



FATAL POLICY

How the Rohingya
Suffer the
Consequences
of Statelessness

This paper is based upon two surveys conducted in Northern Rakhine State, Myanmar and Kutupalong Makeshift Camp, Bangladesh, between July and October 2011





FATAL POLICY

The Rohingya people of Rakhine State are considered outsiders and have been persecuted by the government of Myanmar for decades. Denied citizenship, they are essentially stripped of any rights making them easy targets for systematic discrimination and abuse, which severely impact on their health and quality of life. They are susceptible to extortion and humiliation and targeted by prejudiced policies which restrict movement, religious practice, marriage, land access and ownership and access to education and jobs. In particular, marriage restrictions and their implications have a severe impact. They are one of the main reasons people flee Myanmar and the reason why so many women have unsafe and illegal abortions. **The results of a recent reproductive health survey show that an alarming number of women, fearing the repercussions of unauthorized childbirth, resort to illegal abortions using highly risky techniques.**

As refugees in Bangladesh they are often unwelcome and face further abuse and exploitation. Regarded as “illegal migrants” they remain unregistered and unprotected, and are subject to high levels of exploitation, extortion and harassment. Malnutrition, an indicator of general vulnerability, is a particular concern in Kutupalong makeshift camp, where thousands of Rohingya desperately seek refuge. **The results of a recent survey show above emergency thresholds for malnutrition primarily affecting children, a trend that has not changed significantly in the past year.**

MYANMAR

Marriage Restrictions: The Direct Consequences

“Marriage permission is the worst and most difficult thing we face. It is the most horrible and deadly problem, this thing. It makes our lives so hard and causes so many troubles. It is like we are boiling in a dish full of hot water. We are inside the water and we are boiled over and over, helpless, blistered and in pain”.

Woman, 30, Maungdaw South.

There is a direct link between marriage restrictions and harmful health outcomes. **The survey results demonstrate an alarmingly high induced abortion rate amongst this community: 14.3% of women had had at least one abortion, 26% of these women had had multiple induced abortions.**¹ Couples living together or having children together without official marriage permission are subject to heavy fines and imprisonment. Their children are subject to even worse discrimination than those born to officially married couples and are left with absolutely no social or legal status. Thus many unofficially married couples choose the medically and legally risky option of terminating their pregnancy.

The process for obtaining marriage permission is often a stressful and humiliating experience, and costs on average over 65 days’ wages, a sum that few can afford without entering into debt.² 91% of women surveyed attested to having to undergo a humiliating process in which the bride and groom, their parents and at least three witnesses must physically present themselves to their local NaSaKa³ sector commander at least twice. Women are ordered to remove their **hijab** or headscarf before entering the NaSaKa compound, and men must be cleanly shaven, against their religious customs. Authorities demand large amounts of money and couples can wait up to two years for approval. In order to get permission to marry, the couples must sign a statement that they will not have more than two children. **In most cases a pregnancy test is also performed, either during the presentation or beforehand and attached to the file.**

¹ The first local order on marriage restriction in Northern Rakhine State (NRS) was issued in 1994. This local order also prohibits any cohabitation or sexual contact outside wedlock. Non-compliance, described as a situation in which the “man deceitfully married the woman,” can lead to prosecution, and imprisonment for up to 10 years, under Section 493 of the Penal Code.

² An average daily wage is 1500 kyats (US \$1.80), compared with the average cost to obtain a marriage certificate of 100,000 Kyats.

³ The NaSaKa are the Burmese Border Security Forces and are divided into 9 sectors: 8 in Maungdaw Township, from Sector 1 in the far north up to Sector 8 in the far south, and 1 in Buthidaung Township.

“If you are rich you are ok because you can pay, but either way you must sell land, cattle and/or borrow money to afford marriage. Many just cannot. They live illegally or run away to Bangladesh. I sold all my cattle, but still it was not enough.”

Man, 45, Maungdaw South.

Owing to the difficulties surrounding obtaining marriage permission and the risks associated with not being officially married, many people simply flee the country. Over half of those interviewed in Bangladesh state marriage as one of the main factors in their decision to leave Myanmar. Amongst those who stay in Myanmar, 50% of those surveyed who had not obtained permission to marry chose to face the significant risks of living together illegally, a practice that is highly associated with induced abortion.

Induced Abortion

“I had two pregnancies while waiting for permission to marry. I had both aborted. One at 3 months and the other at 4 months because I was very scared of the authorities - to be jailed, punished and not be able to pay the money asked. Many women in the village here have abortions because of the same reason. We do not want to but have no choice. It is not because we do not want our children. Women die because of this. A woman died in this village recently because she used the stick method and bled too much”.

Woman, 25, Maungdaw South.

The biggest health impact of marriage restrictions is its direct link to induced abortions. Of the 14.3% of women who report having an induced abortion, 88% of them state their reason was related to not being formally married, not having marriage permission or not having yet applied for a marriage license.⁴ **Induced abortions are normally performed in an unsafe environment with 83% of women using the “stick method” - insertion of a particular type of stick into the uterus.** Many women are afraid to seek healthcare when needed because they fear being exposed as either having performed an abortion or living together without marriage permission. Nevertheless, a total of 133 women were treated for severe complications related to abortion within a 6 month period.

⁴ The survey showed a direct link between induced abortions and couples who live together before obtaining marriage permission. 32% of women that lived with their partners pre- marriage authorisation had had induced abortions compared to 2% of women who had not.

Unregistered Children

“I have two children, but only one is registered in the family list, another one could not be because I delivered before I got (marriage) permission. NaSaKa asked 100,000 kyats to register this baby on the list but we could not pay, so my baby has no place and no way to live here”. **Woman, 27, Maungdaw.**

A child born to unofficially married parents or a third child born to officially married parents begins life with no social or legal status. They cannot marry, work or reside formally in their communities and many are either sent away to Bangladesh or must leave to Bangladesh when they become older. The only way out is to seek to register these children through the payment of excessive and arbitrary sums to authorities. 90% of women interviewed declared that if a woman has more than two children she has difficulties to register them in the “family list.”⁵ 79% of them reported the need to pay more for birth registration for any child born after their second child, and 12% declared that from the third child onward it is not possible to register the child at all.

“As I was not officially married and could not register my child, we paid 1 lakh (100,000 kyats) to the Village Authority to have him registered as my brother’s child on his family list. He has marriage permission. I wanted my child to be registered.

But now he lives with my brother’s family, he must seem to be his child, not mine, I cannot acknowledge he is mine in public for fear they (NaSaKa) may find out and we are punished”. **Man, 31, Maungdaw South.**

Travel Restrictions: Deadly Delays

“My sister’s husband died waiting for a travel authorization last month. He was referred to Sittwe, but he had to wait three days for the authorization and during this period he passed away”. **Woman, 37, Maungdaw.**

85% of heads of household declared the need to have travel authorization to leave their villages, even to access emergency care. Fees are often prohibitive and delays in obtaining travel authorization, even when payments are made,

can be fatal. 81% of women interviewed stated that they face problems travelling at night and almost half (47%) of these confirmed this was because of checkpoints, with another 20% stating that the reason was no authorization to travel at night due to the curfew. Many related a fear to travel as the main reason why they do not seek medical care outside of their home for complications during pregnancy. Still, 1192 patients were facilitated access to secondary healthcare facilities between January and September 2011. However, without this assistance many patients would face transport difficulties and/or would not be able to afford the cost of the travel authorisations needed to access these facilities.

“My neighbour died during the delivery of twins. She tried to give birth with the traditional birth attendant at home, but it was not successful. It was night and she could not move to the hospital. We were afraid of the check point, she did not have permission to travel and we could not find transport for her. She died at 5 am, she was 39 years old and leaves seven surviving children”.

Woman, 24 Maungdaw South.

⁵ A list used by the authorities to track and control the population. Those on the list are at least recognized even if such recognition is limited and does not extend to the full rights of a citizen.

BANGLADESH

Unregistered and Unrecognized: The Health Consequences

The high prevalence of acute protein energy malnutrition is currently an overwhelming health problem among children less than 5 years of age in Kutupalong makeshift camp, home to around 22,000 unregistered Rohingya refugees in Cox's Bazar district. In September/October 2010, a nutritional survey conducted in the Camp indicated emergency levels of Global Acute Malnutrition (GAM) - 30.4%; and Severe Acute Malnutrition (SAM) - 5.6%. A follow up survey in October 2011 has shown similar rates of malnutrition, with GAM at 26.8% and SAM at 3.7%.⁶

Disease is an important immediate contributing factor to malnutrition; 61% of children surveyed were also diagnosed with illness. From January to September 2011, 440 (8.6% of the total under 5 population) severely malnourished children with medical complications mainly from Kutupalong makeshift camp were admitted to a clinic in the camp. Further, the data depicts signs of continuing deterioration amongst the under fives. The 75 days retrospective crude mortality rate (CMR) and under five mortality rates (U5MR) of 0.56⁷ and 1.39⁸ respectively indicate an alert situation.⁹

The under 5 population of Kutupalong makeshift camp also have a prevalence rate of 50% for stunted children pointing to deficits in micro and macronutrients consumption. This is due to poor quality diets insufficient in protein and energy. It is also a reflection of consistent and prolonged exposure to disease and inadequate water and sanitation conditions.

“We have nothing here in Bangladesh. Our needs are not met here. We can't really work or live in Bangladesh, we have no food, but we also can't return to Myanmar never ever.”

Woman, 45, Kutupalong Makeshift Camp.

As families living in the Makeshift Camps are neither eligible for formal assistance under Bangladesh regulations nor legally allowed to work or receive any form of food support, their situation is extremely precarious. NGO clinics account for 80% of assistance sought by mothers with sick children.

However authorized access by NGOs to the unregistered refugees to deliver much needed health care is currently denied by the government of Bangladesh. NGOs face continued hindrance by the government of Bangladesh in accessing and assisting this community. Without official recognition, the unregistered refugees will continue to endure unacceptable levels of suffering, remaining extremely vulnerable and in need of immediate assistance.

⁶ According to international standards, GAM prevalence above 15% is considered an emergency.

⁷ Confidence interval [0.25-1.27]

⁸ Confidence interval [0.49-3.91]

⁹ For crude death rate <0.5 is Acceptable, 0.5 to <1 is Alert, 1 to <2 is Serious, while 2-<5 is Critical. For under five years death rate <1 is Acceptable, 1-1.99 is Alert, 2-3.9 is Serious, while 4-9.9 is Critical.

CONCLUSIONS

The surveys conducted in Myanmar and Bangladesh directly link restrictions placed on, and abuses directed toward the Rohingya people with an impact on their health status.

Marriage and travel restrictions in Myanmar have severe consequences. They produce harmful and fatal outcomes, particularly related to unsafe abortions, and are often the driving factor behind why many flee to Bangladesh. Marriage restrictions and their relentless social, economic and health effects on the community must be addressed. The policy of restricting marriages and limiting the number of pregnancies of Muslim women in northern Rakhine State must be abolished.

The critical nutrition situation in Kutupalong makeshift camp indicates the neglect and abuse faced by the unregistered refugees. The refusal of the Bangladesh government to officially recognize this population traps them in a cycle of injustice and suffering. The Rohingya must be ensured a healthy and dignified life and if, due to a well founded fear of persecution, they choose to leave their homeland then they should be afforded refuge and assistance in accordance with humanitarian standards and international law.

METHODOLOGY

Information for the Reproductive Health Survey comes from a combined quantitative and qualitative reproductive health survey conducted in Northern Rakhine State, Myanmar between July and October 2011. Sample size was calculated according to prevalence rate of refused medical care by family members at 13.3% (UNHCR). 479 independent observations were found to be needed to achieve a precision of 20%. A sample size of 400 was agreed to be an acceptable compromise. A total of 450 households were selected and 406 women were interviewed. A total of 9 village tracts were randomly selected and in each one of them 5 hamlets were selected. Within each hamlet, 7% of the total number of households was selected and within each household a list of women aged between 12 and 45 who had been pregnant in the previous 5 years was compiled. From this list one woman was randomly selected. Interviews consisted of closed-end questions collecting demographic information (age, origin, family size...) and child mortality from the women and their children. Marriage was further investigated with collection of marriage authorization information and its consequences.

Information for the Nutrition Survey of Kutupalong makeshift camp, Bangladesh was gathered using the Standardized Methodologies for Assessments in Relief and Transitions (SMART) cluster sampling technique, and was conducted in October 2011. An estimated Global Acute Malnutrition (GAM) prevalence rate of 25% - precision of 4.0% and design effect of 1.5 - was used to estimate a sample size of 675 children. The selection of sample households was done based on the Extended Programme of Immunization random walk method. Children aged 6-59 months were included and had weight for height measured, and categorized according to WHO Z-scores.

