding, being forced to blend in to wherever we live to survive."

Dr. Ambia Perveen

Rohingya Medics Organisation

The overall situation of the Rohingya is deteriorating globally and negatively impacts their ability to cope with the consequences of being excluded from citizenship and a place in the world.[8] Countries in which the Rohingya have sought refuge offer no durable solution, and in many, the Rohingya face increased xenophobia and persecution. Providing shelter to refugees fleeing for their lives is commendable and often politically difficult for countries, but recognizing their basic rights and providing a workable plan for their future is the only humane course of action if they cannot return home. Instead, the Rohingya are increasingly contained, detained or marginalized nearly everywhere they go.

However, Rohingya are not equally marginalized and contained. On one side of the spectrum are the 1% who have managed to obtain a passport, citizenship, or resettlement to a country in which they have no fear of arrest, extortion, or abuse for identifying as Rohingya. On the other end of the spectrum are those who languish in indefinite detention facilities or in situations of modern-day slavery. The overwhelming majority of Rohingya people living outside Myanmar and Bangladesh must hide their identity to avoid detection, arrest, detention, deportation, or loss of legally or illegally attained identity documents or citizenship. The situation between these two extremes varies by gender, education, location, and a myriad of other circumstances.[9] Women and especially adolescent girls overwhelmingly suffer more from containment and marginalization than men and boys.[10]

Degree of Marginalization & Containment

- Obtained passport, citizenship or resettlement
- No fear of arrest, extortion or abuse

- Confined to camps & villages
- Lack of citizenship & rights
- Forced to hide their identity

- Held in detention centres or prisons for immigration violations
- No legal recourse

- *The situation between these two extremes varies by gender, education, location, and a myriad of other circumstances.*[9]

- *Women and especially adolescent girls overwhelmingly suffer more from containment and marginalization than men and boys.*[10]

Containment policies impact Rohingya both physically and psychologically. Physical barriers concentrate Rohingya populations in fenced camps or on the isolated island of Bhasan Char in Bangladesh. Crossing physical barriers like checkpoints or borders comes with either risk or cost. Any attempt may expose Rohingya to extortion, arrest, or violence, which creates psychological barriers that can be even harder to overcome.

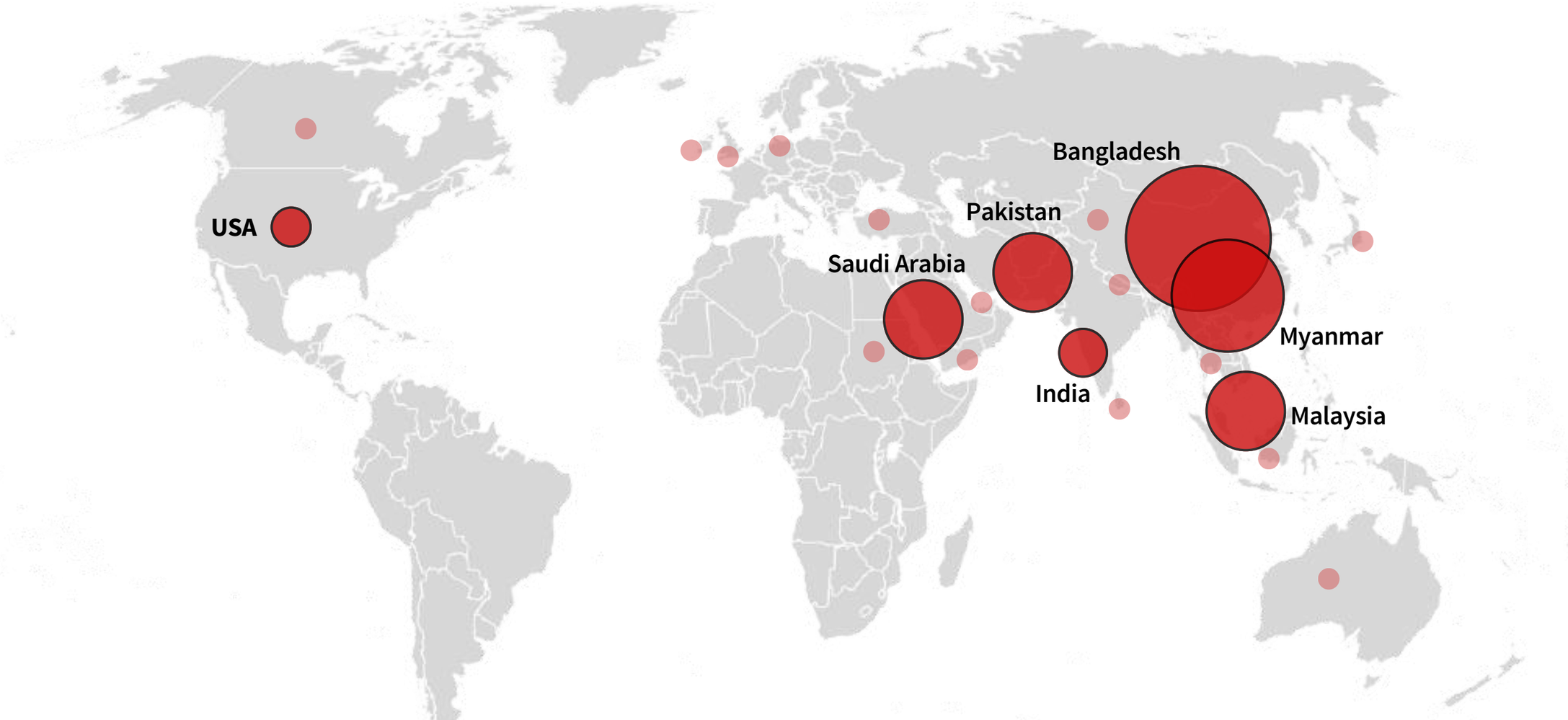
With 39% of Rohingya confined to unhygienic camps, depending on dwindling or blocked humanitarian assistance and limited access to safe healthcare, confinement increases instances of communicable diseases like scabies, cholera, Hepatitis C, and others. In 2023, the Bangladesh camps experienced the highest surge in cholera cases in the past five years, while a scabies outbreak affected almost one in two people. Women and girls face multiple barriers to accessing antenatal care (ANC), which can lead to increased risk of miscarriage, preterm birth, and maternal and neonatal mortality. Moreover, persistent undernourishment and inadequate food rations are likely to have dramatic impacts on the Rohingya, including nutritional and health consequences and worsening living conditions.

Containment policies have major implications on mental health. Decades of persecution and exclusion result in intergenerational trauma with real health and social consequences on child development and Rohingya society. Moreover, the suffocating sense of hopelessness and anxiety experienced by so many Rohingya only serves to heighten the risk of sexual violence, as cumulative trauma, mental health challenges, economic and physical insecurity, and lack of freedom combine. Sexual violence, ranging from systematic to opportunistic and targeted, persists across generations against Rohingya women and girls.

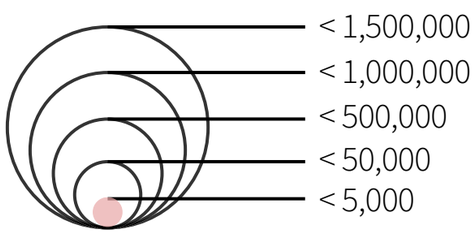
The tenacity and creativity the Rohingya have exhibited in surviving decades of persecution is remarkable. Over generations, by finding any possible workaround and pursuing any opportunity to gain some level of recognition, identity, and security for generations, the Rohingya have survived. Sadly, most of those workarounds tend to involve illegally obtaining identity documents and travelling via irregular routes because there simply has never been another option for the Rohingya since the Union of Burma Citizenship Law of 1982 stripped most Rohingya of citizenship.[11] [12] As the world digitizes and biometric data collection becomes more and more common, loopholes and workarounds will vanish, further entrenching statelessness.[13] If host nations and the international community offered some solutions, biometric data collection of Rohingya refugees would not be a problem.

At present, we see a dire lack of solutions, and a multiplication of systems designed to contain the Rohingya in abject destitution. International political discourse tends to be directed towards attempting to find the solution in Myanmar, rather than in the places to which Rohingya people have managed to escape. More diplomatic efforts and policy choices are urgently needed everywhere the Rohingya exist today.

DISTRIBUTION OF THE ROHINGYA PEOPLE



Population Size



See annex for a more detailed view

Other countries where Rohingya live: (Population Size under 5,000)	Australia	Canada	Sudan
	Nepal	China	Yemen
	Thailand	Ireland	Sri Lanka
	UK	Japan	Turkey
	Indonesia	Germany	Gulf States

CONTAINMENT AND MARGINALIZATION BY COUNTRY

BANGLADESH
(1.1 M)

Bangladesh is home to at least 1,165,467 Rohingya. This is over 40% of all Rohingya in the world today. Over 80% are contained in the fenced camps in Cox's Bazar District or the remote island of Basan Char. A significant population of Rohingya up to 200,000 live in Bangladesh but are forced to hide their identity to avoid extortion or arrest

MYANMAR
(636 K)

At least 636,000 Rohingya remain living in Myanmar, primarily in Rakhine State. At least 143,000 Rohingya remain contained in camps since 2012. Rohingya living in villages are subject to movement restrictions and ongoing conflict

PAKISTAN
(400 K)

At least 400,000 Rohingya live in Karachi, Pakistan, hidden within the larger Bengali community of 3.5 million who also struggle with entrenched statelessness due to exclusionary policies that deny many their rightful legal identity as a Pakistani citizen. Rohingya can obtain citizenship, but only if they hide their identity

SAUDI ARABIA
(340 K)

At least 340,000 Rohingya live in Saudi Arabia today with a significant number of multi-generational families born in Saudi Arabia. There is no current pathway to citizenship for Rohingya in Saudi Arabia

MALAYSIA
(210 K)

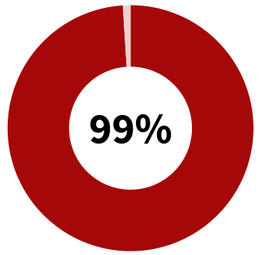
At least 210,000 Rohingya living in Malaysia. Of those, 106,390 are registered with UNHCR which provides only limited protections and no right to work. This also includes multi-generational families who began arriving in significant numbers in the 1980s and 1990s who settled mostly in Penang and in and around Kuala Lumpur

INDIA
(30 K)

There are around 30,000 Rohingya living in India who are not only denied legal status, but are facing risk of detention and deportation because they are treated as illegal immigrants

These are estimated population numbers. See annex for details.

STATS AT A GLANCE

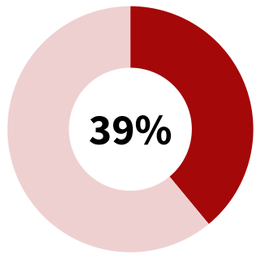


2.7 M

Rohingya that are contained or marginalized

2.8 M

Rohingya people across the world

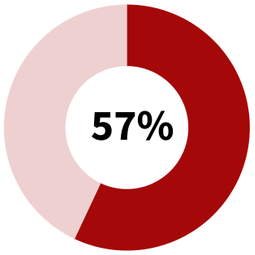


1.1 M

Rohingya contained in fenced camps in Bangladesh & Myanmar

16.3 K

Rohingya may be held in detention centres or prisons largely for immigration violations



1.6 M

Rohingya who face movement restrictions in Bangladesh & Myanmar

4 COUNTRIES

Are home to 75% of Rohingya people living outside Myanmar: Bangladesh, Pakistan, Saudi Arabia & Malaysia

These are estimated population numbers. See annex for details.

IMPACT OF CONTAINMENT POLICIES

PHYSICAL IMPACT

- Exposure to extortion, arrest, and violence when crossing checkpoints or in situations where identification is required
- Camp fencing reduces the ability to flee during emergencies like fires, cyclones, or conflict
- 99% of Rohingya have no legal means to cross an international border separating families permanently & forcing reliance on irregular routes which further expose them to harm

- Intergenerational containment in camps and ghettos impacts childhood development and future opportunities, impacting the functioning of Rohingya society
- Increases anxiety, despair, hopelessness and depression

PSYCHOLOGICAL IMPACT

HEALTH BARRIERS

- Reduces access to safe medical care and increases dependency on unqualified or unskilled services that may increase exposure to infectious disease
- Creates impediments to timely emergency care causing increased mortality

- Containment perpetuates aid dependency by hindering self-reliance strategies and personal or professional development.

AID DEPENDENCY

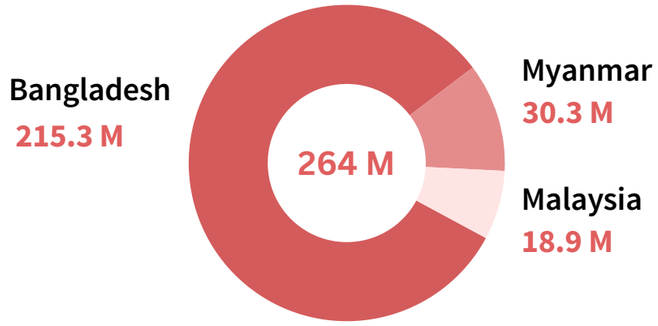
REPORT BACKGROUND

Médecins Sans Frontières (MSF) has provided medical humanitarian assistance to Rohingya communities since 1992, when a wave of violence drove 250,000 Rohingya to seek refuge in Bangladesh. In 1993, MSF established operations to work with Rohingya communities in Rakhine State, Myanmar, and we began working with Rohingya in Malaysia in 2014. From 2017 through 2024, MSF dedicated over €260 million to Rohingya medical and humanitarian projects.

Over the past three decades, we have borne witness to the impact of persecution, discrimination, violence, and containment policies on the Rohingya people and the devastating consequences for their health and wellbeing. We recognize that the overall impact of imposed statelessness on Rohingya society over time is catastrophic.

Yet, measuring the catastrophe through the lens of our medical humanitarian programs has proven extraordinarily difficult. A comprehensive review of MSF's history of advocating on behalf of the Rohingya was published in 2020. This renewed internal reflection and debate on the many dilemmas and challenges faced when providing ethical assistance and advocating on behalf of the Rohingya. One persistent key problem centred around how poor cross-departmental and cross-country communication within MSF reduced the ability of the organization to see trends and engage in unique higher-level analysis. As such, our ability to understand, analyse and explain to external audiences what we witness through the provision of our medical humanitarian programs remained a stubborn issue.

MSF Rohingya program expense



MSF has dedicated over **€260 million** to Rohingya medical and humanitarian projects from **2017 to 2024**

This report is a compilation of what was learned through a review process that began in February 2023 and ended in April 2024, just as the precariousness of the Rohingya's situation in Bangladesh and Myanmar began to further worsen. An initial scoping exercise on the global situation for the Rohingya indicated that up to 99% of Rohingya people in the world likely live without the most basic human rights, particularly the ability to self-identify as Rohingya with access to citizenship, legal residency, and basic services.[15]

<u>This effort consisted of a review of :</u>

- Internal situation reports, medical reports, planning documents, previous public and private briefing papers, and press releases; along with discussions with our Rohingya staff, medical staff, and leadership.

- External sources of information were sought out as well, with a review of over 100 external publications and over 50 meetings or discussions with Rohingya community members, experts, UN staff, diplomats, and donors held directly by the primary author.

- Additionally, external meeting minutes held by other MSF staff members were reviewed on an ongoing basis, though no count exists.

The original objective of this analysis was to summarize our medical data to better communicate what our teams witness as the medical consequences of containment and exclusion policies on Rohingya communities. This effort also revealed that comparing and contrasting the situation of the Rohingya to other local communities in Myanmar, Malaysia, or Bangladesh—or between Rohingya communities in different countries—was extraordinarily difficult. Due to their need to hide, or access restrictions, health research on Rohingya outside the Bangladesh camps is very limited or non-existent.

We ended up with multitudes of highly specialised micro-perspectives, rather than a cohesive analysis due to our regular medical data reporting being tuned towards quality control and managing programs. Also, the nature, scope, and reach of our programs tends to change over time, making comparisons difficult. As such, this report is a patchwork of many different analyses that took place in specific moments. Many may not be repeatable due to program or personnel changes.

INTERGENERATIONAL STATELESSNESS, CONTAINMENT, DISPLACEMENT, AND MARGINALIZATION

CHAPTER 1

INTERGENERATIONAL STATELESSNESS, CONTAINMENT, DISPLACEMENT, AND MARGINALIZATION

Intergenerational statelessness, containment policies, and risky coping strategies have direct consequences on Rohingya health. Political failure and lack of tangible policy actions in dealing with the Rohingya crisis compound interconnected consequences and further threaten the Rohingya as a people.

Impact in Myanmar

Today, at least 636,000 Rohingya remain in Myanmar, [16] [17] including approximately 149,335 people contained in the 24 camps in the central part of the Rakhine State and tens of thousands recently displaced by violent conflict as of June 2024.[18] **Over the past 50 years, conditions for the Rohingya have steadily worsened in Myanmar. As a result, only 23% of the global population of Rohingya still live there.**

While most Rohingya refugees do express a desire to return to Myanmar, it is to a version of Myanmar that has never really existed in their lifetime: one where Rohingya are citizens and have rights. **Conditions for repatriation have never existed in the past 40 years. They do not exist now. They will not credibly exist in the coming years.** Although political discussions to organise the repatriation of Rohingya from Bangladesh back to their homeland are forever ongoing, with approximately a quarter of Myanmar's remaining Rohingya population still confined to inhumane detention camps and tens of thousands newly displaced, it is unimaginable that any safe and dignified repatriations from Bangladesh can begin in the near future. States must direct more resources to ensuring the Rohingya have opportunity, rights, and protection where they are now, while maintaining diplomatic efforts to find just and safe solutions for eventual return.

The situation in Rakhine State is grim and deteriorating. Alienated from Myanmar's central government, people living in the ethnically and religiously diverse Rakhine State have long experienced violence, chronic poverty, and economic and political marginalization. The conflict between the Myanmar Armed Forces (MAF) and Arakan Army (AA) continues to escalate in Rakhine in 2024, deepening the economic and humanitarian crisis there. As of the time of the finalization of this report the situation in Rakhine is highly dynamic without significant humanitarian space, which is already severely restricted by the authorities and by conflict in the area.[19]

All communities in Rakhine are pushed to the limits, with few resources left to cope with conflict, instability, and deprivation. But Rohingya people are most impacted because they are denied citizenship and the rights attached to it.[20] Even granting citizenship may not solve the deep-rooted exclusion of Rohingya from Myanmar society. Even Myanmar citizens from different ethnicities who have citizenship often face the same containment and exclusionary policies as Rohingya if they married a Rohingya partner.

For most Rohingya, it is basically impossible to obtain personal identification, a passport, and birth registration or a marriage certificate.[21] Without documents they cannot move freely between districts, towns, and villages in Rakhine or within Myanmar as a whole. No freedom of movement and lack of documents further impacts access to medical care and the ability to complete education, find formal employment, or establish and run businesses. MSF described some of the consequences of this situation in the 2011 report *Fatal Policy: How the Rohingya Suffer the Consequences of Statelessness.*[22] Many of the discriminatory policies and practices described in the report are still in place in 2024 and pose a barrier to preserving Rohingya's self-reliance and initiative.

The consequences of denial of citizenship go beyond the lack of benefits from acquiring citizenship and rights. It extends to acts of targeted violence against the Rohingya, including killings and sexual violence. The intercommunal violence in 2012[23] left over 140,000 Rohingya displaced from their homes and contained in detention camps[24] across central Rakhine without any freedom of movement or sufficient shelter, water, sanitation, food, or healthcare. In 2017, military violence killed at least 6,700 people[25] and triggered forced displacement of 750,000 Rohingya from northern Rakhine to Cox's Bazar in neighbouring Bangladesh. Now, in 2024 another major wave of violence grips Rakhine.

Violence against Rohingya in Myanmar

2012

140,000 Rohingya displaced from their homes due to intercommunal violence and contained in detention camps across central Rakhine

2017

6,700 Rohingya killed and 750,000 forcefully displaced from northern Rakhine to Cox's Bazar (a refugee camp) in Bangladesh

2024

Another major wave of violence grips Rakhine at the time of writing of this report

The discrimination, segregation, and containment of Rohingya people in Rakhine has proven permanent, with no solution in sight for over 140,000 people in what are de facto open-air prisons and the unknown number of newly displaced Rohingya who have nowhere safe to flee. Without citizenship most are forced to use irregular routes to other countries, including Malaysia or attempt to sneak into Bangladesh where they cannot register or receive humanitarian assistance, forcing them to hide while seeking safety from the conflict in Rakhine.

The wealthiest or most influential Rohingya who may have managed to gain identity cards or passports in Myanmar have been able to fly to destination countries and apply for asylum over the past decades. This is not the case for 99% of the population, who must brave deadly and brutal journeys. Many men, women, and children are arrested and imprisoned by Myanmar's de facto authorities en route.[26] Sexual violence on journeys to Malaysia is common and some women and girls have reported brutal stories to MSF.

"I feared for my life in Myanmar and was compelled to seek refuge in another country. The uncertainty and at times hostility of a new land is preferable to perishing in a place where I was never treated as a human being since birth. Rohingya are desperate for safety and security. We have nowhere to go. Taking a boat is like jumping in the sea without knowing the consequences. You can so easily lose your life in these unseaworthy boats unfit to make these journeys."

Muhib (2023)

A Rohingya man who fled Myanmar in 2013 and is now living in Malaysia. Muhib's journey to safety is illustrated in www.lostatsea.org

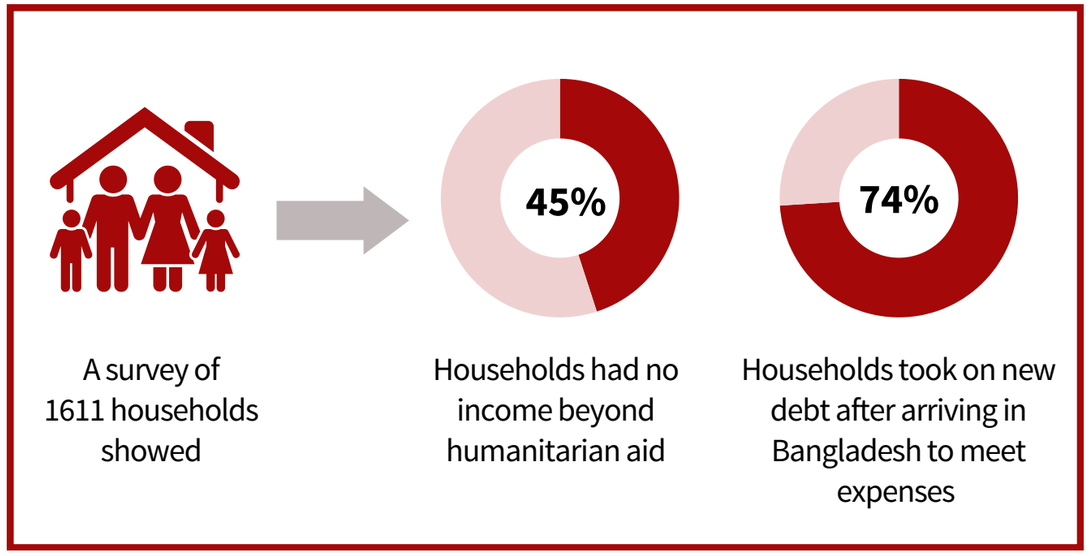
Impact in Bangladesh

Bangladesh is now **home to a third of the global Rohingya population**, and the government of Bangladesh maintains that the solution to the crisis is the return of Rohingya to Myanmar, a place from which roughly 80% of the Rohingya population has either fled or been violently driven, with houses burning behind them. Official data from UNHCR and the government of Bangladesh lists 965,467 Rohingya living in Cox's Bazar refugee camps.[27] UNHCR estimated 200,000 Rohingya lived informally within Bangladesh prior to 2017,[28] and there are now approximately **1.2 million Rohingya** in Bangladesh. They are subject to restricted movement, must hide their identity if outside the camps, are vulnerable to extortion or arrest, and have no choice but to resort to risky strategies that break the rules imposed upon them to survive.

The camps in Bangladesh are a dystopian nightmare. Cox's Bazar, the world's largest refugee camp,[29] is also perhaps the world's largest bamboo makeshift slum. The main mega-camp in Kutupalong is a maze of twisting alleyways and stairs that can take over an hour for a fit individual to traverse and prove a taxing hike in sweltering humidity and heat.[30] With a near ban on localized transportation in the camp, this means the majority of the residents struggle to leave their home block and whatever services are available close to their home.[31] The further Rohingya go from their home block, the greater the risks of extortion, violence, abduction, or other ill treatment.

Due to lack of legal status Rohingya have no right to live and work in Bangladesh, and informal livelihood opportunities and remittances are the primary source of income generation for a majority, beyond the limited and insufficient assistance received via the humanitarian response. A 2020 survey of 1611 households conducted by Centre for Peace and Justice (CPJ), BRAC University, offers a more complex narrative. According to their results, 45% of all households had no income beyond what was provided by the humanitarian response. Furthermore, 74% of households took on new debt after arriving in Bangladesh because the average income from all sources (remittances, informal labour, etc.) was not enough to meet monthly expenses.[32]

Rohingyas in Bangladesh are in financial distress



Survey conducted by Centre for Peace and Justice (CPJ), BRAC University in 2020
"Beyond Relief: Securing Livelihoods and Agency for Rohingya Refugees in Bangladesh".
The Asia Foundation (blog).

KEY DRIVERS:

- No right to live and work in Bangladesh
- Insufficient humanitarian assistance
- Normalisation of substandard conditions & negative informal economic coping mechanisms

This situation is exacerbated by negative attitudes of some individuals in humanitarian organizationswho have normalized the substandard conditions and negative informal economic coping mechanisms forced on the Rohingya. Officials have described the situation as being "not too bad". Unfortunately, this reflects the fatigue of a protracted crisis amongst humanitarian actors, including in MSF,UN agencies, and others. One senior UN official even described the response in Bangladesh as an "innovative protection response" in discussions with the author.

In the past, those with greater resources obtained National Identification Cards (NID) or Bangladesh passports and fled onwards seeking out opportunities in Saudi Arabia or elsewhere. With increased scrutiny by Bangladesh, this avenue of escape has become more difficult and rarer in recent years. Those with fewer resources often risk the dangerous journey to Malaysia. The biometric database administered by UNHCR and shared with the Government of Bangladesh also entrenches statelessness, as it makes illicit strategies for onward flight more expensive and difficult. This increased scrutiny has the effect of trapping more Rohingya in the camps in Bangladesh and of making them increasingly dependent on a political solution.

From early 2023 on, health indicators in Rohingya camps began to show alarming signs of worsening. This is likely due to the reduction in funding for the humanitarian response and reduced food rations. In March 2023, the camps experienced the highest surge in cholera cases in the past five years. In 2023 a scabies outbreak affected around 40% of the camp population—almost one person in two. The efficacy of the mass drug administration that finished in December 2023 for scabies is questionable, as it did not include improved water and sanitation measures.[33] [34] **Persistent undernourishment and inadequate food rations are likely to have dramatic impacts on the Rohingya people, including nutritional and health consequences and a worsening of refugees' living conditions.** In addition to nutrition and health consequences, UN Human Rights Council independent experts warned that "the impact on the Rohingya will be severe and long-lasting, stunting the development of children and dimming the hopes of future generations. Vulnerable populations, including pregnant and breastfeeding women, adolescent girls, and children under five will bear the brunt of the cuts and be further exposed to exploitation and abuse". [35]

The current humanitarian system in Bangladesh, and the lack of any clear mid-term solutions for Rohingya confined to camps there, entrench multi-generational statelessness.

A Rohingya couple carry their sick child through the camp to find a doctor. (Cox's Bazar, Bangladesh, Oct 2023) | © Sahat Zia Hero

Impact in Malaysia

Based on official data, population growth rates, and figures on new arrivals, MSF estimates there are at least **210,000 Rohingya** living in Malaysia. Of those, 106,390 are registered with UNHCR.[36] This also includes multigenerational families who began arriving in significant numbers in the 1980s and 1990s who settled mostly in Penang and in and around Kuala Lumpur. [37] [38]

Protection is very limited for refugees and asylum seekers in Malaysia. According to domestic law, they are considered undocumented migrants. As such, they are criminalized for violating the Immigration Act 1959/63 under Section 6(1)c for entering the country without a valid pass.

Punishments for the violation of this law include imprisonment, fine, and/or whipping. Rohingya and other refugees have no freedom, and they constantly live in fear. UNHCR documents do not provide absolute protection for registered refugees, as these documents are often not recognized as valid by state agencies because there is no law regulating refugees in Malaysia. This means that refugees and asylum seekers, including new arrivals, are constantly exposed to the risk of arrest and detention.

As a result of deterrence-based policies, refugees with and without UNHCR documents have been detained for immigration offenses and placed in immigration detention centres indefinitely and arbitrarily, especially since UNHCR was denied regular access to immigration detention centres in August 2019. As of April 2022, there were 2,264 Rohingya refugees in immigration detention centres. Despite being denied access to these facilities, UNHCR continues to advocate for registered Rohingya refugees. However, the release process has been made increasingly challenging by deliberate administrative barriers that complicate tracing of refugee detainees.

Apart from the risk of arrest and detention, refugees and asylum seekers have no right to education or legal employment. Out of the need to survive, refugees often find informal work, which typically consists of difficult, dangerous, and dirty basic-skilled jobs, and they are often exploited by employers, with wages not being paid in full or at all. They have little access to the protection and recourse afforded by labour laws, as they are not legally recognized as employees.

Increasing xenophobia also poses a threat to refugees in Malaysia, with locals tipping off authorities to conduct raids in areas where refugees live. Forcible eviction of refugees has occurred because of alleged misbehaviour of refugees, alongside banners calling for their expulsion. Vigilante groups have harassed refugees in their homes, with little tangible protection afforded by authorities to those affected by these attacks. Hate speech on social media is continuous, with locals calling for existing refugees to be deported and for Malaysia to close its doors to new arrivals.

Rohingya workers employed on a construction site in Penang. Construction sites, which are numerous in Malaysia, are one of the few ways the Rohingya can earn a living in the informal economy, but some employers take advantage of their irregular legal status to deprive them of their full wages. (Penang, Malaysia, Apr 2019) | © Arnaud Finistre

© MSF

THE IMPACT OF VIOLENCE ON ROHINGYA COMMUNITIES

CHAPTER 2

THE IMPACT OF VIOLENCE ON ROHINGYA COMMUNITIES

Pervasive multi-generational persecution and violence is sadly central to Rohingya existence. Fear of physical, sexual, and emotional violence influences the choices of Rohingya people on a day-to-day basis. Profound life decisions, like choosing to indebt oneself and flee to a third country or increasingly to seek marriage for adolescent girls, are made in reaction to fear of violence or in response to experienced violence. Extensive exposure to violence impacts every facet of Rohingya life, as people seek coping strategies to change the fundamental circumstances of their suffering.

The Rohingya experience the consequences of violence directly and indirectly. Generations of Rohingya have witnessed and experienced beatings, village burnings, rape, and killings since the 1970s.[39] *Indirect consequences of violence include the many thousands who die when trying to flee and the impact of lost access to health and other services in times of conflict and violence on health outcomes. Being subject to violence increases the likelihood of committing violence and influences the choices families make, such as marrying their daughters at a young age.*[40]

Violence in Myanmar

The Rakhine State programs for the Rohingya in Myanmar were once one of the largest medical programs in the world for MSF. Between 2005 and 2011, MSF treated more than a million people for malaria. In 2011, MSF conducted roughly 500,000 medical consultations, providing primary healthcare (PHC), TB, HIV, and maternal health services primarily to the Rohingya.[41]

From 2012 to 2017, well documented waves of violence in Rakhine State,[42] [43] xenophobic vitriol, anti-INGO/UN sentiments, arrests, suspensions, and intimidation dramatically reduced MSF's ability to provide health services at scale while ultimately the majority of the Rohingya population fled to Bangladesh in 2017 due to the violence. What is less well documented is the overall impact of violence on access to healthcare for Rohingya people.

By December 2016, prior to the largest ever forced displacement of Rohingya to Bangladesh in 2017, MSF was only able to manage about a fifth of the volume of care, planning only about 100,000 consultations per year.[44]

In 2024, with the ongoing access restrictions and escalation of conflict between the Arakan Army and the Myanmar military, MSF's ability to provide healthcare is at a historic low, with just 56 OPD consultations provided in MSF's Sittwe Project and 0 OPD consultations in MSF's Maungdaw Project in the month of December 2023. As of time of publication, the conflict in Rakhine coupled with severe movement restrictions prevents MSF from running any of the 25 mobile clinics that delivered approximately 1,500 patient consultations a week in total, before the resumption of conflict.[45]

During the 2012 to 2014 violence in Rakhine, MSF was forced to suspend medical activities, stating "MSF has been providing medical services for 20 years, focusing on maternal health and infectious diseases such as malaria, diarrhoea, HIV/AIDS and TB. In 2011, MSF conducted more than 487,000 consultations, and has over 600 patients on antiretroviral treatment for HIV/AIDS. In addition to meeting immediate emergency needs, getting MSF's regular programmes back on track is critical to the longer-term health and well-being of people from all communities throughout the state."[46] In 2012, "MSF was only able to treat approximately 50,000 people between June and December."[47]

The 2012–2014 violence and the threat of violence drove over 112,000 Rohingya to flee to Malaysia between 2012 until 2015 in what became known as the Andaman Sea crisis.[49] Conservative mortality estimates by UNHCR put the mortality rate at 1–2% based on 1,800 known dead or missing.[50]

Sea journeys, either short ones between Bangladesh and Myanmar or long ones to Indonesia or Malaysia, remain a typical part of every Rohingya movement still, regardless of their final destination or route combination.[51] The recent boat journeys appear to be particularly deadly, with 984 people reported dead or missing in 2022 and 2023 by UNHCR. A further 727 are listed simply as "unknown". According to UNHCR, 8179 Rohingya attempted sea journeys in 2022 and 2023, largely from Bangladesh, which would mean the mortality rate is an alarming 12%. Including the cases listed as "unknown" as deaths would increase mortality estimates to 21%. [52]

One study of regional health professionals provides an outstanding overview of the continuum of health vulnerability for those who risked their lives at sea. They trace vulnerability from pre-departure poor baselines to the violence and inadequate conditions enroute and during interception to barriers to healthcare on arrival in a strange land or in detention centres.[53]

A decade after the 2012 violence, 149,335 Rohingya people continue to languish in 24 detention camps throughout Rakhine.[54] MSF provides PHC and facilitates emergency referral to specialised care, including boat transportation in only five of these camps before the current violence and restrictions. As of June 2024, MSF is unable to refer any patients anywhere other than those already in Sittwe, to Sittwe General Hospital.

"What we are seeing now, as expressed by some of our staff, is worse than any other period of violence in the state since 2017, when hundreds of thousands of people from Myanmar's minority Muslim Rohingya community were forced to flee to Bangladesh."[48]

Dr Nimrat Kaur

MSF Project Coordinator in Maungdaw, Myanmar from Apr 2023 - Apr 2024

"We cannot move outside of camp because we have movement restrictions. We cannot go to Yangon, and we also cannot go to the Sittwe General Hospital by our ourselves [……] Only MSF can refer us." [55]

39-year-old Rohingya man living in Pawktaw Camp

Interviewed Jul 2023

In 2017, through the publication of retrospective mortality surveys taken of Rohingya refugees recently arrived in Bangladesh, MSF documented that at least 6,700 Rohingya people were killed in Rakhine State between August 25 and September 24, 2017, of whom at least 730 were children under the age of five.[56] The total number of Rohingya killed in Rakhine in 2016 and 2017 is estimated to be much higher, as this recall period represents only a portion of the peak period of violence and is based on those who survived and made it to Bangladesh. There were reports that entire families were killed, and these deaths were not captured by the survey. A 2018 MSF report "No one was left" - Death and Violence Against the Rohingya[57] delved deeper into the mortality survey findings.

It also showed the prevalence of violence, with 21.5% of all displaced Rohingya experiencing violence, with an average of 3.7 incidents per person. This means that approximately 150,000 people who survived experienced multiple incidents of violence in 2017.

Rohingya who remain in Rakhine State also see access to healthcare limited when armed conflict increases. In the 2022 conflict between the Myanmar Military and Arakan Army in Rakhine State, MSF clearly observed reduced access to healthcare for Rohingya people. Around July 2022, parties to the conflict started imposing restrictions on the movement of goods and people. The de-facto military authorities banned aid organizations from accessing six townships in central and northern parts of the state, including the transportation of lifesaving medical and humanitarian supplies.

Towards the end of 2022, MSF lost access to most of our 25 clinics, which was restored only in February 2023. Between August and December 2022, we recorded over 18,000 missed patient consultations, a decline of consultations up to 70% in some months, and a drop in referral capacity by around 20%. Restrictions on access meant that many patients went without access to routine healthcare or medication. The medications to control diseases, such as diabetes and hypertension, are either not available or not affordable for many patients in Rakhine. **With conflict on the rise in Rakhine at the time of writing, MSF observes another cycle of reduced healthcare access, leading to avoidable loss of life.**[58]

Violence in Bangladesh

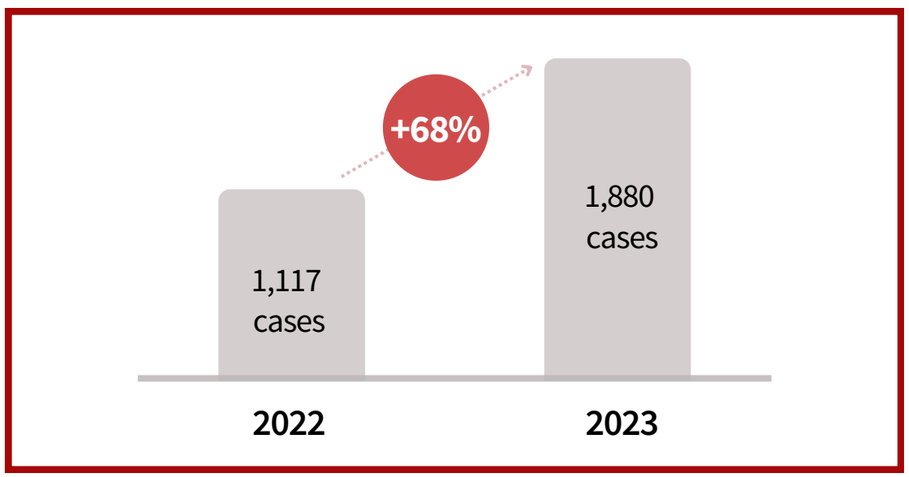
The Rohingya fled violence and persecution in Myanmar for life in the makeshift camps of Cox's Bazar, Bangladesh. However, Cox's Bazar, a major transnational trafficking hub, has a long history of criminality and violence. One million vulnerable humans who have few legal protections and experience systematic barriers to justice and accountability mechanisms, with inter-generational trauma predisposing them to not trust people in uniform are an easy target for organised criminality to thrive. [59]

Between 2017 and 2023, MSF has observed a shift in violence-related injuries treated in the Kutupalong Emergency Room next to the Cox's Bazar mega camp. In recent years, we noticed rising severity of the injuries sustained as a result of violence, including targeted gun violence and stabbings by criminal groups, kidnappings for ransom, and further rise in violence between neighbours over the use of resources, such as water or land.

In MSF facilities there has been a 68% increase in violence-related injuries in 2023, with 1,880 people treated for blunt trauma, stab wounds or gunshot wounds, versus in 2022 when 1,117 were treated. Every month in 2023, MSF treated an average of over 150 violent injuries in its health facilities. The number of **gunshot patients in 2023 also increased by 76% in 2023** with 67 treated, compared to 38 in 2022.

Abductions by armed groups in the camp also increased sharply in 2023, going from a few dozen in years past to over 100 per month in 2023. Abductions were committed to obtain ransom payments and as retribution against individuals who refuse to cooperate or join with these groups, or who report them to police. During abductions, victims are sometimes held in detention-like facilities, tortured, and forced to make videos stating that they support the perpetrating group to prevent them from reporting to authorities. In general, victims are unlikely to report their abductions to avoid further harm.[60]

Rise in violence related injuries in MSF facilities



40-year-old Rohingya woman living in the Bangladesh camps

Interviewed Nov 2023

I live with six of my family members. My son is 22 years old and is married. His wife also lives with us. About a month ago, my son was asked to join ARSA [the Arakan Rohingya Salvation Army]. We all were scared hearing that, as it might result in some consequences if we say no. However, as it could be worse if he joins than refuse, I forbid him from joining. He was avoiding the gang and moved to another block to hide and is living with a relative.

Meanwhile, the gang keeps coming to my house to look for him. Not finding him, they became angry and started yelling and shouting at me.

All of a sudden, they started beating me and two of my daughters. One of my daughters was beaten severely [which] later resulted in a knee infection, as we were not able to take her to hospital on time, being afraid. They also tried to rape her, but she managed to escape. They keep patrolling overnight to see if my son returns.

A few weeks later, they found and caught my son and took him away to another block. They beat him severely and left him under a bridge. The community heard the noise but no one came out to rescue him from the gang. When some people from the community found him, they brought him to the shelter. On that day, after a few hours, police and some members from Islam-E-Mahadh [another armed group] group came to our shelter and took him to the hospital.

Now everybody knows in the camp about the incident. The group is searching for my family. My son has been staying with my daughter in another camp. How long he can run from their searching and keep changing camps?[61]

In 2023, with conditions in the camp deteriorating, MSF observed an increase in adolescent girls and women sent to Malaysia for arranged marriage. This choice is often made to protect women and girls from unwanted and forceful "marriage" proposals from criminal elements within the camps. Due to the precariousness of their situation, adolescent Rohingya girls are often faced with a double-edged choice: forced marriage in Bangladesh to criminal elements or armed groups or an arranged marriage to an unknown man in Malaysia after a harrowing, dangerous, often deadly journey.

Furthermore, MSF has witnessed forced trafficking of children, men, and women for profit from the Bangladesh camps, with people held hostage for ransom in Myanmar. For example, in early 2023, a Rohingya youth was lured to Teknaf by a friend to a remote warehouse where he was handed over to traffickers.

While many Rohingya people freely choose to attempt dangerous irregular routes, forcibly trafficking or tricking them into being trafficked from the Bangladesh camps is not a new phenomenon either. There is documentation describing the horrors of women and girls sold into bondage in Pakistan in the 1990s,[62] and MSF also spoke with survivors who were tricked into joining a boat movement to Malaysia a decade ago.

"In the beginning of 2022, my father was assaulted by ARSA many times because one of the members wanted to marry me. However, my father did not accept the proposal. Following the refusal, one of the group members took my father away and kept him for two days to convince him. They released my father, but no one told me what the group told my parents; they threatened him with death. Within a week my father contacted one of my uncles living in Malaysia and decided to send me there. My father said he would send me to Malaysia, as the camps will not be safe for me. My father and uncle contacted a broker residing in Teknaf. The next day my dad rushed to take me to Teknaf. The decision was not easy for me, since I was very young, and I had to leave my parents."[63]

Adolescent Rohingya girl living in the camps in Bangladesh

Interviewed Nov 2023

45-year-old father living in the camps in Bangladesh

Interviewed Nov 2023

My second son is thirteen years old and was studying in a madrasa in the camp. He didn't like the madrasa. We also didn't get him into any other school, as there is no standard education that can be helpful for the future. He is a daredevil. Often, he used to go to my relatives' houses in other camps, for two to three days without informing anyone and used to return home by himself.

Around a month ago, my son went missing. First, I thought it was like the other days and he would return home in a couple of days. After a week, we started looking for him in my relatives' places in the camps, but he was not there. I informed the Majhi and relatives to tell me if they hear anything about my son. I didn't go to CIC, police, or an NGO, thinking they can't help.[64]

After nine days, a person came to the Majhi and was looking for me. He was asking my son's name and is he missing. I was surprised as well as happy, hoping that he might have my son's news. Then he explained that my son is in Thailand.

I was shocked hearing that and thinking how is it that a thirteen-year-old boy from camp can go missing and be in Thailand in just a week? My son joined a group leaving to go to Malaysia. The traffickers offered that no payment was needed in advance, all payment can be paid in instalments. But the story changed when he left the camp. Many people are leaving the camps considering the rising violence and pressure from groups to join them.

The person informed me that it would cost US$350 for my son to continue the journey from Thailand to Malaysia, otherwise he would be lost and would not be taken further with the group. I was crying and nervous hearing all this and worried about organising the money. I requested time to organise money.

It took two weeks to arrange the money. I sold my wife's gold and took a loan from my relative as well. I contacted the person and gave the money to him. Meanwhile, I received three calls from traffickers, and they were yelling and shouting over the phone threatening that they will leave my son if I don't get them money on time. My son told me (when I talked with him) he was beaten twice while they were reaching out for money.

On the twentieth day my son finally arrived in Malaysia and is now staying in one of my neighbour's (from the original village in Myanmar) house. I still didn't get a chance to talk with him for long—only for five to ten minutes a week. What I know so far is he is safe. He doesn't have any documentation with him, and he is yet not registered under UNHCR registration in Malaysia.

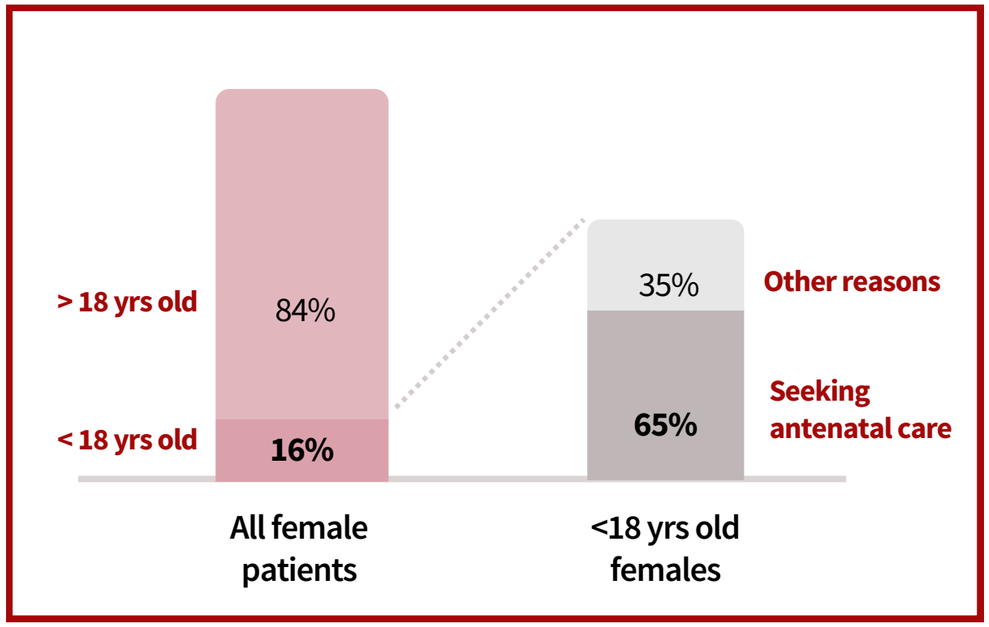
The camp is not secure for us or for our kids. People are leaving the camps, as they don't see things are changing and there is no edge of hope we see. We are also thinking of leaving.[65]

Violence in Malaysia

We observe how the “push factors” of deteriorating conditions, violence, and discrimination in Myanmar and Bangladesh contribute to risky migration choices, including a significant number of adolescent Rohingya girls sent to Malaysia for arranged marriages. Among all our female patients, 16% are younger than 18 when they visit our clinic. The main reason for their first visit is antenatal care (65% in the age group 12–17). Many of these girls are anaemic, owing to complications common in pregnancies at a very young age.

Violence and negligence in immigration detention centres, where Rohingya are frequently held arbitrarily and indefinitely, have resulted in the deterioration of the health and wellbeing, including death, of refugee and other migrant detainees. In a Human Rights Watch report released in early March 2024 on the arbitrary detention of migrants and refugees, the Home Affairs Ministry reported 247 deaths in immigration detention from 2021 to mid-2022, including four children, due to tuberculosis, pneumonia, heart disease, dengue, diabetes, and other causes.

Antenatal care is the main reason for clinic visit among under 18 female patients



In recent years, through refugee detainees who had been released, MSF and Human Rights Watch received information about insufficient and poor-quality food and water, lack of access to hygiene items, denial of medication, and overcrowded and unhygienic living conditions without mattresses and blankets. In addition, detainees were reported to be subjected to degrading treatment and physical and psychological abuse by immigration officers in addition to coercion to return to their countries of origin. Children were detained with unrelated adults or separated from families.

Rashida, 22 years old, was born in Rakhine state, Myanmar. She fled alone in 2012 when she was 15 years old and sought refuge in Bangladesh. From there, she travelled to Thailand, which entailed an eight day trip on a boat with around 500 passengers on board. She reached the Malaysia border by foot with the assistance of smugglers, then spent three and a half months in a Penang detention centre. Since arriving, she's married a Malaysian-born Rohingya who works for a cleaning company. (Penang, Malaysia, Apr 2019) | © Arnaud Finistre

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THE BURDEN ON WOMEN AND GIRLS: SEXUAL AND GENDER-BASED VIOLENCE

CHAPTER 3

THE BURDEN ON WOMEN AND GIRLS: SEXUAL AND GENDER-BASED VIOLENCE

The pervasiveness of systematic, opportunistic, and targeted sexual violence against Rohingya women and girls spans generations.[66] *Containment and marginalization policies combined with the lack of empowerment of Rohingya women in their society create conditions that lead many to live lives locked away in their homes and fathers to make desperate decisions on behalf of their daughters. Such restrictions and exclusions contribute to deep mental and physical health problems for women and girls.*

Within Rohingya society:
child marriage and dowry

In 2023, the practice of child marriage appeared to be increasing among Rohingya refugees, based on MSF observations in Malaysia. It is seen as a negative coping mechanism for households desperate to reduce economic pressure by marrying off their children, while others hope it will protect their daughters from increasing risks of sexual violence in the camps. Among the Rohingya, this is a result of the fear and intergenerational trauma linked to decades of sexual violence in Myanmar (committed in the context of military violence) and ongoing risks of sexual violence in the Cox's Bazar refugee camps, where criminality thrives. [67]

Furthermore, the practice of dowry payments (outlawed in Bangladesh, but the ban is not enforced in Rohingya camps) contributes to higher rates of child marriage. Some families marry off their sons to receive a dowry; others marry off their daughters young, which enables them to pay a lower dowry. In Malaysia, Rohingya families marrying off their daughters reportedly pay less or no dowry, and the cost of traveling there via irregular routes are often mostly covered by the groom.[68] The risks associated with the perilous journeys are well known among the Rohingya (including risks of sexual violence), but the economic hardship and/or the wish to give daughters better opportunities are stronger.

MSF also received reports suggesting that **child marriage may be linked to increasing rates of criminal activities and violence in the camps.** This includes frequent abductions and incidents of sexual violence against girls, who are then forced to marry the perpetrator, often members of armed gangs. MSF is aware of cases in which criminal groups operating with impunity throughout the camps in Bangladesh allegedly forced families to marry off their daughters to members.

Rohingya girls subjected to child marriage are discriminated against on the basis of their gender and lack of legal status, exposed to high risks of sexual and/or intimate partner violence, and deprived of access to medical and psychological care and protection services. As members of a group that is subjected to exclusion and systematic discrimination, Rohingya women and girls are not afforded the space to challenge harmful practices such as child marriage. For access to services and advocacy, they often rely on humanitarian organizations such as UNHCR, UNICEF, and MSF, which assume some of the roles that would typically be carried out by state institutions.

Girls married to older men are exposed to asymmetric power relations and are more likely to experience intimate partner violence, which has a negative impact on their physical and psychological health.[70] Married girls risk exposure to HIV, sexually transmitted infections, and unwanted pregnancies, while poor access to safe abortion care results in increased maternal mortality and morbidity. Girls who are married before the age of 18 years often become pregnant while still adolescent, which increases the risk of pregnancy-related complications or complications during childbirth.

"I didn't feel safe in the Bangladesh refugee camp. In Bangladesh, I did not see any couple married for a long time. I've witnessed several Rohingya men leave their pregnant wife for another woman in the camp. The groom's family also asks for dowry, almost 3 lakhs (approximately US$2,700). Since the Rohingya men in Malaysia do not ask for [a] dowry, my family decided to get me married off with someone in Malaysia. After marrying the groom of my parent's choice, I was able to give some money (savings from my husband) to my parents although it was not doable for long."[69]

17-year-old Rohingya girl who arrived in Malaysia in May 2022 from Bangladesh

Interviewed Aug 2023

"[Widows in a Rohingya community] have less respect and rights. They can easily be manipulated and are targeted by criminals for exploitation. She will need to fight for every small thing and is extraordinarily at risk. Her mental health and physical health will suffer from stress and anxiety."[73]

Dr Ambia Perveen

Rohingya Medics Organisation (RMO)
Interviewed Jan 2024

This includes anaemia, eclampsia (a severe complication in which high blood pressure causes seizures during pregnancy), puerperal endometritis (infection of the uterus, typically caused by bacteria from the lower genital or gastrointestinal tract), and systemic infections. Adolescent mothers have a higher risk of delivering babies prematurely and with low birthweight. These complications are the leading cause of death among adolescent girls. Babies born to adolescent mothers are at higher risk of developmental delays, behavioural disorders, severe neonatal conditions, and neonatal death.[71]

Child marriage severely limits the future prospects of girls and cuts short their childhood. Married adolescent girls are more likely to drop out of school and have worse economic outcomes than girls who are not married as children. Married girls also risk isolation from their friends and family and exclusion from activities in their communities. All these consequences negatively impact girls' psychological well-being.[72]

Furthermore, Rohingya women who find themselves widowed or divorced live precariously within Rohingya society.

Sexual and gender-based violence in Myanmar

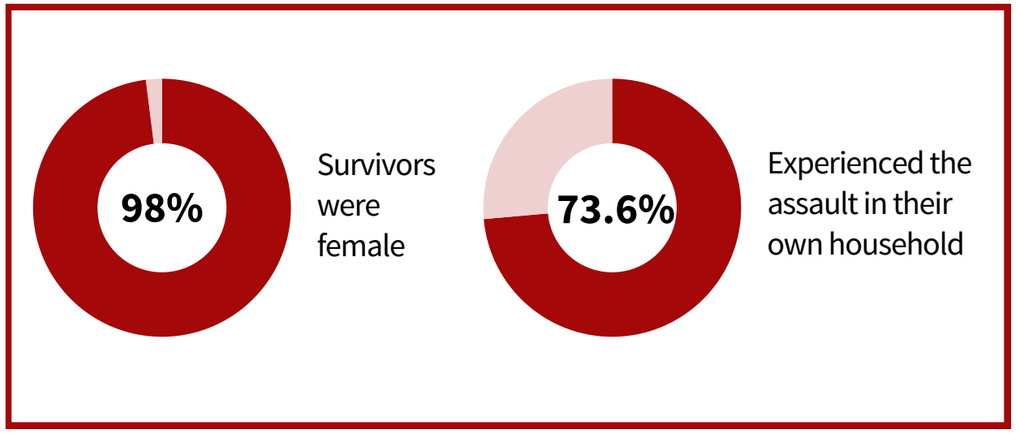
In Myanmar, MSF struggles to reach survivors of sexual and gender-based violence (SGBV). Coupled with our knowledge of the significant movement restrictions and limited availability of health-care, it seems safe to assume that the vast majority of survivors are left without access to timely medical care.

"Sexual and reproductive health care for Rohingya in the camps falls perilously short of international standards … [with] particularly grave consequences for pregnant Rohingya women in central Rakhine, [of whom] least 15% require emergency services … The UN special rapporteur on Myanmar said following a visit to the camps that she had 'received disturbing reports of [maternal] deaths in camps owing to the lack of access to emergency medical assistance and owing to preventable, chronic or pregnancy-related conditions.'"[74]

Between 2020 and June 2023, only 519 SGBV consultations were reported in Rohingya-focused MSF clinics in the Sittwe Project, and between 2021 and June 2023, only 42 consultations were reported in these MSF clinics in the Maungdaw Project. Among all SGBV consultations, over 98% (n=551) of survivors were female.

Among the SGBV consultations reported in the above-mentioned project clinics, 91.3% (n=21) of the SGBV survivors younger than 15 years old experienced rape. The majority of SGBV survivors (73.6%; n=413) across all age groups experienced the assault in their own household.

MSF SGBV program observations



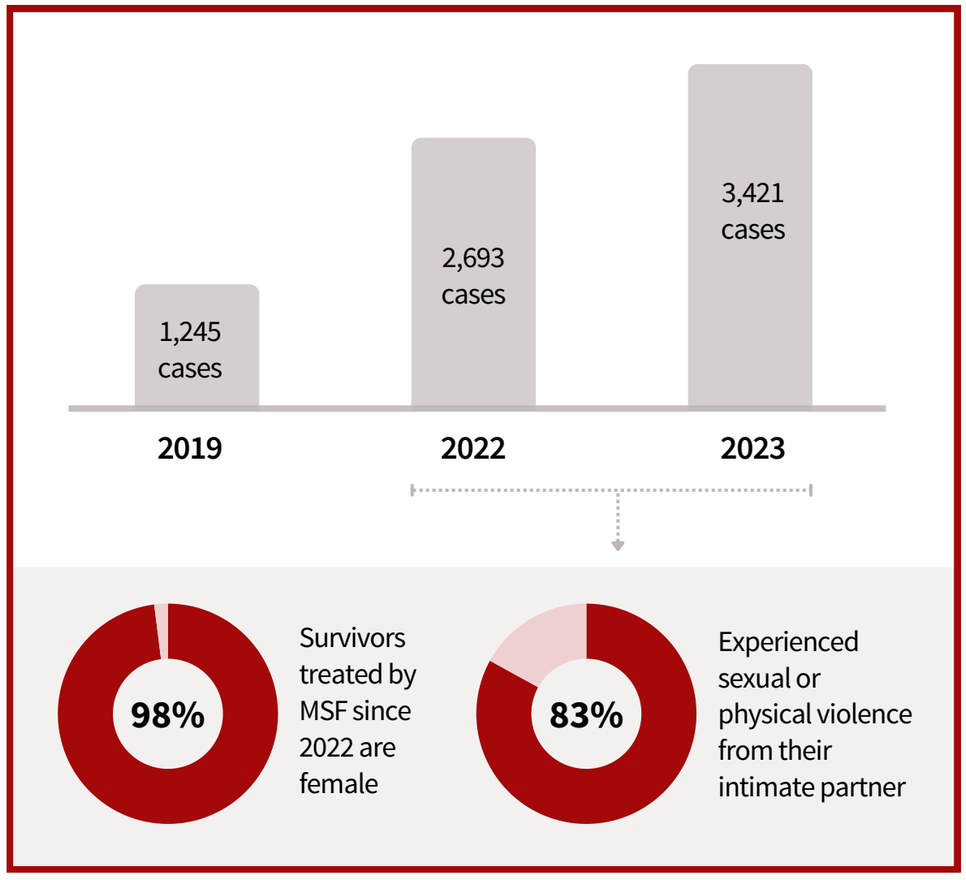
Sexual and gender-based violence in Bangladesh

In 2023, MSF provided care to 3,421 survivors of SGBV in Bangladesh camps. Patient numbers have been steadily trending upwards, from 1,245 patients in 2019 to 2,693 patients in 2022, which is a small fraction of the total number of survivors in the camps and is not representative of a pattern. **The key issue is that more survivors are reporting barriers to accessing care and information about available services.**

A shift in accessibility of services coincided with the construction of fencing in and around the camps in 2021. This barrier had a direct impact on access to care for people in the camps. Prior to 2021, approximately 58% of survivors reported experiencing barriers to care, lack of information, lack of transportation, or too-long distances. In 2022, this proportion increased to approximately 75% and remained constant throughout 2023.

Of survivors treated by MSF since 2022, 98% are female and 83% experience sexual or physical violence from their intimate partner. MSF doctors have noted that the degree of violence has changed over time as well, with more significant physical violence and increased use of blunt or cutting weapons.

MSF SGBV program observations



This represents only a small fraction of the total number of survivors in the camps and is not representative of a pattern

30-year-old Rohingya woman living in the Bangladesh camps

Interviewed Nov 2023

I live in one of the older parts of the camp and came to Bangladesh in 1990. I have been married for 17 years. My husband is a daily worker. I cannot tolerate his unbearable torture. After three years of our marriage, when I had my first son, he started taking drugs. I did not know what to do or [from] whom to seek support. It wasn't that bad in the beginning. I thought [since] we have a child, all will be fine. However, with time, things started changing. The abuse became intolerable.

When my second and third babies [were] born, the level of his abuse increased even more. He takes drugs every day and does not support [our] family when there is need. I often have to hassle him. Sometimes he disappears for a couple of months, and no one knows where he goes and what he does.

I decided to inform the Majhi to find us some solution and mitigate these ongoing family conflicts. The Majhi called us several times and mitigated issues, but it didn't last for long. [My husband] again started beating me and continues to take drugs.

The Majhi stopped caring when I reached out and took [my husband's] side as he was paying the Majhi. He sold all of my gold and small cash I saved for my children and used it on drugs. He is also involved in another relationship with another woman. I even reached out to CiC [Camp in Charge] and TAI [Technical Assistance Inc.] and made a complaint against him. He was called by CiC but it didn't work. He left me after that event, and I was four months pregnant at that time. It was hard for me to manage food for my kids, as going to collect distributions was not easy for me. However, I survived. Even during my last delivery, I was alone. He continued to leave us and come back whenever he needed.

About four days ago, he came back again to see our daughter, [who is] four months old now. I didn't let him in, but he managed with the Majhi and his family to convince me. The Majhi and [my] in-laws confirmed that my husband will not beat me again, so I forgave him. But then on 19 November, I asked him to buy some food for my kids. He was angry and started beating me without reason. I am in the hospital just because of him. I don't want this anymore.[75]

Reports of non-civilian perpetrators, either police or military, are quite rare, amounting to less than 1% of all reported cases. The vast majority—92%—of all cases take place at the victim's home or at a friend or family member's home. Less than 10% report violence to police due to fear of authorities, another manifestation of intergenerational trauma caused by the Rohingya's lived experience of persecution by military and police in Myanmar. However, these statistics must be contextualized. We are not able to quantify the extent of non-intimate partner violence because we only see the women who are able to reach MSF facilities, and these women are probably not the most vulnerable Rohingya women and girls, such as those sold into slavery or debt bondage, those working in Bangladeshi brothels, or those raped and left for dead while trying to reach to safety. [76]

A health promotion session in progress for Rohingya women in the refugee camps in Cox's Bazar, Bangladesh. Health promoters usually invite several families to a session, to raise awareness around the importance of seeking healthcare. The team also discusses the availability of medical and mental healthcare at MSF facilities.
(Bangladesh, Jul 2022) | © Elizabeth Costa//MSF

Sexual and gender-based violence in Malaysia

Compared to 2022, MSF saw an increase in adolescent pregnancies in 2023 among patients presenting for antenatal care (ANC) in the MSF health facility in Penang, Malaysia. Nearly all of our patients there are Rohingya refugees.[77]

In the first quarter of 2023, **14.5% of ANC consultations on average were attributed to adolescent pregnancies (defined as pregnancies in girls under 18 years old).** By comparison, adolescent pregnancies represented on average 9.3% of ANC consultations from April to August 2022 and 11.2% from September to December 2022. Among these underage pregnancies, the average age was 16 years old while the youngest patient in MSF's clinic was 12 years old. One in four adolescent pregnancies were in girls younger than 16 years old.

Three out of every four pregnant girls we received had arrived in Malaysia in 2022 or in the beginning of 2023. This increase in the percentage of ANC consultations who are under 18 years old should be considered in the context of concerns raised by MSF teams in Cox's Bazar refugee camps in Bangladesh, where deteriorating living conditions (including worsening water, sanitation, and hygiene [WASH] infrastructure, rise in criminality, and reduced access to livelihoods and food rations) could be drivers of child marriage practices.

From January 2021 to March 2023, MSF treated 437 survivors of SGBV. Of these survivors, 92% were women and 58% were minors. Just over half—51%—of the assaults were sexual in nature, while 41% were physical and 4% were emotional. Intimate partner violence was responsible for 71% of cases and 44% were assaulted more than once.

Among MSF's cohort of survivors of SGBV, 17% reported being assaulted on the way to Malaysia. Among these, 74% were assaulted physically and 5% were assaulted sexually. A third received death threats.

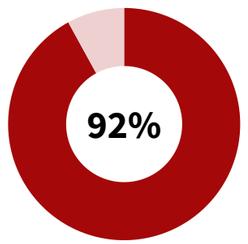
Sexual violence is the most commonly reported form of violence among people younger than 18 years old (80%), whereas physical violence becomes more common in those older than 18 (80%). In cases of sexual exploitation, 93% occur among minors and 89% are linked to child marriage.

Sexual exploitation related to child marriage is most common among minors older than 12 years old. Of victims of sexual exploitation, 91% are married minors, with an average age of 15.9 years old when they visit our clinics. A majority (79%) of them are already pregnant. In addition, 10% of married girls require counselling support due to general anxiety or trauma-related symptoms.

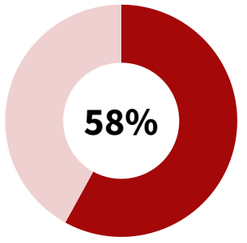
Among survivors of SGBV who are over 18 years old, the leading type of assault is physical violence (79%), followed by psychological or emotional violence. Perpetrators tend to be intimate partners, family members, or known civilians (90%), and assaults usually take place at the survivor's home. Apart from medical care, about 10% of survivors seek counselling services.

While MSF provides care for survivors of SGBV, there are many challenges accessing the range of care in public healthcare settings and the criminal justice system. As a result of the exclusion of the Rohingya from these services, survivors struggle to report cases of domestic violence and intimate partner violence to the police due to victim-blaming and issues linked to refugee status, fear of detention, or lack of ability to communicate in a local language. Social welfare services often exclude refugee survivors. Shelter options are very limited, especially if the survivor has children.

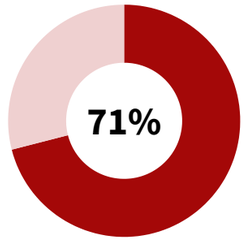
MSF SGBV program observations



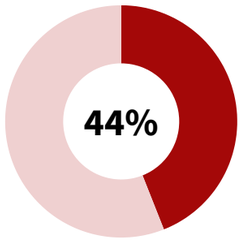
Survivors were female



Survivors were minors



Experienced intimate partner violence



Assaulted more than once

NATURE OF ASSAULT	51% Sexual	41% Physical	4% Emotional

Sexual violence is the most commonly reported form of violence among people younger than 18 years old, whereas physical violence becomes more common in those older than 18

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AID DEPENDENCY: WATER, SANITATION, AND NUTRITION

CHAPTER 4

AID DEPENDENCY: WATER, SANITATION, AND NUTRITION

Governments and humanitarian actors have a responsibility to provide sufficient resources for the 39% of the world's Rohingya who are involuntarily confined in camps in Myanmar and Bangladesh and depend on humanitarian assistance.

"It is not that the humanitarian system is failing. It is no longer fit for [its] purpose. It is perpetuating aid dependency and an inequitable, false economy inside the camps; this in turn results in negative health outcomes for many (especially women, children and the elderly), social dystopia and rampant crime, and political tensions between the Rohingya and host Bangladeshi communities."[78]

Arunn Jegan

MSF Representative to Australia who has worked in the Bangladesh camps at various points between 2017 and 2023

Water and sanitation in Bangladesh and Myanmar

An MSF water and sanitation survey of Rohingya households in the camps in Bangladesh conducted in 2023 showed a substantial drop in several WASH indicators compared to a similar survey conducted in 2018. While there were significant advances in access to improved water quality (from 53% in 2018 to 99% in 2022), more than half (56%) of households reported that water was not continuously available. Maintenance issues and movement restrictions likely contributed to interrupted access to water. More concerning still is the sanitation situation. Only 11% of respondents had access to proper sanitation facilities (with a water point and soap), while over three-quarters of respondents (76%) used toilets that were overflowing (35% in 2018). More than half of households (58%) used latrines with visible faeces (30% in 2018).[79]

Aziz digs in a canal to improve drainage near his shelter. (Cox's Bazar, Bangladesh, Oct 2023) | © Sahat Zia Hero

Results of WASH indicator survey in Bangladesh camps

WATER

- **56%** households reported that water was not continuously available
- **99%** households had access to improved water quality

SANITATION

- Only **11%** of respondents had access to proper sanitation facilities (with a water point and soap)
- **76%** used toilets that were overflowing
- **58%** used latrines with visible faeces

An MSF water and sanitation survey of Rohingya households in the camps in Bangladesh conducted in 2023

Between October 2022 and October 2023, MSF carried out an assessment of WASH facilities in eight camps surrounding two of its hospitals (Hospital on the Hill and Goyalmara Mother and Child Hospital).[80] Results of the evaluation outlined gaps at camp or block level in the quantity of water available for refugees, the maintenance of water and sanitation systems, and the quantity of latrines available.[81] Mitigating the risk of a cholera outbreak in the camps has revolved around cholera vaccination campaigns, the last carried out in October 2021. The immunity derived from an oral cholera vaccination campaign usually lasts between two and five years.

In 2023, Cyclone Mocha demonstrated the increased vulnerability of populations confined to camps in Myanmar, where a greater proportion of shelter as well as WASH infrastructure was damaged or destroyed in the storm. Afterward, humanitarian actors' emergency response activities were hindered by a lack of access and travel authorization, leaving communities to fend for themselves in the critical first days following the disaster.[82] Cases of acute watery diarrhoea are recurrent in these confined settings where overcrowding and seasonal reductions in water supply magnify the transmission risk.

Nutrition in Bangladesh

Ensuring nearly one million Rohingya have enough to eat has been a major challenge for the humanitarian response. Initially set at US$12 per person per month, equivalent to 2100 Kcal, food rations per person per day distributed to Rohingya people suffered two successive decreases in 2023. In July 2023, due to a funding shortfall of $56 million,[83] food rations distributed decreased by 40%, to $8 per person per month, below the minimum standard of 2,100 Kcal per person per day. In 2024, it will cost $12.50 to provide 2,100 Kcal, and in January, the World Food Programme (WFP) announced it would be able to reverse some of the ration cuts with a ration level equivalent to $10 per month.

WFP further noted that, as of November 2023, food consumption was inadequate for 90% of the camp, global acute malnutrition among children under 5 had increased to 15.1%,[84] and the lack of food was contributing to risky choices among refugees. [85]

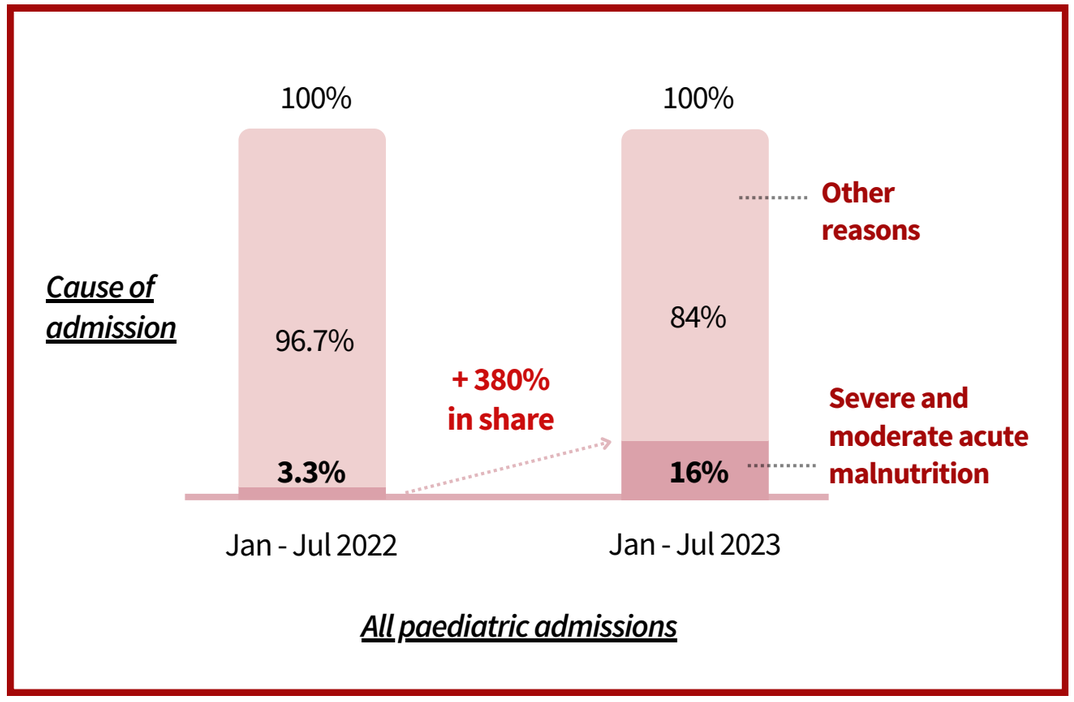
Based on our experience in other camp settings, we know that when food rations are reduced below the minimum standard, there are repercussions on people's health, worsening already-fragile health conditions and increasing vulnerability to other diseases. In children under five, untreated malnutrition increases the risk of infectious diseases and can impact development, with potentially lifelong consequences, such as through stunting and permanent cognitive deficits.

The UNHCR, on behalf of the Bangladesh Nutrition Sector and its partners, conducted two standardized expanded nutrition surveys (SENS) from 2–20 November 2023 to assess the general nutrition and health situation of Rohingya refugees living in registered camps and mega camps in Cox's Bazar. The results indicated a deteriorating acute malnutrition situation of very high public health concern in the mega camps (15.4%) and an unchanged status of medium public health concern in the registered camps (9.6%). The difference in the surveys was attributed to varying coping mechanisms among the established refugee population and the post-2017 influx, infant and young child feeding (IYCF) indicators, and the incidence of diarrhoea at the time of the survey, which was higher in the mega camps.

In both surveys, chronic malnutrition (stunting) remained critical and unchanged (41.2%) compared to 2022, while anaemia improved among refugees compared to 2021 (anaemia was not measured in 2022) although it remained near critical levels among children under five (38.2%) and medium levels among women of reproductive age (24.1%).

In MSF facilities, we are observing that in a population already critically affected by chronic malnutrition, in which 40% of children under five in the camp are stunted, severe acute malnutrition is noticeably increasing among the children presenting in our hospitals. Severe acute malnutrition is known to have a higher risk of death if combined with common childhood illnesses that we often see in the camp, such as diarrhoea and pneumonia. Between January and July 2023, severe and moderate acute malnutrition accounted for more than 16% of all paediatric admissions. This proportion represents a 380% increase compared to the same period in 2022.

Analysis of paediatric admissions during ration cuts



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MENTAL HEALTH: COMPOUNDING TRAUMAS

CHAPTER 5

MENTAL HEALTH: COMPOUNDING TRAUMAS

In the past three years, MSF provided individual counselling to over 28,000 and psychosocial support to over 50,000 Rohingya in our projects in Bangladesh, Myanmar, and Malaysia. These consultations address the impact of forced displacement, appalling living conditions, and transgenerational persecution and abuse that make many Rohingya vulnerable to an array of mental health conditions.

Protracted conflict is proven to affect the mental health of any given population. For the Rohingya, unsafe living conditions and lack of hope for a better future due to containment and marginalization exacerbate mental health suffering and negatively impact treatment outcomes.[86]

Across the three countries, the majority of patients at our clinics report struggling to cope with overwhelming feelings of sadness, hopelessness, fear, and despair, which affects their ability to function in day-to-day life. For the Rohingya, the overwhelming feelings caused by earlier trauma—where they were violently uprooted from their communities, faced discrimination, were violated and tortured, and often saw family members and friends killed or detained—continued through their journey of displacement, despite thinking they would reach a safe haven in exile.

Yet, wherever the Rohingya go, uncertainty, containment, and marginalization await. There is typically no recourse for the Rohingya to find a safe space to heal. This compounding trauma makes it nearly impossible to recover and is passed from generation to generation in negatively reinforcing cycles.[87]

MSF mental health program across Bangladesh, Myanmar & Malaysia

28 K

Rohingya were provided individual counselling

50 K

Rohingya were provided psychosocial support

Majority of the patients reported struggling to cope with overwhelming feelings of sadness, hopelessness, fear, and despair, which affects their ability to function in day-to-day life.

Mental health in Myanmar

Mental health support is a core component of MSF's medical work in Rakhine state. However, decades of containment policies, denial of citizenship, violence and xenophobia mean the available care is insufficient to the needs. For displaced Rohingya in the detention camps, the burdens created by incidents like cyclone Mocha or the recent wave of violence compound the day-to-day challenges "underlined by fear, struggles to afford food and feelings of hopelessness."[88]

"Rohingya will continue to struggle with their mental health while the root causes of their distress remain unresolved."[89]

Forty percent of our patients in 2023 sought our support because of worries about the deterioration of their physical health and disruption in their socioeconomic functioning. Fourteen percent sought our support for severe mental health conditions.

With the current unrest in Myanmar, people with severe mental health conditions are especially vulnerable to relapse due to the rise in conflict, uncertainty, and scant access to their regular medications.

Habiba, a young Rohingya person, points to a picture she drew of an MSF doctor in a clinic. She dreams of becoming a doctor to help her people but finds that there is no opportunity or pathway to do so. (Myanmar, Jun 2023) | © Victor Caringal/MSF

Mental health in Bangladesh

The Rohingya are confined to overcrowded and increasingly violent camps, deprived of their basic needs for privacy, safety, and the ability to work and provide for their families. A densely populated camp full of young people with a paucity of resources and no clear hope for a better future generates conditions that give rise to societal and interpersonal violence.[90] MSF teams in Bangladesh have witnessed this.

In 2023, an MSF psychiatrist returned for a second assignment in the camps following an assignment in 2018. Upon his return, he was startled by the despair that had changed the overall dynamics in the clinic, with many patients exhibiting a listlessness and a loss of mental vitality that was present in 2018 when the camps were being constructed. At that time, people had a sense of purpose, a passion to complain and tell their stories.

Young people playing in the camps. At six years since the exodus from Myanmar, many of the children have grown up only knowing camp life and have limited opportunities. With the forced closure of community-led schools since early 2023, the youngest generation are losing their connection to Myanmar. (Bangladesh, Jun 2023) | © Victor Caringal/MSF

“Compared to when I did similar work in Bangladesh in 2018, I observe less life in the waiting area. The patients and family members are quiet; still, I see no energy, nor irritation with the delay, or the heat, or the lack of lunch. I don’t see much interaction between family members. When they bring children with them, they stay around their parents, between their legs. Eventually the children explore around, but without liveliness and no shouting. When inside the consultation room, children generally lean on the table and look without blinking. Sometimes they risk touching the alcohol gel or a pen. Even the cookies we offer are received with indifference. Only the children make eye contact. It looks like a wake, but there isn’t the intensity of a wake.”[91]

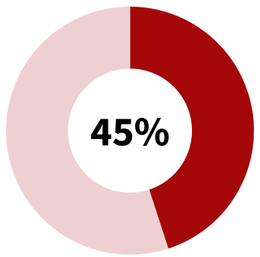
Alberto Hexsel (2023)

MSF psychiatrist who worked in Cox's Bazar from Feb to Mar 2018 and Jun to Sep 2023

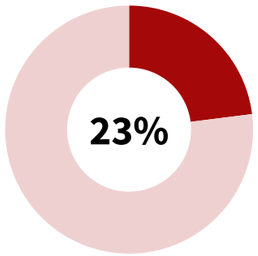
In the camps, 45% of Rohingya seek mental health services after a potentially traumatic event; half of these events are related to domestic violence. Another 11% mention that what triggered their mental health deterioration was disruption in their family and relationships—a disruption that is a direct result of all the atrocities they and their families are enduring, the cycle of despair leading to cycles of violence, and families split across multiple countries who have no hope of ever seeing one another again in person.

About 23% of those who seek care have severe manifestation of mental health symptoms such as chronic psychosis and severe depression. These patients are especially vulnerable to deterioration of existing medical conditions, and more abuse, marginalization and violence. Severe mental health conditions affect a person’s thoughts, their ability to understand the difference between their internal thoughts and external environment, and impacts relationship to their surroundings.

MSF mental health program observations



Rohingya in the camps seek mental health services after a potentially traumatic event



Patients have severe manifestation of mental health symptoms such as chronic psychosis and severe depression

TRIGGERS:

50%

Of the events relate to domestic violence

11%

Trigerred by disruption in their family and relationships

They often feel distressed and misunderstood, which can affect how they relate and communicate with others, creating conditions in which people can become more violent or violated. In an overcrowded camp, it is difficult to have a relative with a mental health condition that may affect their movement and behaviour. People come to our clinics begging for medications to make a family member sleep and calm down so they can go on with their lives. Patients are sentenced to diagnosis.[92] From a very young age, they need to be sedated forever. In another context and with resources, they would receive treatment and be productive and valued members of their community. They can access medications and individual support from our teams, but **without social support, a sense of meaning and purpose, and freedom of choice and movement, their recovery journey will probably never be complete.**

Mental health in Malaysia

MSF works mainly with undocumented Rohingya people in Malaysia. In 2023, we provided 1,402 individual counselling sessions and 951 group sessions. Of individuals attending these sessions, 55% sought our support for anxiety and distress symptoms that mainly resulted from an unstable financial situation and the constant fear of being arrested while working due to their irregular legal status. Men usually reported financial instability and irregular work opportunities. Pregnant women reported becoming more anxious as they approach their due dates while their husbands have no means to support them.

Overall, more than half the people who seek mental health support in MSF clinics in Malaysia show signs of anxiety such as excessive worrying, fear, sleeping problems and nervousness. Medical illness and socioeconomic functioning are among the most important precipitating factors to seek counselling, with each contributing by approximately 20%. Among the reasons for counselling were non-communicable diseases (NCDs) (22%), pregnancy (10%), infectious diseases (7%) and the financial stresses of managing ongoing costs of insulin, or in managing a medical emergency. Most people who have a medical illness present with anxiety, followed by physical symptoms; 17% have mood disorders and 6% have problems with social functioning.

The proportion of people seeking counselling for socioeconomic reasons has grown since 2018, from 9% to nearly 30% in 2023. Poverty and unemployment are the main precipitating factors further resulting in mental health symptoms such as anxiety (60%), mood-related problems including sadness, lack of future prospects, feeling worthless, suicidal thoughts (15%), and problems with social functioning such as feeling overwhelmed (20%).

MSF mental health program (2023)

1,402
Individual counselling sessions

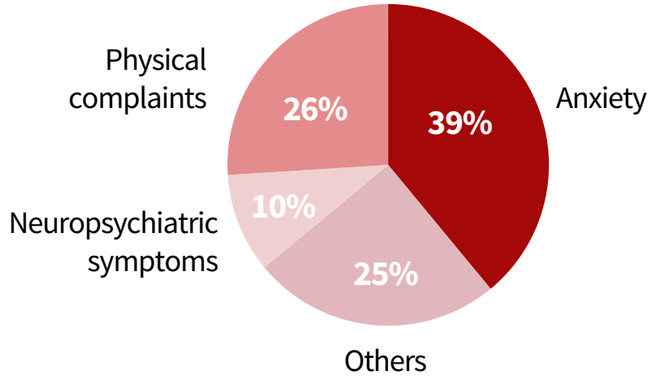
951
Group sessions

- MSF works mainly with ***undocumented*** Rohingya people in Malaysia
- *55% sought help for anxiety and distress due to financial instability and fear of arrest*

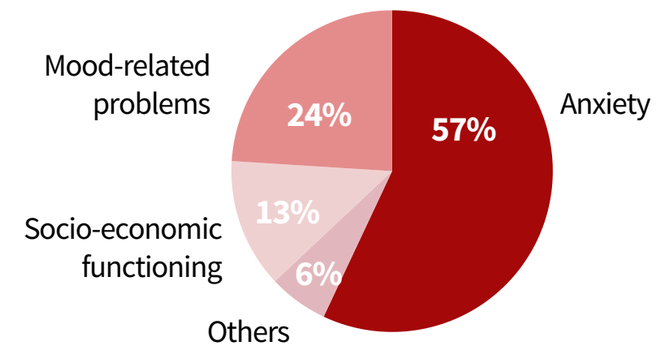
Out of 85 Rohingya refugees (54 female, 31 male) who reported being detained at some point as adults, 57% of females report that anxiety remains the main presenting factor (57%), followed by mood-related problems (24%) and socio-economic functioning (13%). Among males, the main presenting complaint is anxiety (39%) followed by physical complaints (26%) and neuropsychiatric symptoms (10%). Nearly three-quarters (74%) of females relate their symptoms to prolonged detention (more than three months) in contrast to 26% of males.

Mental health factors in Rohingya refugees who were detained as adults

MALE



FEMALE



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ACCESS TO HEALTHCARE

CHAPTER 6

ACCESS TO HEALTHCARE

The Rohingya face major challenges in accessing affordable and safe healthcare in Bangladesh, Myanmar, and Malaysia. Translation issues, racism, and fear of detention drive Rohingya to delay care or seek higher-cost care from untrained medical providers.

Access to healthcare in Myanmar

"The intensification of conflict in Myanmar since October 2023 has led to a lack of humanitarian access to areas where people need urgent assistance, as well as a decimation of the health care system and increasing fears of military conscription or forced recruitment by other armed groups." [93]

Prior to October 2023, MSF supported access to healthcare for Rohingya in central Rakhine, where we witnessed the tedious and cumbersome bureaucratic process that Rohingya patients are required to navigate to access hospitals. This includes obtaining permission to travel, covering travel costs by boat and road, passing through checkpoints, and navigating layers of extortion and exploitation by state and non-state actors.

Patients at MSF clinic in a refugee camp on the outskirts of Pauk Taw township (Myanmar, Feb 2013) | © Kaung Htet/MSF

Until recently, those who did manage to reach Sittwe General Hospital were treated at a segregated ward for Rohingya people, where patients reportedly experienced humiliating treatment, extortion by guards, verbal abuse, or even physical violence. In one particularly painful example, patients told MSF that they could not receive blood transfusions because donors had refused to allow their blood to be given to Rohingya patients.

Denial of freedom of movement is the main barrier for Rohingya people in the camps. All emergency patients supported by MSF must obtain recommendation letters from camp or village administrators based on an MSF referral to Sittwe General Hospital. In the case of people travelling without MSF referral assistance, travel costs and bribes at checkpoints are additional burdens for seeking higher-cost medical care in private clinics in Sittwe. A long-standing military naval checkpoint between the Pauktaw camps and Sittwe General Hospital has caused delays due to which MSF has witnessed numerous adverse health outcomes.[95]

"Since November 13, 2023, we have seen an escalation of conflict in Rakhine state and the townships of Maungdaw, Buthidaung, and Rathedaung have been cut off from the rest of the state. People were locked out and blocked in. Communities were not able to move across the state, and supplies could not [pass]. I don't just mean health care supplies, but basic life-supporting supplies like food, fuel, and water. These kinds of things have been restricted, which led to whatever supplies were available becoming inflated in price. There were some fearful days, and we had to move the team to the safe room almost three or four times one day."[94]

Nimrat Kaur

MSF Project Coordinator Maungdaw

“The checkpoint [on the way to Buthidaung downtown] is not allowed to cross at night. They tell you to wait till the next morning … In May, a pregnant woman in an emergency tried to go to Buthidaung Hospital. First, the MAF checkpoint stopped her. The patient’s family tried to give some bribes to them, but they didn't agree. The family couldn't afford that money …Then they tried the waterway, and the Arakan Army also stopped them this time. So, they called a ‘quack’[96] to their home, and luckily, she gave birth at dawn.”[97]

64-year-old Rohingya man living outside Buthidaung

Interviewed Aug 2023

In northern Rakhine, Rohingya are contained in village settings, and they can travel to schools and markets within their villages or townships. However, it is still costly and potentially dangerous for Rohingya to seek medical treatment: there is a curfew at night and if someone lives in a rural remote village far from downtown, they must pass checkpoints where they may face intimidation, demands for paperwork and/or bribes, even in an emergency.

In Myanmar, access to specialised healthcare or tertiary care was always extraordinarily difficult for Rohingya. This impacts the quality of healthcare that MSF can provide to its own staff. In Rakhine, during more peaceful times, MSF was able to refer non-Rohingya employees to Yangon for specialised care but could not do the same for Rohingya staff due to travel restrictions imposed by the military government.

Access to healthcare in Bangladesh

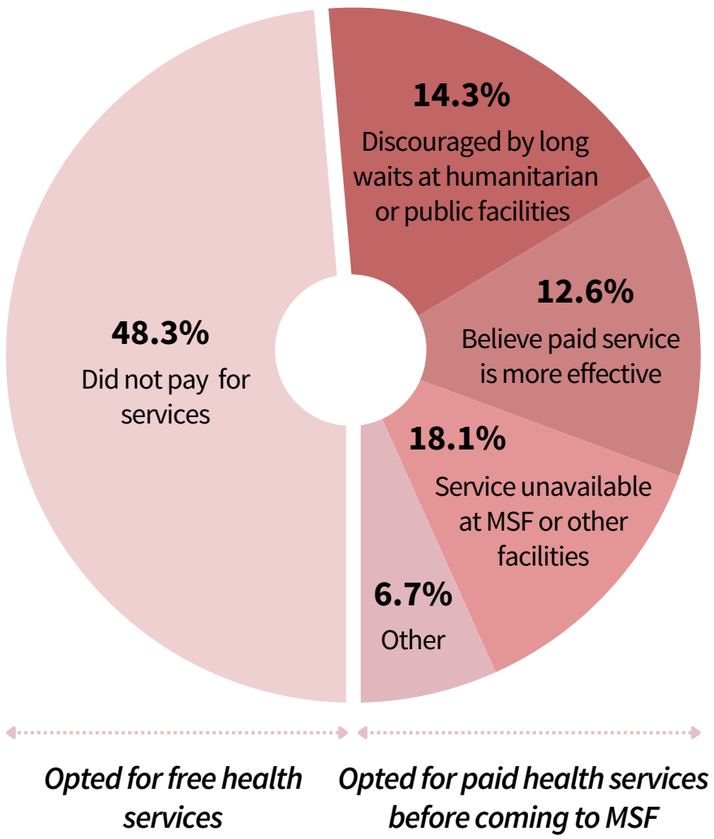
Despite the existence of free medical humanitarian services in the refugee camps, around half of the patients interviewed in MSF's community-based monitoring analysis reported paying for health services before coming to MSF.[98] People said that they paid for services primarily because treatment in humanitarian or public health facilities nearby was unavailable (18%); to avoid long waiting hours in humanitarian or public facilities (14%); or because they believed they would receive better service in private facilities (13%). Approximately half visited a "quack doctor" or a "pharmacist"[99] before coming to an MSF facility, typically at a high cost and with dubious medical qualification.[100]

In community-based monitoring, 33% of people interviewed told MSF they were selling food rations to manage the costs of healthcare. Refugees interviewed in MSF facilities (13%) and in the community (17%) said they borrowed money to manage healthcare costs and nearly 7% of people in the community-based monitoring had to beg to pay for healthcare. Only 15% of patients in the facility-based monitoring and 17% in the community said they used their income to manage the costs.[101]

Nearly 90% of patients (1,315) interviewed in MSF facilities, and 73% of people (152) interviewed in the camps faced barriers to access health services, such as being held at checkpoints by the police, distance and lack of public transportation in the camps, and poorly functioning local primary care close to home.[102] [103]

As a result of these barriers, many patients in MSF facilities delay seeking medical care. **Mortality data analysis conducted at MSF's Kutupalong hospital from January to October 2022 showed that 45% of the deaths were related to delayed decision to seek treatment because they did not arrive at the health facility in time for medical assistance to make a difference.**[104]

Accessing paid vs. free healthcare services



Findings from facility-based monitoring by MSF in 2022

Barriers in accessing healthcare

Long walking distance

Held at checkpoint

Lack of public transportation

Poorly functioning local primary care close to home

- Nearly *90%* of patients interviewed in MSF facilities faced barriers to access health services
- *As a result of these barriers, many patients in MSF facilities delay seeking medical care causing death in several cases*

Findings from facility-based monitoring by MSF in 2022

Outpatient care in Bangladesh

While primary healthcare (PHC) is organised through a network of PHC facilities located in each camp, the increase in patients' attendance at MSF PHC facilities and the increasing number of patients coming from distant camps raise significant concerns about growing medical needs and the reality of access to PHC for Rohingya people.

The number of patients arriving at the outpatient department of the Hospital on the Hill—built by MSF in the middle of the camps in 2017—increased by 50% during 2022. This coincided with several health centres closing in the area in 2023 due to a lack of funding and a rampant scabies epidemic. In this hospital, as well as in our Goyalmara Mother and Child Hospital, we saw an unusually high rise in paediatric admissions from January to June 2023 compared with the same period in the previous year. In July 2023, our paediatric hospital admissions were at capacity even though the annual peak season of medical needs was only just starting. Worse yet, during the access analysis of 2022, which was done prior to the round of rationalization cuts, only 71% of people reported that health facilities nearby their households were accessible.[105]

In the third quarter of 2022, the MSF general outpatient department (OPD) located in camp 8W (named OPD3) experienced a 40% increase in the number of general medical consultations.

Mohammad carries his sick grandson back from the health centre (Cox's Bazar, Bangladesh, Oct 2023) | © Sahat Zia Hero

This increase was due to two main factors: a significant increase in the number of patients seeking scabies treatment and the closing of several nearby PHC facilities. Near OPD3, four health posts located in surrounding camps closed during 2022. Starting from the third quarter of 2022, the number of patients seeking a consultation remained stable before experiencing another increase until August 2023, when the number of general OPD consultations increased by 15%, reaching nearly 10,000 consultations that month.[106] **In July 2023, more than 60% of people coming for general OPD came from a camp outside of camp 8W where OPD3 is located.**

The paediatrics OPD, part of Goyalmara Mother and Child Hospital, experienced the same trend in 2023. **As of August 2023, the number of paediatric consultations in Goyalmara OPD was already 54% higher than the same period in 2022.** Located outside of camp 16, Goyalmara paediatrics OPD receives children living in both the Rohingya camps and the host community. Between April and August 2023, the OPD facility experienced an increase in the number of patients coming from more distant locations to seek healthcare. **In August 2023, despite the existence of PHC facilities in other camps, more than 50% of Rohingya children coming for a consultation in Goyalmara paediatrics OPD came from over 3 kilometres away.**

A rapid assessment conducted by MSF in August of 2023[107] indicated that the underfunded humanitarian response used a rationalization of services process to reduce expenses. However, that process was based on a facility-based monitoring, which can misrepresent or misinterpret the level of needs because only those who utilise services are counted. Individuals who have given up on the system, or fear leaving their homes are not counted.

Misrepresentation arises from primary healthcare planning based on the number of patients per disease, neglecting the fact that many people don't seek healthcare due to social, cultural, security risks, and transportation gaps, leading to an underestimation of needs. Misinterpretation occurs because it assumes the availability of services, while their capacities may be insufficient, inadequate, and unreliable.[108] This means that the number of patients doesn't accurately reflect the need, but rather the service's capacity, as many are turned away or unable to access care.

There is no systematic counting of those who seek treatment but are turned away or who end up paying for healthcare from unqualified medical providers that should be free. The humanitarian response lacks comprehensive planning, considering distribution of services per-population numbers without accounting for borders, checkpoints, camp divisions, and safe passage to care.

Inpatient care in Bangladesh

MSF hospitals represent one of the few options for Rohingya and members of the host community living in and around the camps in need of specialised paediatrics and neonatology. Throughout 2023, MSF secondary healthcare facilities, Hospital on the Hill and Goyalmara Mother and Child Hospital, experienced an increase in the number of paediatric patients. In August of 2023, the number of paediatric patients admitted in these facilities was 35% higher than the same period in 2022.[109] Neonatology IPD departments in Goyalmara Mother and Child Hospital also experienced a very high level of activity with an average bed occupancy rate of around 90% in 2023.

These paediatric and neonatology IPD facilities operated at full capacity for most of 2023. Apart from their own internal capacities, MSF facilities are left with very few options to care for patients with severe medical conditions. When reaching maximal bed occupancy, field hospitals are supposed to refer patients to general Ministry of Health facilities. However, general secondary facilities have been significantly impacted by a sudden interruption of funding in 2023 by the World Bank, leading to a decrease in their capacity to support severe patients, which has not been mitigated by alternative solutions since.

Halima is a local resident from Goyalmara, Cox's Bazar. She is pictured while admitted to MSF's Goyalmara Mother & Child hospital after the birth of her baby boy. (Bangladesh, Apr 2024) | © Farah Tanjee/MSF

In 2023, to respond to the increase in the number of children admitted in its facilities, MSF reviewed its bed capacity for the peak season. Paediatrics and neonatology bed capacity was temporarily scaled up in Goyalmara hospital (an additional 29 beds) and in the Hospital on the Hill (an additional 8 beds). Additionally, in July 2023, MSF alerted members of the health sector about the increase in the number of paediatric patients and the need to scale up the hospital bed capacity overall.

The temporary measures MSF has put in place will not solve the chronic gap in available specialised hospital beds. MSF will not have the capacity to further scale up bed capacity. In the absence of a strong and coordinated response by donors and health actors, Rohingya will be left with inadequate access to hospital services. In a context of funding decreases and worsening living conditions for Rohingya, the necessity to ensure sufficient access to specialised secondary healthcare is made even more critical by the risks of a further deterioration of the health situation in the camps.

Access to safe and effective healthcare may also have contributed to the extraordinarily high prevalence of HCV within the Rohingya refugees in Bangladesh. A recent study indicates a prevalence of one in five within the camps. [110]

MSF provides treatment for patients with HCV infection at the Hospital on the Hill facility. As of October 2023, MSF was the only provider of HCV treatment for the whole camp population. Since 2020, more than 4000 patients were enrolled for HCV treatment in designated MSF health facilities.

However, due to the sheer lack of access to treatment, MSF had to limit enrolment of new patients to focus on patients the most at risk, according to medical criteria. Consequently, access to HCV treatment for Rohingya people living in the camps is insufficient. In October 2023, the health sector announced the opening of two additional HCV treatment centres for the end of 2023, with a total capacity to treat 1,000 patients with HCV infection.[111] While the opening of additional treatment centres is a welcomed reinforcement in the current treatment capacity, it will be insufficient to reinforce access to a level adequate to the size of the population living in the camps.

Non-communicable diseases in Bangladesh

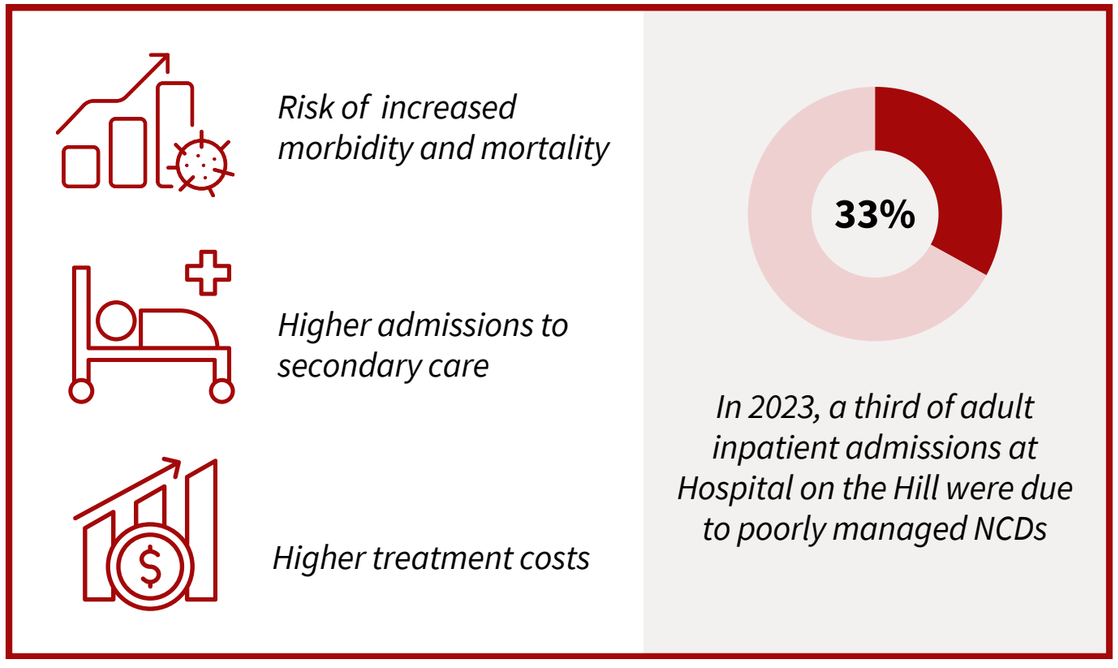
As per guidance of the Health Sector, treatment for NCDs (e.g. diabetes, hypertension, etc.) should be included by PHC facilities in the minimum package of healthcare provided. An analysis of the situation in two OPDs located in camp 13 and camp 8W where MSF provides NCD treatment reveals that, from 2020 on, MSF has faced an increase in the number of patients coming for NCD treatment, outlining the insufficient availability of such treatment in other PHCs.

The number of patients with NCDs followed up by MSF in these camps reached more than 3,000 patients in 2021 with around 1,300 newly enrolled patients. Confronted with this increase, in the end of 2021, MSF took the decision to focus on patients coming from its direct catchment area while calling for accountability of other health actors. As of August 2023, these two NCD OPDs conducted more than 16,000 consultations for patients with NCDs.

MSF reiterates its concern about the sheer lack of availability of NCD treatment as part of the PHC minimum care package. Discussions by MSF with other health actors outline several barriers in the inclusion of NCD treatment, including lack of medication and lack of a proper cohort follow-up.

Confronted with insufficient treatment, people suffering from NCDs are left with few options and are at risk of suffering from increased morbidity and mortality, are more prone to needing admittance to secondary care, and are more expensive to treat than if properly managed. In 2023, a third of patients admitted in Hospital on the Hill's adult inpatient care were admitted because NCDs were not properly managed at the primary healthcare level.

Consequences of insufficient treatment for NCDs



Financial challenges in Bangladesh

If the Rohingya in Bangladesh continue to be contained in camps and trapped in a cycle of dependency on humanitarian aid, it is imperative that international donors significantly scale up their financial contributions to provide adequate support and prevent further irreversible consequences on the physical and mental health of the Rohingya.

Accessing healthcare services comes with financial challenges that expose gaps in the system, which encompass indirect costs for basic services, direct costs for expensive specialised services, and opportunity costs. Financial costs borne by the patients can serve as proxy indicators to the quality and real availability of services.

Indirect costs consist of various types such as informal checkpoint bribes, chair-based transportation costs, and informal gratuities requested at the Cox hospital. These all typically cost between US$1 to $5, a huge cost when 45% of all Rohingya in the Bangladesh camps subsist on rations worth only $10 per month and 74% took on debt after arriving in Bangladesh because the assistance provided was not enough to cover basic living expenses.[112]

Direct costs can be due to issues with distrust of the health system, drug stock outs in health posts and primary health care centres, and access challenges as patients are not able to leave the camps to seek quality care so are compelled to seek care from unqualified medical providers offering injectables, with fees ranging from 500 taka to 1,000 Taka (about US$4 to $8).[113]

Financial distress is particularly evident in people who have conditions such as polycythaemia, kidney stones, appendicitis, uterine tumours, tuberculosis, and hepatitis C (treatment or testing), which can cost as much as 80,000 Taka (US$727). To afford these costs, people borrow money, sell their food rations, or even sell medications.

Costs involved in accessing healthcare

Indirect costs

$1 - $5

- *Informal checkpoint bribes*
- *Chair-based transportation costs*
- *Informal gratuities requested at the Cox hospital*

Direct costs

$4 - $8

- *Lack of trust in public health system leading to opting for paid services*
- *Medication shortages in PHCs*
- *Access challenges compelling them to seek unqualified medical providers within their camp*
- *Cost can go upto $727 for specific conditions like TB, hepatitis C, etc*

These costs are huge when 45% of all Rohingya in the Bangladesh camps subsist on a monthly ration valued at **only *$10*** and 74% took on debt after arriving in Bangladesh to cover basic living expenses.*

**Survey conducted by Centre for Peace and Justice (CPJ), BRAC University in 2020*

"Beyond Relief: Securing Livelihoods and Agency for Rohingya Refugees in Bangladesh". The Asia Foundation (blog).

Access to healthcare in Malaysia

Access to healthcare is very limited for non-citizens including Malaysia's stateless populations, refugees and asylum seekers, and irregular migrants. People with these statuses are classified as non-citizens and without proper documentations are either denied care (except for lifesaving care) or face "foreigners fees", which are 100 times the price for locals. Refugees holding UNHCR documents are offered a 50% discount off foreigner rates in public health facilities. However, UNHCR is far behind in registering people and in the absence of a legal right to employment, these fees remain unaffordable, especially for secondary and tertiary care.

The Ministry of Health Circular 10/2001 policy obliges government healthcare staff to report undocumented persons to the authorities at the point of seeking healthcare. On the basis of this Circular, refugee and asylum seeker patients without UNHCR documents are often threatened to be reported to the authorities, to expedite payments of unaffordable deposits for treatment, or to be turned away until they can present with UNHCR documents.

In Malaysia, a majority of Malaysian women have satisfactory access to antenatal care (ANC) with 98.1% reporting a minimum of four ANC visits in 2022. This is in stark contrast to refugees and asylum seekers who face obstacles accessing ANC in government and private healthcare clinics and hospitals.

Patients fear repercussions linked to their documentation status, language barriers, and inability to afford ANC services. Eleven percent of women seeking ANC services in the MSF clinic between June 2022 and August 2023 were from states outside our area of coverage, indicating challenges in accessing ANC in their home state. Without removing the barriers to accessing ANC in public health facilities, many pregnant patients risk not being able to access follow up care, and complications in pregnancy may go undetected, leading to increased risk of miscarriage, preterm birth, and maternal and neonatal mortality.

Healthcare in the detention system should be provided by medical assistants (equivalent to a paramedic). No specific budget is allocated for healthcare in detention facilities and thus availability depends on the good will of individual commanders. Conditions in detention centres may in fact be worse than those in the criminal prison system, where minimum standards are in place.

CONCLUSIONS

The situation for the Rohingya is dire and deteriorating. There is no credible political dialogue currently underway that appears to have any hope of reversing this trend. Most political and public discourse over the past years on the Rohingya crisis centred stubbornly around the logistics of returning Rohingya refugees to Myanmar despite ample evidence Rakhine state is unsafe for them.

Worsening the current global situation are policies and public discourse in countries in which Rohingya currently live that seek to drive them out. For 99% of the global Rohingya population, the reality is one of containment, extortion, violence, and marginalization.

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Where theoretical protections should be offered in Bangladesh and Myanmar, we see extreme containment policies that keep 57% of all Rohingya in the world today restricted to fenced camps, to isolated villages in Myanmar, or newly displaced by armed conflict in 2024. The reality in 2024 is that more than half the Rohingya in the world live in a situation of extreme precariousness where even the most basic needs of food and water are not adequately met.

A striking example of the trend of ignoring the Rohingya's present circumstances and seeking solutions in Myanmar is the Organisation for Islamic Cooperation's (OIC) support for the International Court of Justice (ICJ) Case Gambia v. Myanmar, which has garnered many headlines about OIC support for Rohingya.[114] The OIC's statement on August 25th, 2022 expresses this contradiction fully: "Five years later, Rohingyas in Rakhine State still lack freedom of movement and other basic rights such as access to adequate food, healthcare and education. This anniversary is a reminder that the crimes committed against Rohingya call for accountability."[115] Yet over 75% of all Rohingya alive today in the world live or have sought refuge in OIC member states. In every one of these states, policies reinforce their statelessness and precariousness, and offer few or no solutions to secure their basic rights where they live now.

"Denial of citizenship and identity means denial of health and basic rights. If you don't exist by law, you have nothing. This means Rohingya lose opportunities for education to make better informed life decisions. For example, in healthcare, Rohingya women struggle for education and rights, which means they struggle to have any control over their reproductive rights or make informed decisions on safe delivery or contraception. Denial of political rights creates cascading chains of misery. It leads to a lack of education, opportunity, poverty, and reduces peoples' ability to make informed life decisions. This leads families into bad healthcare choices like understanding when it is safe or unsafe to have another child and in what circumstances."

Dr. Anita Schug

Rohingya Medics Organisation

“The survival of the Rohingya nation in these conditions would be miraculous.”[117]

Michaël Neuman

Director of Studies MSF CRASH

With only 23% of the global Rohingya population still in Myanmar, many Rohingya who have been living outside Myanmar do not want to go back. According to UNHCR, “Some 76% of Rohingya refugees who arrived in their country of asylum in the last 5 years intend to return, compared to 28% of those who have spent more than 20 years in exile.”[116] This indicates **multigenerational statelessness significantly reduces interest in return to Myanmar, a country many Rohingya have never been.** It also indicates a threat to loss of culture and community as Rohingya communities isolated from each other drift apart. **This means Saudi Arabia, Bangladesh, Malaysia, and Pakistan have the power to fundamentally change the course of history for the majority of Rohingya who are born on their lands by offering protections and incentives to maintain their culture rather than assimilating locally. These states must not pretend that the only solution to Rohingya displacement lies solely in repatriation to Myanmar.** Without support, even voluntary returns will be increasingly difficult, as generations have grown up focused on surviving where they are present.

Without any viable solutions and faced with raising a generation of children in apartheid conditions nearly everywhere in the world they live, the Rohingya will continue to attempt to find any possible escape from this dead-end trap. Continued containment will drive increasingly desperate decisions to send adolescent daughters to marry strangers in another country. Containment without hope will continue to drive high mortality in the Andaman Sea and drive young Rohingya men to join criminal groups or accept the risk of being a mule for drug syndicates.

As this trend continues, the negative impact on the health and vitality of the Rohingya will increase. Rohingya people will continue to suffer from direct and indirect forms of violence, caught in the conflict in Myanmar, or beaten by authorities for trying to move from one place to another while trying to scratch out a living in the shadows of society. Undernourished mothers will continue to give birth to low birthweight infants without access to professional healthcare, with a high risk of catching hepatitis C. Many of those children will experience stunted growth, which could impact their future cognitive abilities and potential.

Technology will advance, and biometric registration will expand. Rohingya who registered their biometrics with UNHCR to obtain minimal protections will grow up to find that data locks them out of any possible informal solution in the continued absence of political solutions. This means fewer Rohingya will escape the noose of poverty and containment and advance their education or livelihood opportunities.

Containment and exclusion policies will lead to increasing numbers of Rohingya living in desperate poverty. This will trap almost an entire people in a perpetual underclass, contained in ghettos and fenced camps, and seeking solutions to their desperation in the shadows and margins of society.

When a global lens is applied, the situation for the Rohingya is so completely unacceptable that states that are hosting Rohingya, including Bangladesh and Malaysia, must take a critical look at their policies that cement statelessness through containment and exclusion. Meanwhile, states that host a negligeable proportion of Rohingya refugees, in particular high-income states of the Global North that actively contribute to global containment policies in regions of origin, must urgently question how their policies of global containment are reinforcing continued exclusion and suffering, especially in the context of dwindling international funding for humanitarian responses in places such as Bangladesh.[118] States must ask themselves, in the absence of a political breakthrough and peaceful return of millions of Rohingya to Rakhine, how would they want the next generation of Rohingya people to grow up in their society? As productive tax-paying members? Or as people begging in the shadows?

The tenacity of the Rohingya in surviving the past 40 years is remarkable, but they need help to recover from generations of displacement, persecution, and trauma. States must recognize the time has come take a fresh look at how the policies of the past 40 years are a failure and that the current situation—which unquestionably originated in Myanmar—is their responsibility as well.

ANNEX: THE GLOBAL SITUATION

ANNEX: THE GLOBAL SITUATION

In early 2023, in order to contextualize the deteriorating situation for Rohingya in Myanmar, Bangladesh and Malaysia, MSF sought a global overview of where the Rohingya live and in what conditions. An initial scan and analysis indicated there were only two other major population centres, Saudi Arabia and Pakistan, and little was known by MSF about the situation of Rohingya people in those countries.

Methodology

The author conducted a comprehensive review of public and private sources.[119] The author held 70 discussions with over 40 individuals, of which 25 discussions were with Rohingya community members around the world.[120] According to the report author's analysis, the most credible conservative global population total is 2.8 million (range between 2.6 and 3.2 million). Population percentages in this report were generated based on the 2.8 million total to provide perspective on the overall impact of individual state policies on the Rohingya people as a whole.

Low and high population estimates were drawn from the literature and interviews. Estimated Rohingya population is analysis by the author based on all sources on the most credible, conservative population total. Ultimately, it is a judgement based on best available evidence to be used as an analytical tool to help policy makers reframe their perspectives rather than a demographic analysis.

Summary

Overwhelmingly 98% of all Rohingya in the world live in Bangladesh (1.2 million), Myanmar (636,000), Pakistan (400,000), Saudi Arabia (340,000), Malaysia (210,000), and India (30,000).

The initial scan indicated the situation was poor nearly everywhere for Rohingya, and it was probable that nearly every Rohingya in the world lived in situations where they were contained by harmful policies and denied fundamental rights. Alarmingly, this initial scan indicated that up to 99% of all Rohingya in the world suffered the harmful consequences of statelessness.

An effort was made through external discussions and desk research to find a comprehensive global overview of the Rohingya and their situation. No such overview was found. In combination with a review of all public and private information available to MSF, and over the course of this research, the author found the situation globally far more dire than expected.

In addition to the information provided in the report above on the countries in which MSF does work with Rohingya communities, the following information concerns countries in which MSF had no direct knowledge and little understanding prior to this research.

ESTIMATED ROHINGYA POPULATION BY COUNTRY

Country	Population Range Low	Population Range High	Estimated Rohingya Population	Rohingya living and hiding in the margins	Rohingya contained in fenced camps with humanitarian programs	% living in fenced camps	% contained by policies that reinforce statelessness
Bangladesh	1,100,000	1,200,000	1,165,467	200,000	965,467	83%	100%
Myanmar	600,000	700,000	636,000	493,000	143,000	23%	100%
Pakistan	400,000	500,000	400,000	400,000	0	0%	100%
Saudi Arabia	300,000	400,000	340,000	339,000	0	0%	99%
Malaysia	200,000	250,000	210,000	210,000	0	0%	100%
India	20,000	40,000	30,000	30,000	0	0%	100%
Other populations resettled or with asylum in USA, Canada, Europe, Australia	25,000	40,000	30,000	Unknown	0	0%	Unknown
Other Underreported Populations (China, Turkey, Nepal, UAE, Sudan, Sri Lanka)	10,000	25,000	10,000	Unknown	0	0%	Unknown
Thailand & Indonesia	3000	5000	4000	3300	0	0%	83%
Total	**2,658,000**	**3,160,000**	**2,825,467**	**1,675,300**	**1,108,467**	**39%**	**99%**

Pakistan

At least 400,000[121] Rohingya live in Karachi, Pakistan, hidden within the larger Bengali community of 3.5 million who also struggle with entrenched statelessness due to exclusionary policies that deny many their rightful legal identity as a Pakistani citizen.[122] Possibly, only 35% of Rohingya are able to obtain a computerized national ID card (CINC)[123] with the digitization of documentation and biometrics within the NADRA managed system. The remaining 65% of the population either struggles to gain the necessary information or do not try to obtain it because of lack of education, apathy by officials, or discrimination.[124] 20% of Rohingya are reported to have no form of ID at all.[125] Further reporting indicates active bias by authorities in denying legal identification to Rohingya.[126] Rohingya live and work within mixed ethnicity environments with other marginalized communities. Those able to obtain economic means, education, and identity can live normal lives. But, as Rohingya must hide their identity and attempt to blend into the larger Bengali community to have a chance at obtaining an ID card, this cannot be considered a fully free existence.

UNHCR reports fewer than 100 Rohingya in Pakistan.[127] This is because there is no benefit for the Rohingya to register. They are safer hiding within the persecuted Bengali community, despite the challenges that present in the Karachi slums, than they are seeking protection from UNHCR. Yet, ignoring their existence completely also deprives people in need of potential humanitarian assistance.

At present, MSF runs a program in Machar Colony in Karachi, providing Hepatitis C treatment. Based on these findings MSF will seek to understand how to assist the Rohingya community in a more targeted way in 2024.

Saudi Arabia

At least 340,000 Rohingya live in Saudi Arabia today.[128] Over 40%[129] of these were likely born in Saudi Arabia, and local community leaders say a majority would refuse to return to Myanmar under any circumstances. The Rohingya are one of the multi-generational migrant (MGM) communities also known as Mawalid al-Saudia (Saudi-born). Multigenerational migrant communities are generally more favoured than other migrants. Those with proper paperwork benefit from many exemptions to labour laws, are not considered foreign workers, and are exempted from deportation. While a few early Rohingya arrivals in the 1950s were able to obtain citizenship (a few thousand at most), most must still be sponsored by a Saudi citizen within the kafala system that regulates migrants. Having a valid passport is central to that process.[130] With the exact number of Rohingya with Saudi passports reported to be so low, the author estimates 99% of Rohingya living in Saudi Arabia face marginalization or containment due to statelessness, though due to the lack of information this estimate is quite arbitrary and could be slightly higher.

Over 90% live in Mecca, where recent modernization construction has displaced many from their traditional neighbourhoods in the hills surrounding the city, forcing families that once lived in a home they owned close to employment to move far from the city centre into poorer accommodation shared with four to five other families.[131] One individual commented that there are now more beggars visible in Mecca and Jeddah and many are internally displaced Rohingya unable to cope with the loss of their home.[132]

The majority are poor or lower-middle class, though some have also firmly established themselves in the middle to upper classes. The Rohingya native to Saudi Arabia have also worked their way up from the most menial jobs and are now frequently regarded as more skilled labour who work within a tight-knit community. The recent destruction of thousands of homes and displacement of families may impact these gains in the coming years along with the inability for native Rohingya, or those with Bangladesh or Pakistan passports, to obtain passports for their children. [133]

The trajectory for Rohingya in Saudi Arabia appears threatened. The ad-hoc nature of fixes applied over the years to address Rohingya statelessness without Saudi Arabia providing citizenship leaves the Rohingya trying to navigate a complex maze of permissions and fees depending on their paperwork status. Tightened controls on passports by Bangladesh and Pakistan mean the population in Saudi Arabia will be more isolated from the broader community.

Saudi Arabia has the power to grant citizenship, particularly to those born in Saudi Arabia. Excluding Rohingya from this option is a policy choice that further entrenches statelessness. The Rohingya, despite some benefits and considerations by the government, are still marginalized by current policy and practice in Saudi Arabia, leaving many Rohingya worried about the future upward mobility of their children. Recent efforts by Saudi Arabia to pressure Bangladesh to renew passports is welcome but are just another example of a temporary fix to a multi-generational problem as this does not provide passports for family members, in particular children.[134]

India

The situation for Rohingya in India is of particular concern. Population estimates range from 21,000 to 40,000, mainly in Jammu, Hyderabad, and the outskirts of New Dehli. Approximately 20,000 Rohingya are registered with UNHCR.[135] Human Rights Watch estimates the population to be 40,000, which is often cited.[136] India is not party to the 1951 Refugee Convention and does not have a national refugee protection framework. Rohingya are not only denied legal status in India, but they are facing risk of detention and deportation because they are treated as illegal immigrants. Refoulement of Rohingya refugees back into Myanmar, where they could face further persecution, has been well documented.[137] Furthermore, Rohingya specifically are framed by the government authorities as a threat to national security.

The situation has deteriorated in India for Rohingya since 2017. Even those registered with UNHCR are not entitled to an Aadhaar card, which is a biometric form of ID necessary to access essential services. Rohingya in India are typically able to access basic health care informally, but struggle to access and afford specialised care.[138] Rohingya also face extreme xenophobic rhetoric.[139] [140] An ongoing petition with the Indian Supreme Court seeks to secure the release of illegally detained Rohingya, believed to be approximately 600 people at the time of publication.[141] Furthermore there is a trend towards leaving India for Bangladesh due to the uncertainty of the situation there.[142]

Other populations resettled or with asylum (USA, Canada, Europe, Australia)

There is no comprehensive analysis of Rohingya resettled from Myanmar and Bangladesh to countries with strong humanitarian funding and program support. Most Rohingya in these countries arrived through asylum and resettlement programs or endured Australia's draconian offshoring system, which detains asylum seekers for years. The total is somewhere between 25,000 and 40,000 people. The United States has resettled more Rohingya through UNHCR than any other country. As of October 2023, just over 12,000 Rohingya had been resettled.[143] The total number or Rohingya living in the United States, either born there or who arrive through asylum claims or by family reunification, would increase the total to 20,000 or more.[144] Only approximately 5,000 Rohingya live in Europe,[145] [146] about 1,000 live in Canada,[147] and over 3,000 live in Australia.[148] [149]

What is striking about these numbers is their insignificance in the broader scheme of things for the wellbeing of the Rohingya people. While transformative for the few thousands who make it, they represent only a symbolic statement of solidarity by countries that can and should do far more. This is especially the case considering the role high income Global North states play in attempting to contain refugees in their regions of origin, including in South Asia.

To illustrate, Australia's inhumane deterrence policy of offshoring refugees in Nauru and Papua New Guinea over the past two decades has set a dismal human rights example for neighbouring countries in the region. MSF worked briefly on Nauru—and some Rohingya were among our patients—and we found the containment conditions negatively impacted the mental health of the refugees.

"Close to one-third of MSF's refugee and asylum seeker patients had attempted suicide, while 12 patients were diagnosed with the rare psychiatric condition of 'resignation syndrome'. Nauruan nationals also had high levels of severe mental illness; almost half of MSF's Nauruan patients needed treatment for psychosis."[150]

Other underreported populations (China, Turkey, Nepal, UAE, Sudan, Sri Lanka)

Small pockets of Rohingya communities exist in many countries and their individual stories should be investigated and told. In total though, we believe these small enclaves add up between 10,000 and 25,000.

In Asia, some have found niches in China's Yunnan province (600 individuals).[151] A few families have managed to establish themselves in Turkey.[152] There are 100 Rohingya living in Sri Lanka after being rescued on a failed attempt to reach Malaysia.[153] About 300 found their way to Japan.[154] There may be up to 3,000 living in Nepal with limited assistance or protections.[155]

Further west, those in the UAE and other Gulf States (possibly 5,000 individuals)[156] are there typically with Bangladeshi or Pakistani passports obtained either legally or illegally. A small enclave existed in Sudan, which prior to the current conflict, was one of the few places a Rohingya with some means could send their children for higher education.[157]

Thailand and Indonesia

The situation for Rohingya in Thailand is not widely reported. Population estimates vary and lack substantiation, with estimates ranging between 3,000 and 40,000—though 3,000 seems the more likely figure based on discussions with several key experts.[158] Rohingya living in Thailand hide their identity to avoid the attention of authorities. Many may obtain localized residency cards or Myanmar migrant work permits, but most resort to small bribes and arrangements to live on the margins of society in self-employment situations with whatever real or fake documentation they can manage. For many Rohingya, Thailand's jungles are known as a dangerous transit route used by smugglers to take them from Myanmar to Malaysia and beyond.[159]

The situation in Indonesia has recently become more dynamic. As of October 2023, UNHCR reported only 900 Rohingya refugees registered in Indonesia.[160] However, 1,752 individuals arrived in Indonesia on 11 boats between November 14, 2023, and the end of the year. Of those, 243 have "spontaneously departed" and are suspected of traveling onwards to Malaysia.[161]

Endnotes

Executive Summary

1 MSF does not work directly with Rohingya communities in Saudi Arabia, Pakistan, India, or elsewhere currently. However, their situation was explored during interviews and research for this report.

2 "Surviving Statelessness and Trafficking: A Rohingya Case Study of Intersections and Protection Gaps." Institute on Statelessness and Inclusion (ISI). June 2023. https://files.institutesi.org/Surviving_Statelessness_and_Trafficking_a_Rohingya_Case_Study.pdf (accessed January 2024) The entire body of work by ISI in documenting and analyzing the impact of statelessness on the Rohingya community is an invaluable contribution to understanding the correlation between entrenched statelessness and increased vulnerabilities. It was through the influence of this report that MSF reframed our own analysis to consider intergenerational issues more centrally. This report is also a comprehensive analysis of protection gaps facing the Rohingya in the region and the difficult choices they must make.

3 Rohingya living in villages in Rakhine state are not considered in the confined category for data analysis in this report which is focused on fenced camps. However, decades of movement restrictions and the current conflict certainly contain them with similar consequences.

4 Based on key informant interviews encompassing all known locations listed in this document for Rohingya in Saudi Arabia, Malaysia, Myanmar, Thailand, and India. See Annex One: Global Situation for detailed breakdown by country.

5 PRRiA Partners. "Promoting Regional Responses to Rohingya Displacement in Southeast Asia". June 2023. https://reliefweb.int/report/bangladesh/promoting-regional-responses-rohingya-displacement-southeast-asia (accessed August 2023). This report provides an excellent overview of the protection frameworks and issues within southeast Asian region specific to the plight of the Rohingya. For more info by country see Annex One: The Global Situation.

6 Estimates based on high vs. low range population growth analysis. It is impossible to arrive at definitive figure since fertility rates and death rates for Rohingya are unavailable in individual countries.

7 At the 17 October 2023 High Level Meeting on Rohingya Refugees in Bangkok, a key deliverable was support to the UNSC Resolution 2669 (2022); "Expressing concern that recent developments in Myanmar pose particularly serious challenges for the voluntary, safe, dignified, and sustainable return of Rohingya refugees and internally displaced persons, and underlining the risks that the Rohingya situation poses for the wider region."

8 Excerpt from ***Myanmar's Rohingya Genocide: Identity, History and Hate Speech***. Ronan Lee. "The Rohingya's situation was not always so bleak. For centuries prior to the British colonial period, the Rohingya's forebears – a mostly Muslim Indo-Aryan people – were a well-integrated part of the Arakan Kingdom, a sovereign state on the Bay of Bengal between the Burma Empire and Mughal India that roughly corresponds to Myanmar's modern-day Rakhine state and its surrounds. The Rohingya were integrated into Burmese society during the British colonial era and enjoyed full civil and political rights when Burma became independent in 1948."

9 The framing of containment and marginalization was a central point of discussion with external experts and in meetings that brought together MSF Rohingya staff members from Myanmar, Bangladesh, and Malaysia. It was through staff discussions that we came to frame the "spectrum." What was abundantly clear from every conversation is that Rohingya everywhere felt contained in one way or another. When Rohingya women were given a safe space to speak for themselves, they were also adamant in highlighting the specific barriers they experience due to gender.

10 Rohingya women tend to suffer containment more extremely due to cultural practices keeping women at home in addition to the broader containment and marginalization of the Rohingya. This is addressed in depth later in the report.

11 Htun, Su. (2019). Legal Aspects of the Right to Nationality Pursuant to Myanmar Citizenship Law. Journal of Southeast Asian Human Rights. 3. 277. 10.19184/jseahr.v3i2.13480.

12 A very small percentage of Rohingya do obtain Myanmar passports (likely a small fraction of 1%) though never through identifying as Rohingya.

13 Kohari A. "Pakistan's Biometric ID Scheme Is Stripping Citizenship from Thousands of People". Coda Story (blog). November 2, 2021, https://www.codastory.com/authoritarian-tech/pakistan-biometric-identification-nadra/ (accessed August 2023); Tiwari AD, et al. "Locked In and Locked Out: The Impact of Digital Identity Systems on Rohingya Populations". The Institute on Statelessness and Inclusion, November 2020.

Report Background

14 MSF. "MSF and the Rohingya: 1992–2014". November 19, 2020. https://www.msf.org/speakingout/msf-and-rohingya-1992-2014 (accessed January 2024).

15 See Annex: The Global Situation for details.

Intergenerational statelessness, containment, displacement, and marginalization

16 UNHCR Asia Pacific. "Expanded Solutions and Enhanced Resilience: A Multi-Stakeholder Pledge for Rohingya Refugees." https://www.unhcr.org/asia/media/expanded-solutions-and-enhanced-resilience-multi-stakeholder-pledge-rohingya-refugees (accessed January 10, 2024).

17 "Equal Only in Name: The Human Rights of Stateless Rohingya in Malaysia". Equal Rights Trust, October 17, 2014. https://www.equalrightstrust.org/content/equal-only-name-malaysia-full-report (accessed January 2024). Pg. 5. Notes that, "To a large extent, Rohingya have been contained in Rakhine State, through successive government policies. However, small numbers of Rohingya have settled in Yangon, the capital of Myanmar, and other places in Myanmar".

18 The 2014 Myanmar Census denied the option to identify as Rohingya. At the time, the population of Rohingya was estimated by the central government to be little over 1 million, but according to UN agencies, this number was likely higher. These numbers are based on CCCM Camp Profiles - https://data.unhcr.org/en/dataviz/306

19 MSF. "Medical Facilities, Patients and Healthcare Workers Must Be Protected as Conflict Escalates across Myanmar." November 18, 2023. https://www.msf.org/medical-facilities-patients-and-healthcare-workers-must-be-protected-conflict-escalates-across (accessed January 10, 2024).

20 The 1982 Citizenship Law in Myanmar and its impact over ethnicities not included in the list of 135 recognized ethnicities, have left many, including Rohingya people, in a state of protracted statelessness. Those unable to prove that they belong to one of the prescribed ethnic groups are denied citizenship and fundamental rights attached to it.

21 Tiwari AD, et al. "Locked In and Locked Out: The Impact of Digital Identity Systems on Rohingya Populations".

22 MSF. "Fatal Policy: How the Rohingya Suffer the Consequences of Statelessness". October 1, 2011. https://www.msf.org/fatal-policy-how-rohingya-suffer-consequences-statelessness (accessed July 3, 2022).

23 In June 2012, deadly communal clashes led to Myanmar's Rakhine State being placed under an official state of emergency. An estimated 75,000 people were displaced and many of their homes were burned down. Further outbreaks of violence in October in that year exacerbated the humanitarian crisis, forcing a further estimated 36,000 people out of their homes and into

makeshift camps without sufficient shelter, water, sanitation, food, or healthcare.

24 Bauchner S. "'An Open Prison without End'". Human Rights Watch. October 8, 2020. https://www.hrw.org/report/2020/10/08/open-prison-without-end/myanmars-mass-detention-rohingya-rakhine-state (accessed November 2023).

25 Based on MSF mortality surveys conducted in Bangladesh camps in 2017.

26 Brinham N, Karanika V, Paul S. "Surviving Statelessness and Trafficking: A Rohingya Case Study of Intersections and Protection Gaps". Institution on Statelessness and Inclusion. June 2023. https://files.institutesi.org/Surviving_Statelessness_and_Trafficking_a_Rohingya_Case_Study.pdf (accessed August 2023).

27 UNHCR Bangladesh – Operational Update September 2023. https://data2.unhcr.org/en/documents/details/104911.

28 "Bangladesh Fact Sheet". https://www.unhcr.org/media/bangladesh-fact-sheet (accessed January 2024) and "States of denial: A review of UNHCR's response to the protracted situation of stateless Rohingya refugees in Bangladesh". 13 December 2011. https://reliefweb.int/report/bangladesh/states-denial-review-unhcr's-response-protracted-situation-stateless-rohingya (accessed January 2024). "Bangladesh is currently host to some 29,000 recognized refugees who are accommodated in camps and an estimated 36,000 unrecognized refugees who have congregated in makeshift sites to which UNHCR and other international and national humanitarian actors have limited access. In addition, there are thought to be at least 200,000 undocumented Rohingya living in host communities and who are also considered to be of concern to UNHCR".

29 The "camp" is not one camp. There are five main camp locations in Cox's Bazaar along with the island of Bhasan Char, which house over 965,000 Rohingya registered with UNHCR. For an overview of the camp system in Bangladesh see: https://data.unhcr.org/en/documents/details/103837

30 In June 2022, a fit, well-nourished, well-hydrated MSF international staff member who regularly hikes mountains monitored a 5.3 kilometer walk through the mega-camp. It took 73 minutes of moving time to travel the distance with an elevation gain of 91 meters. The trip required one very welcome break of about 15 minutes along the way. Accessing any services even just a kilometer away from a home block for highly vulnerable Rohingya women—particularly pregnant and lactating women—or children is truly a barrier. Furthermore, security is a real concern—an individual was murdered along the same route about an hour after they passed by.

31 As of time of report writing there is a noticeable increase in the number of 'tuk tuks' operating in the camps. These are small taxis that can carry three to four people. This is a welcome development, though public transportation on a larger scale and capacity with buses would be more appropriate for the situation.

32 "Beyond Relief: Securing Livelihoods and Agency for Rohingya Refugees in Bangladesh". The Asia Foundation (blog). https://asiafoundation.org/publication/beyond-relief-securing-livelihoods-and-agency-for-rohingya-refugees-in-bangladesh/ (accessed December 5, 2023).

33 "Bangladesh - MSF calls for an urgent and comprehensive response to the scabies outbreak affecting hundreds of thousands in Cox's Bazar refugee camps", MSF July 12, 2023. https://www.msf.ie/article/bangladesh-msf-calls-urgent-and-comprehensive-response-scabies-outbreak-affecting-hundreds

34 As of the finalization of this report, it appears the mass drug administration for scabies eased the pressure temporarily but did not solve the problem, as MSF predicted. As of March 2024, a few months after the MDA, MSF's Jamatoli health facility was seeing on average 264 patients for scabies per day (including from the host community). In November 2023 the same facility was seeing an average of 617 per day and deferring approximately an additional 300 per day.

35 "UN in Bangladesh announces devastating new round of rations cuts for Rohingya refugees." UN News. June 1, 2023. https://news.un.org/en/story/2023/06/1137252 (accessed November 2023).

36 UNHCR. "Figures at a glance in Malaysia". https://www.unhcr.org/my/what-we-do/figures-glance-malaysia (accessed January 2024).

37 "Equal Only in Name." https://www.equalrightstrust.org/ertdocumentbank/Equal%20Only%20in%20Name%20-%20Malaysia%20-%20Full%20Report.pdf (accessed January 2024). p 16. "They reside throughout Malaysia, with larger communities in and around Kuala Lumpur, and in other states such as Penang, Johor, Kedah, Kelantan, and Terengganu. For years, this population, and particularly those not registered with UNHCR, have been navigating the insecurities and human rights concerns associated with living and working in a country that considers them to be 'illegal immigrants'. Furthermore, on page 45, "Although the long-term Rohingya population in Malaysia may be traced back to the 1980s, a large proportion of the current population made their journey through varying routes in the early to mid-1990s following the exodus in 1991–1992. In December 1993, UNHCR Malaysia registered some 5,100 Rohingya. Most of the long staying Rohingya refugees who were interviewed for this report were originally from Maungdaw in Rakhine State. Almost all of them came to Malaysia during 1993–1995 and have been living in the country for approximately 20 years. Most made the journey from Bangladesh by air through 'brokers' who obtained some form of identification documentation, visa, or passport for them."

38 Equality Rights Trust. "Trapped in a Cycle of Flight: Stateless Rohingya in Malaysia". January 2010, p 8.

The impact of violence on rohingya communities

39 Habiburahman, Ansel S. "First They Erased Our Name: A Rohingya Speaks" . London: Scribe, 2019. This book provides a first-hand account of the hardships experienced by a Rohingya man growing up in Rakhine in the 1970s and 1980s, his flight to Malaysia, and incarceration in Australia. An account of his book can also be found on https://www.theguardian.com/world/2019/aug/04/rohingya-refugee-myanmar-australia-oppression-suffering

40 Nivedita Sudheer, Debanjan Banerjee. "The Rohingya refugees: a conceptual framework of their psychosocial adversities, cultural idioms of distress and social suffering. Cambridge Prisms: Global Mental Health. Cambridge University Press. Dec 17, 2021

41 Binet L. "MSF and the Rohingya: 1992–2014". 2020. p 255. https://www.msf.org/sites/msf.org/files/2020-11/socs-rohingya-en_0.pdf (accessed January 2024

42 McPherson P, Lone W. "New evidence shows how Myanmar's military planned its brutal purge of the Rohingya". Reuters. August 4, 2012. https://www.reuters.com/investigates/special-report/myanmar-rohingya-warcrimes-investigation/ (accessed January 2024).

43 Lee, Ronan. "Myanmar's Rohingya Genocide: Identity, History, Hate Speech". London: Bloomsbury Publishing, 2021. Lee gives one of the best researched and most academic presentations of Rohingya history.

44 Internal planning documents. See also MSF International Activity Report for 2016, which shows that while MSF planned to provide 100,000 consultations, the reality was far more difficult: "The attacks on border police in northern Rakhine on 9 October 2016 prompted a complete lock-down and all humanitarian assistance was suspended, leaving thousands of patients without access to primary healthcare for over two months.

MSF conducted just over 2,000 medical consultations during the last quarter of 2016, compared to the roughly 15,000 consultations staff would have expected based on the monthly average. Hospital referrals were also halted, increasing the likelihood of avoidable deaths." See also Binet L. p 244.

45 MSF. "MSF office and pharmacy in Rakhine state destroyed in fire by ongoing violence". April 16, 2024.

46 Binet L. "MSF and the Rohingya: 1992–2014." pp 190–6. Furthermore, "With the help of PHAS (Persons living with HIV/AIDS) (self-help groups) and our HIV pts and some MSF Staff, we have been able to reach over 60% of our HIV cohort (we have around 670 pts +/- in all of Rakhine State on ART) but unfortunately at least over 100 have already had drug interruptions. Unless we secure proper consultation and constant drug supply, we cannot restart them due to risk of complications/side-effects from restarting and higher risk of development of resistance if there is stop and go type management." pp 203–4.

47 2012 MSF International Activity Report. https://www.msf.org/sites/default/files/msf_activity_report_2012_interactive_final.pdf

48 "Denial of humanitarian assistance is a death sentence in Myanmar." The New Humanitarian. June 11, 2024. https://www.thenewhumanitarian.org/opinion/2024/06/11/denial-humanitarian-assistance-death-sentence-myanmar

49 "The Andaman Sea refugee crisis a year on: what happened and how did the region respond?". The Conversation. May 25, 2016. https://theconversation.com/the-andaman-sea-refugee-crisis-a-year-on-what-happened-and-how-did-the-region-respond-59686 (accessed November 2023).

50 "UNHCR - Mixed Movements in South-East Asia - 2016". UNHCR. https://reporting.unhcr.org/sites/default/files/UNHCR%20-%20Mixed%20Movements%20in%20South-East%20Asia%20-%202016%20--%20April%202017_0.pdf (accessed December 7, 2023).

51 "The Dirty History Surrounding Rohingya Movements since 1978". https://www.unsw.edu.au/news/2021/02/the-dirty-history-surrounding-rohingya-movements-since-1978 (accessed January 10, 2024). Provides an excellent summary and historic overview of the regional dynamics driving Rohingya movements and state reactions.

52 https://data.unhcr.org/en/situations/myanmar (accessed January 2024). Note, while the majority of Rohingya left from Myanmar in 2012–2015 this trend has shifted and in 2022–2023, the majority depart Bangladesh because of violence and lack of opportunities. Flight from Rakhine remains persistent and is not limited to Rohingya. Ethnic Rakhine increasingly leave Myanmar as well and flows to Malaysia as a whole by land or sea are mixed.

53 Legido-Quigley H, et al. "Southeast Asian Health System Challenges and Responses to the 'Andaman Sea Refugee Crisis': A Qualitative Study of Health-Sector Perspectives from Indonesia, Malaysia, Myanmar, and Thailand" PLoS Med 2020; 17(11):e1003143.

54 Sheltercluster.org. https://app.powerbi.com/view?r=eyJrIjoiYzhlMGNjNDctMDhjZS00MWNiLThhNmMtNzc5MDBjY2YzOTExIiwidCI6ImU1YzM3OTgxLTY2NjQtNDEzNC04YTBjLTY1NDNkMmFmODBiZSIsImMiOjh9&pageName=ReportSection. (accessed May 24, 2024).HRW.

55 Interviewed July 2023. Testimony on file with MSF.

56 Based on MSF mortality surveys conducted in Bangladesh camps in 2017.

57 MSF. "'No one was left' - Death and Violence Against the Rohingya". March 9, 2018. https://www.msf.org/myanmarbangladesh-'no-one-was-left'-death-and-violence-against-rohingya (accessed January 2024).

58 The degree to which dynamics in Rakhine are developing between November 2023 and time of publication makes it difficult to address the new complexities faced by Rohingya communities in Rakhine. While MSF has already observed preventable loss of life, such as pregnant mothers and infants unable to reach hospitals, our ability to witness and document these incidents is significantly hampered. Access restrictions, implemented since November, have deprived MSF teams of direct access to patients and all Rakhine communities. As a result, the actual numbers of casualties are unknowable, along with a rise in other health concerns. See also: MSF. "MSF office and pharmacy in Rakhine state destroyed in fire amid ongoing violence". April 16, 2024. (https://www.msf.org/msf-office-destroyed-fire-amid-ongoing-violence-rakhine-myanmar).

59 The International Institute for Strategic Studies. "Competing Armed Groups Pose New Threat to Rohingya in Bangladesh". IISS Myanmar Conflict Map. https://myanmar.iiss.org/analysis/rohingya (accessed January 2, 2024).

60 Ibid

61 40-year-old Rohingya woman living in the Bangladesh camps. Interview conducted in November 2023. Testimony on file with MSF.

62 "Trafficked from Hell to Hades: The Plight of Rohingya Women from Burma Trafficked in Pakistan". Images Asia. November 1999. https://www.burmalibrary.org/sites/burmalibrary.org/files/obl/docs3/Trafficked%20from%20Hell%20to%20Hades.htm (accessed August 2023). Further information about this research was discussed in an interview with Chris Lewa of the Arakan Project in August 2023.

63 Adolescent Rohingya girl living in the camps in the Bangladesh camps. Interview conducted November 2023. Testimony on file with MSF. The girl ended up being arrested in Myanmar and spent 18 months in prison before being released. The family needed to use the same agent and trafficking network in reverse to bring her back to her parents in Bangladesh.

64 A Majhi is a local Rohingya leader in the Bangladesh refugee camps and a CiC is short for "Camp in Charge" this is a Bangladesh Government civil servant who is responsible for the administration of the camps.

65 45-year-old father living in one of the camps in the Bangladesh camps. Interview conducted November 2023. Testimony on file with MSF.

The burden on women and girls: sexual and gender-based violence

66 Rohingya men and Hijra (third gender, transgender, intersex people) also suffer sexual violence, but the extreme situation for Rohingya women and girls necessitates dedicated focus. At present 2% of consultations for sexual and gender-based violence are male.

67 This observation is based on many discussions with patients, staff, and MSF medical providers.

68 Based on MSF's understanding through a series of discussions with Rohingya men and women, in Myanmar, dowry payments were high (commonly including furniture, motor bike, cash and gold,) on average around US$1,000–1,500. In Bangladesh, dowry is slightly lower and is paid either in cash or gold by the bride's family. Of course, dowry payment amounts vary greatly by family and socio-economic situation. The dowry costs for families sending off their daughters to marry in Malaysia are much lower (or none), and the journey from Bangladesh to Malaysia is paid by the groom (cost varies by route US$3,500–6000). Dowry costs among families in Malaysia are the highest.

69 Seventeen-year-old Rohingya girl who arrived in Malaysia in May 2022 from Bangladesh. Interview conducted August 2023. Testimony on file with MSF.

70 Kidman R. Child marriage and intimate partner violence: a comparative study of 34 countries. Int J Epidemiol 2016; 46: 662–675.

71 UNICEF. "Girls Not Brides Impact Report 2020." https://www.girlsnotbrides.org/learning-resources/resource-centre/girls-not-brides-impact-report-2020/

72 UNICEF. "Girls Not Brides Thematic Brief: Girls'

Education and Child Marriage. (Accessed January 2024). https://www.girlsnotbrides.org/documents/1821/Girls_education_and_child_marriage_brief_Sept_2022.pdf

73 Dr Ambia Perveen. Rohingya Medics Organisation (RMO). Interview January 2024. See https://rohingyamedics.org for more information on RMO's work.

74 Excerpt from Human Rights Watch Report "An Open Prison without End" Myanmar's Mass Detention of Rohingya in Rakhine State". October 2020.

75 30-year-old Rohingya woman living in the Bangladesh camps. Interview in November 2023. Testimony on file with MSF.

76 Internal Assessment available on request. "Barriers to access to health care for Rohingya living in Cox's Bazar refugee camps: Analysis of results of community feedback mechanisms".

77 For more information; In 2016, UNHCR reported the results of a study focused on Rohingya women and girls on the move; "92% percent of the women and girls interviewed were married, and in all three countries had married at similar ages, between an average of 16 and 17; 18% married before they turned 16. The 80% of interviewees who had children gave birth to their first child at an average age of 18."

Aid dependency: water, sanitation, and nutrition

78 Op Ed by Arunn Jegan, MSF Representative to Australia who has worked in the Bangladesh camps at various points between 2017 and 2023. A ring-fence around the Rohingya can't last—Australia's policy needs to change. Lowry Institute. March 13 2024. https://www.lowyinstitute.org/the-interpreter/ring-fence-around-rohingya-can-t-last-australia-s-policy-needs-change

79 The 2022 survey is available online: https://reliefweb.int/report/bangladesh/bangladesh-assessment-water-sanitation-and-hygiene-services-among-populations-19-camps-coxs-bazar-june-2022 (accessed February 2024). The 2023 survey is being finalized for public distribution.

80 Restricted dissemination: MSF Wash assessment interim report – October 2023.

81 Ibid.

82 MSF. "Cyclone Mocha: Aid efforts severely hampered by new restrictions." July 26, 2023. https://www.msf.org/cyclone-mocha-aid-efforts-severely-hampered-new-restrictions (accessed September 2023).

83 "UN in Bangladesh announces devastating new round of rations cuts for Rohingya refugees". UN News. June 1, 2023. https://news.un.org/en/story/2023/06/1137252 (accessed September 2023).

84 "WFP to increase food ration from US$8 to US$10 for all Rohingya refugees in Cox's Bazar". ReliefWeb. December 1, 2023. https://reliefweb.int/report/bangladesh/wfp-increase-food-ration-us8-us10-all-rohingya-refugees-coxs-bazar (accessed January 2024).

85 "WFP to Increase Food Ration from US$8 to US$10 for All Rohingya Refugees in Cox's Bazar ". ReliefWeb. December 31, 2023. https://reliefweb.int/report/bangladesh/wfp-increase-food-ration-us8-us10-all-rohingya-refugees-coxs-bazar (accessed January 2024).

Mental health: compounding traumas

86 Fiona Charlson et al., "New WHO Prevalence Estimates of Mental Disorders in Conflict Settings: A Systematic Review and Meta-Analysis," The Lancet 394, no. 10194 (July 2019): 240–48, https://doi.org/10.1016/S0140-6736(19)30934-1.

87 Nivedita Sudheer, Debanjan Banerjee. "The Rohingya refugees: a conceptual framework of their psychosocial adversities, cultural idioms of distress and social suffering". Cambridge Prisms: Global Mental Health. Cambridge University Press. Dec 17, 2021

88 MSF. "Ten years in dire conditions perpetuates severe mental health problems for Rohingya". July 14, 2022. https://www.msf.org/after-10-years-camps-myanmar-rohingya-mental-health-continues-suffer

89 Ibid

90 Armstead TL, et al. Structural and social determinants of inequities in violence risk: A review of indicators. J Community Psychol 2021; 49(4): 878–906. https://pubmed.ncbi.nlm.nih.gov/31421656/

91 Alberto Hexsel, psychiatrist who worked in Cox's Bazaar February to March 2018 and June to September 2023

92 "Sentenced to their diagnosis," expressing the idea that the individual's prognosis or medical condition seems so severe or debilitating that it feels like they've been given a life sentence, as if they're bound to suffer from the effects of their diagnosis indefinitely. This phrase often conveys a sense of hopelessness or resignation about the patient's situation, emphasizing the perceived inevitability of their condition. It underscores the idea that certain diagnoses can profoundly impact a person's life and future. However, it's important to remember that diagnoses don't always dictate a predetermined outcome, and medical interventions, support, and personal resilience can play significant roles in managing and sometimes even overcoming illnesses.

Access to healthcare

93 MSF. "How a near-total absence of humanitarian access is impacting lives in Myanmar". April 17, 2024. https://www.doctorswithoutborders.org/latest/how-near-total-absence-humanitarian-access-impacting-lives-myanmar.

94 Ibid

95 Since February 2021, access to healthcare is a challenge for all communities in Myanmar. In 2024, ethnic Rakhine also struggle with accessing quality healthcare due to the collapse of the health system amidst the current crisis. What differentiates the experience of the Rohingya from the Rakhine, and is the focus of this report, is the targeted exclusion of Rohingya from the system before and after February 2021.

96 A quack is a common term still used in Myanmar and Bangladesh for an unlicensed or untrained doctor, typically with limited medical knowledge.

97 64-year-old Rohingya man living outside Buthidaung. Interviewed August 2023. Testimony on file with MSF.

98 Internal Assessment available on request. "Barriers to access to health care for Rohingya living in Cox's Bazar refugee camps: Analysis of results of community feedback mechanisms". In 2022, MSF carried out monitoring of the obstacles faced by Rohingya in accessing medical care among patients in MSF facilities and refugees in the catchment areas where MSF operates. The first phase of the monitoring was carried out between March 3 and March 13, 2022, in four MSF health facilities: three located within the boundaries of the camps—Hakimpara, Hospital on the Hill, and Balukhali—and one outside, Kutupalong. The objectives were to: a) estimate, among Rohingya refugees accessing healthcare in MSF facilities, the proportion of people encountering one or more barriers to accessing healthcare at the time of the monitoring; b) identify the key barriers they faced; and c) understand the indicators of delayed healthcare linked to these barriers. Following systematic random sampling methodology, 1,473 interviews were conducted with patients who completed a consultation (inpatient or outpatient). Their verbal consent was obtained and documented. The second phase of the monitoring focused on interviews with 207 refugees outside MSF health structures in 13 Rohingya refugee camps covered by MSF health services. This community-based monitoring was conducted between May 29 and June 2, and on June 8, 2022. It relied on simple random sampling using a geographic information system (GIS) to select interviewees. Similar to the first phase, the objective was to identify and quantify barriers faced by Rohingya refugees in accessing healthcare in Cox's Bazar refugee camp.

99 There are numerous unlicensed pharmacies inside the refugee camps as well as in local villages.

100 “Barriers to access to health care for Rohingya living in Cox’s Bazar refugee camps: Analysis of results of community feedback mechanisms”.

101 Ibid

102 Ibid

103 A refugee-led September 2023 report by Youth Congress Rohingya entitled “This persecution is the worst there is” found 93.8% of respondents identified containment policies as a barrier in accessing healthcare. This correlates to the MSF findings. https://youthcongressrohingya.com/this-persecution-is-the-worst-there-is/ (accessed October 2023).

104 “Barriers to access to health care for Rohingya living in Cox’s Bazar refugee camps: Analysis of results of community feedback mechanisms”.

105 Ibid

106 This increase does not account for the patients MSF facilities are forced to defer daily and therefore is not a true estimation of needs as these MSF facilities were also deferring approximately 10% of all OPD presentations during peak demand due to being over capacity.

107 An internal assessment was conducted in August 2023 prompted by funding cuts, closure of facilities, and a surge in patients to MSF facilities in 2023. This assessment is a qualitative context analysis for Rohingya and communities contained in the Bangladesh camps and dependent on humanitarian assistance. It aimed to assess access barriers to healthcare in sexual and reproductive health and general primary outpatient care (mainly in camps 14 and 15). “Rapid Qualitative Assessment of Access Barriers to Healthcare Among the Rohingya and Affected Populations: Reality Check on Functional SRH and OPD services based on the perspectives of patients and providers”.

108 Many health services in the camp have more limited opening hours than required (often 09:00 to 14:00 only) and face frequent basic drug ruptures driving Rohingya to seek out a provider. While the services in principle might be available, they are not functioning in an adequate capacity or consistent capacity to meet the demand.

109 Data comparison includes children (younger than 15 years) admitted in Goyalmara Mother and Child Hospital and in Hospital on the Hill.

110 1 in 5 adult Rohingyas infected with Hepatitis C: Study. The Daily Star. February 16, 2022. https://www.thedailystar.net/health/disease/news/1-5-adult-rohingyas-infected-hepatitis-c-study-2963461 (accessed January 2024).

111 Restricted dissemination – Health sector. Coordination meeting minutes. October 4, 2023.

112 “Beyond Relief: Securing Livelihoods and Agency for Rohingya Refugees in Bangladesh”. The Asia Foundation (blog). https://asiafoundation.org/publication/beyond-relief-securing-livelihoods-and-agency-for-rohingya-refugees-in-bangladesh/ (accessed December 5, 2023).

113 Many Rohingya patients are habituated to use injectables and will pay for an injection rather than be satisfied with a tablet and many unqualified medical practitioners sell unsafe treatments.

Conclusions

114 OIC Ministerial Contact Group on Rohingya Muslims Meets in New York. 19 September 2023. (accessed February 2024). https://www.oic-oci.org/topic/?t_id=39579&ref=26634&lan=en

115 OIC General Secretariat calls on international community to stand firm with the Rohingya people in their Plight. 25 August 2022 (accessed February 2024). https://www.oic-oci.org/topic/?t_id=37400&t_ref=25861&lan=en

116 “Rohingya Refugees from Myanmar: A Regional Perspective (Summary of Report)”. UNHCR Operational Data Portal (ODP). https://data.unhcr.org/en/documents/details/91423. (accessed December 7, 2023).

117 “In Cox’s Bazar”. Michaël Neuman. London Review of Books. September 8th, 2023. https://www.lrb.co.uk/blog/author/michael-neuman (accessed February 2024).

118 Yolanda Weima and Jennifer Hyndman, Managing displacement: negotiating transnationalism, encampment and return, in Handbook on Critical Geographies of Migration, Elgar Online, https://doi.org/10.4337/9781786436030.

Annex: The global situation

119 One of the more comprehensive published attempts is by Ronan Lee in, “Myanmar’s Rohingya Genocide: Identity, History, Hate Speech”. London: Bloomsbury Publishing, 2021. Pgs. 11-14. UNHCR only publishes figures for Rohingya registered as refugees resulting in historically undercounting the needs of the unregistered.

120 Including regular discussions with MSF staff as well as external Rohingya community leaders. In addition to this, our analysis and understanding of Rohingya is shaped by day-to-day discussions with the 768 Rohingya who are in contract with, and who are part of, MSF and are central to every aspect of our community engagement and understanding of their lived reality in Myanmar (n=250), Bangladesh (n=487), Malaysia (n=31) and who contribute on a daily basis to every internal report or analysis in the three countries.

121 “Trafficked from Hell to Hades: The Plight of Rohingya Women from Burma Trafficked in Pakistan.” This report from the 1990’s by Chris Lewa tracks information from three key informant interviews conducted between July 2023 and October 2023 and extensive desk research, which indicate that 400,000 is likely a conservative but credible population total. One pertinent reminder within the Hell to Hades report is the extreme vulnerability of Rohingya women within trafficking schemes. The lessons outlined in this report from the route to Pakistan in the 1990’s are a potent reminder of the threats faced by Rohingya women in the Bangladesh camps today.

122 Key informant interview (C). August 2nd, 2023.

123 Kohari. "Pakistan’s Biometric ID Scheme Is Stripping Citizenship from Thousands of People".

124 Key Informant interview (C). August 2nd, 2023.

125 Key Informant interview (C). August 2nd, 2023.

126 Kohari. "Pakistan’s Biometric ID Scheme Is Stripping Citizenship from Thousands of People".

127 "Expanded Solutions and Enhanced Resilience". https://www.unhcr.org/asia/media/expanded-solutions-and-enhanced-resilience-multi-stakeholder-pledge-rohingya-refugees

128 Obtaining information on the Rohingya situation in Saudi Arabia proved most difficult and very risky for people to discuss. Despite the large population size, there is little public information. In addition to what was available from public sources, MSF interviewed three Rohingya people with direct knowledge of the situation in Saudi Arabia and reviewed a confidential document written for a concerned government over a decade ago. Population estimates range from 300,000 to 600,000. Based on discussions with Chris Lewa of the Arakan Project whose team estimated the population to be 300,000 over a decade ago and discussion with KII (A), (B), (C), a total population of 340,000 in 2024 is considered a conservative estimate.

129 Key Informant Interview (A).

130 “Belonging in transience: multi-generational migrants in Saudi Arabia”. Migrants Rights. October 7, 2019. https://www.migrant-rights.org/2019/10/belonging-in-transience-multi-generational-migrants-in-saudi-arabia/ (accessed December 2023).

131 Chris Lewa, Key informant interviews (A), (B),(C)

132 Key informant interviews (A).

133 Chris Lewa, KII (B).

134 KII (C), see also “Issue Passports to Rohingya or Face ‘Consequences’, Says Saudi Arabia to Bangladesh”. WION.

https://www.wionews.com/world/issue-passports-to-rohingya-or-face-consequences-says-saudi-arabia-to-bangladesh-335750 (accessed June 14, 2022).

135 UNHCR reported 21,600 registered Rohingya refugees in India at the Bangkok High Level Meeting on Rohingya on October 17, 2023, though this figure was not included in a scan of their website on November 1, 2023.

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Description for all images

Page: Cover
Copyright: Zoe Bennell/MSF
Description: Patients wait at a busy MSF mobile clinic in Northern Rakhine while the doctors triage and organise.

Page: 3
Copyright: MSF
Description: In the camps of Cox's Bazar, Bangladesh, half of the estimated one million Rohingya refugees are children. This new generation is growing up in a context of pervasive fear and despair, stopped in time. Their situation is not expected to improve as humanitarian funds keep decreasing. Meanwhile, the level of violence Rohingya refugees are exposed to is worsening day after day with mounting targeted killings, sexual assaults and kidnappings. This 28' documentary focuses on a generation of children, teenagers, young adults through the eyes of their parents, living in containment amidst daily violence, and their perspectives for the future.
Documentary link: https://www.youtube.com/watch?v=tDm0LePykHs&t=68s

Page: 13
Copyright: Mohammad Hijazi/MSF
Description: Habibullah holds his driver's license alongside a family photo, tangible memories of the life he once had in Myanmar and among the select items he carried during his departure. When violence surged, it was ordinary civilians like Habibullah who found themselves caught amidst the turmoil. "Our villages became targets," he recalls with a heavy heart. "Staying there was no longer safe. We were left with little choice but to leave, or risk our lives." Given only a few days to make a lifealtering decision, and with the intensity of the fighting approaching, Habibullah and many of his neighbors sought temporary safety in the mountains.

Page: 20
Copyright: Sahat Zia Hero
Description: A Rohingya couple carry their sick child through the camp to find a doctor. Cox's Bazar, Bangladesh, October 2023

Page: 22
Copyright: Arnaud Finistre
Description: Rohingya workers employed on a construction site in Penang. Around half of the workers on the site are Rohingya, who, with no legal status in Malaysia, are not legally allowed to work. The other workers are Bangladeshi, Indian, Indonesian or Malaysian. Rohingya workers often work in particularly precarious safety conditions, frequently sleeping on site in basic shelters to save money. This allows them to send money to their families who have stayed in Myanmar or who have fled to Bangladesh. Some unscrupulous employers take advantage of their irregular legal status to deprive them of their full wages. Construction sites, which are numerous in Malaysia, are one of the few ways the Rohingya can earn a living in the informal economy, but many workers have been cheated out of their earnings. Penang

Page: 23
Copyright: MSF
Description: In the camps of Cox's Bazar, Bangladesh, half of the estimated one million Rohingya refugees are children. This new generation is growing up in a context of pervasive fear and despair, stopped in time. Their situation is not expected to improve as humanitarian funds keep decreasing. Meanwhile, the level of violence Rohingya refugees are exposed to is worsening day after day with mounting targeted killings, sexual assaults and kidnappings. This 28' documentary focuses on a generation of children, teenagers, young adults through the eyes of their parents, living in containment amidst daily violence, and their perspectives for the future.

Page: 33
Copyright: Arnaud Finistre
Description: Rashida, 22 years old, was born in Rakhine state, Myanmar. She fled alone in 2012 when she was 15 years old and sought refuge in Bangladesh. From there, she travelled to Thailand, which entailed an eight day trip on a boat with around 500 passengers on board. She reached the Malaysia border by foot with the assistance of smugglers, then spent three and a half months in a Penang detention centre. Since arriving, she's married a Malaysian-born Rohingya who works for a cleaning company. Penang

Page: 34
Copyright: Zoe Bennell/MSF
Description: Rohingya women hoping to get seen by doctors in crowded waiting room at MSF mobile clinic in Rakhine state.

Page: 42
Copyright: Elizabeth Costa/MSF
Description: A health promotion session in progress for Rohingya women in the refugee camps in Cox's Bazar, Bangladesh. Health promoters usually invite several families to a session, to raise awareness around the importance of seeking healthcare. The team also discusses the availability of medical and mental healthcare at MSF facilities.

Page: 45
Copyright: Sahat Zia Hero
Description: Rohingya refugees queue to collect water before Friday prayers. Cox's Bazar, Bangladesh, October 2023

Page: 47
Copyright: Sahat Zia Hero
Description: Aziz digs in a canal to improve drainage near his shelter. Cox's Bazar, Bangladesh, October 2023

Page: 51
Copyright: Victor Caringal/MSF
Description: Children walking through the outskirts of the camps.

Page: 54
Copyright: Victor Caringal/MSF
Description: Habiba, a young Rohingya person, points to a picture she drew of an MSF doctor in a clinic. She dreams of becoming a doctor to help her people but finds that there is no opportunity or pathway to do so.

Page: 55
Copyright: Victor Caringal/MSF
Description: Young people playing in the camps. At six years since the exodus from Myanmar, many of the children have grown up only knowing camp life and have limited opportunities. With the forced closure of community-led schools since early 2023, the youngest generation are losing their connection to Myanmar.

Page: 60
Copyright: Kit Chan
Description: Patients, most of whom are from the Rohingya community, waiting to see the
doctor at the MSF clinic in Butterworth, Penang.

Page: 62
Copyright: Kaung Htet
Description: Patients at MSF clinic in a refugee camp on the outskirts of Pauk Taw township, February 3, 2013.

DESCRIPTION FOR ALL IMAGES

Page: 67
Copyright: Sahat Zia Hero
Description: Mohammad carries his sick grandson back from the health centre. Cox’s Bazar, Bangladesh, October 2023

Page: 69
Copyright: Farah Tanjee/MSF
Description: Halima is a local resident from Goyalmara, Cox’s Bazar. She is pictured while admitted to MSF's Goyalmara Mother & Child hospital after the birth of her baby boy.

Page: 74
Copyright: Victor Caringal/MSF
Description: A Rohingya MSF worker looks towards the mountains of Myanmar. The Rohingya refugee camp sites, housing at least one million people, spans to the far distance.

Page: 94
Copyright: Hasnat Sohan/MSF
Description: MSF staff Tanbin Muftah observes from a high point the Jamtoli refugee camp in Cox’s Bazar, south-east Bangladesh.

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Acknowledgment

Thank you to the 768 Rohingya people working for MSF in Myanmar, Bangladesh, and Malaysia who guide MSF in providing care for your communities. A special thank you to our staff who helped frame the concepts of containment and marginalization, and who sat and educated me on the many challenges affecting your communities. In an ideal world each of your names would be listed here. However, a decision was taken to anonymize all Rohingya quoted or consulted living in countries in which policies of containment or marginalization could put them at risk.

Elena Wasylew, Karel Hendriks, Raphael Torlach, Jarmila Kliescikova, Salman Khan Bappa, Tae-Eun Kim, Raghda Sleit, and Kalyan Velivela all provided significant analysis and contributions to the body of this work. Thank you all! In many ways I am more an editor than an author in putting much of this work together. Also thank you to the work of the Manson Unit, MSF New York, and South Asia offices editorial teams. Special thanks as well to Paul Brockmann and Laura McAndrew for the strategic vision and drive to push this effort over time to completion. One thousand apologies to anyone I missed and for those who wrote amazing internal documents that influenced our perspectives.

Jason Mills

Author, Behind the Wire